MENTAL HEALTH AND WELL-BEING AMONG TAMIL YOUTH OF SRI LANKAN ORIGIN LIVING IN TORONTO: A MIXED METHODS APPROACH

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Abstract

Literature on the mental health of Tamil youth of Sri Lankan origin living in Canada is scant. In this study, I applied an interpretive descriptive approach to explore, discover, and understand the meanings, beliefs, practices, and experiences of health, well-being, and mental health of thirteen first and second-generation Sri Lankan Tamil youth. I used a convergent parallel mixed methods research design and applied an emancipatory approach to informing culturally competent mental health nursing practice, influenced by critical race, postcolonial feminist and intersectionality theories. Parents, the Tamil community and Tamil culture emerged as major themes reflecting the important roles they play in Tamil youth's mental wellbeing. Experiences related to the Sri Lankan civil war/genocide and immigration appear to impact both collective and intergenerational trauma and resilience. Recommendations include applying a holistic, trauma-informed and integrated/multilevel approach, including traditional and collective methods of healing, capacity building and recognition/acknowledgement of the Tamil Genocide.

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Dedication

To those who fought for my right to education and freedom. Without you, I might not be alive to tell this story. To Canada, thank you for the privilege to call you home and the openness to hear our voices. To the Tamil community, thank you for the opportunities. I hope the information in this thesis challenges, teaches, and helps you in some way.

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List of Abbreviations

WHO – World Health Organization

CNO – College of Nurses of Ontario

RNAO – Registered Nurses Association of Ontario

IRER – Immigrant, refugee, ethnocultural and racialized

ED – Emergency department

MHCC – Mental Health Commission of Canada

MH – Mental Health

HPAS – Health Promoting Activities Scale

LTTE – The Liberation Tigers of Tamil Eelam

1.0 Chapter One: Introduction

Health has always been a challenging concept to define and over time, in the process of grasping for a definition that is inclusive of all aspects of health, there has been a gradual shift from the medical approach to a more holistic approach to health. The Constitution of the World Health Organization (WHO) states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946). Human abilities and interactions such as thinking, experiencing emotions, interacting with others, supporting one's living, and enjoying life are essentially dependent on mental health and well-being (WHO, 2018). Good mental health contributes to a state of well-being where individuals realize personal abilities, manage common life stressors through resilience, work effectively and contribute to society (WHO, 2018). The determinants of mental health include social, economic, and environmental aspects, and their intersections with gender and life stage (WHO, 2014), as well as political, psychological, and biological factors. These determinants are reflected in the ways that individuals grow, develop, and experience life influenced by their families, peers, communities, environments, and global and local political contexts (Khanlou, Bender, Mill, Vazquez, & Rojas, 2018). The types and ways in which these intersections occur contribute to the health inequities that individuals and groups face. As such, mental health promotion, protection and restoration play significantly important roles at individual, societal and global levels (WHO, 2018).

Recent literature recommends a life course approach to understanding and addressing health inequities (WHO, 2014). The period between the ages of 18 and 29 can be a particularly challenging time for those living in high income countries due to the increased prevalence of mental health illnesses such as anxiety disorders, mood disorders and substance

misuse (Arnett, Žukauskienė, & Sugimura, 2014). Jeffrey Jensen Arnett identified the period occurring in modern industrialized societies roughly between the ages of 18 and 29, as a distinct developmental period called emerging adulthood (Arnett, 2000). Consideration of the recent cultural and economic changes in developed countries is paramount to contextualizing the experiences of this population and identifying the need for the recognition of this developmental period as distinct from adolescence and adulthood. The shift in the economy from one previously based in manufacturing to now being based on more professional services requires individuals to have higher levels of education resulting in individuals spending more time obtaining this education (Arnett, Žukauskienė, & Sugimura, 2014). Additional cultural changes in the delayed timing of marriage, parenthood, and entrance to work that is stable has further contributed to the transition period to adulthood being longer and occurring later in life than it has in the past (Arnett, 2000; Arnett, Žukauskienė, & Sugimura, 2014).

Postponing these transitions until at least the late twenties leaves the late teens and early twenties available for exploring various possible life directions (Arnett, 2000). This crucial period of social and developmental growth is culturally influenced and can involve professional and interpersonal role experimentation/changes, identity development, and the navigation of independence (Arnett, 2000). As a result, experiences during this period of emerging adulthood are quite unsettled compared to the experiences that those in this age group experienced historically. On the one hand, mental health challenges and disorders during this stage can be impairing and result in limitations in work, education, and social abilities (Wittchen, Nelson, & Lachner, 1998). On the other hand, positive coping and resilience can enhance mental health, and in turn opportunities for success, happiness, and

fulfillment. Healthy development during these crucial stages can prevent mental health problems and promote good mental health.

Experiences of immigration can further compound and magnify the mental health challenges experienced during this life stage, especially if the individuals or their families originated from countries engulfed by sectarian violence or civil war. Kessler et al. (2007) noted that the highest risk-to-prevalence ratios of mental disorders were in countries exposed to sectarian violence. Tamil people of Sri Lankan origin currently living in Canada belong to such a group. I also refer to this population as Tamils in this thesis. Most of this population left their homeland because of a civil war which stemmed from postcolonial differences between the Tamil minority and Sinhalese majority. The war lasted over 30 years involving genocide and war crimes and ended in 2009; however, political tensions on the island persist. The first and second-generation Canadians belonging to this population have grown up navigating between the dual cultural backgrounds, identities, and political climates of their, or their parent's, country of origin, and that of the country they grew up in. Similar to the generation of Tamils preceding them, these emerging adults continue to grow, receive education, and contribute to the Canadian labour market, culture and community. Despite their ongoing contributions, and unique experiences, research on Tamil youth of Sri Lankan origin and their mental health is scarce. Thus, the purpose of my thesis is to expand and contribute to the literature on Tamil youth of Sri Lankan origin and their mental health. As I myself belong to this same community, I address my positionality vis a vis the thesis focus in chapter three.

1.1 Background

In 2012, Canada launched a new Mental Health Strategy recommending the expansion of our understanding of the challenges faced by diverse immigrant populations through focused

mental health research (Mental Health Commission of Canada, 2012). One of the goals of the strategy is to improve mental health services and supports by and for immigrants, refugees, ethno-cultural and racialized groups (Mental Health Commission of Canada, 2012); however, there remains a paucity of research focused on the mental health of the ethnocultural population of Tamil Canadian youth. I hope to close this gap in knowledge through exploration of the meanings, beliefs, practices and experiences of mental health and well-being of first and second-generation Tamil youth of Sri Lankan origin. I identify relevant determinants of mental health for this population within the context of a systems framework and apply Wesp et al.'s (2018) emancipatory approach to cultural competency which is informed by critical race, postcolonial feminist and intersectionality theories. In other words, I examine identified determinants of mental health within individual, micro, meso, and macrosystems and the ways in which social constructions of power and privilege manifest within these systems as it relates to shaping the mental health of Tamil youth (Crenshaw, 1989; Khanlou, Bender, Mill, Vazquez, & Rojas, 2018). By acknowledging Tamil youth's social constructions of difference including historical, cultural, political and developmental contexts (Caiola, Docherty, Relf, & Barroso, 2014; Khanlou, Bender, Mill, Vasquez, & Rojas, 2018), I analyze the relations between their identity and the structural systems of society that maintain them (Collins, 1990; Stewart & McDermott, 2004) including the acts and policies that work together to create social location (Warner, 2008). I then make recommendations for ways in which mental health care, services and support can be provided to this population.

A systems perspective was applied to the following sections in chapter one. Section 1.1.1 starts at the individual level and discusses individual experiences of mental health and resilience, as well as statistics related to the prevalence of mental health disorders and disabilities within

Canadian youth. Next, section 1.1.2 moves into the microsystem to examine the factors of employment and education as it relates to mental health during this life stage. Section 1.1.3 expands the discussion into the level of the mesosystem by reviewing the Canadian mental health system's current status, issues, and actions. Lastly, section 1.2 reviews the significance of the research through discussions at the macrosystem level about the historical and political aspects of the evolving youth population in Canada. It justifies the need for increased health equity and social justice for specific populations including Tamil youth. Chapter one concludes with a discussion on the aims and purpose of this thesis, and the definitions and conceptualizations used within it. Factors at the macrosystem level are continuously discussed in chapter two.

1.1.1 The mental health status of Canadian youth.

Overall, more than 6.7 million people in Canada, or in other words, one in five Canadians lives with a mental illness or addiction problem in any given year (Smetanin, et al., 2011; Mental Health Commission of Canada, 2013). Mood and anxiety disorders are the most prevalent conditions across the age range (Mental Health Commission of Canada, 2013). In 2017, one in five Canadians above the age of 15, had one or more disabilities according to the Canadian Survey on Disability, with mental health disabilities being the fourth most common disability (Morris, Fawcett, & Hughes, 2018). The prevalence of mental health related disabilities was higher among women than men, with women being twice as likely to have a mental health related disability (Morris, Fawcett, & Hughes, 2018). Mental health related and learning disabilities were also the most prevalent disability among youth aged 15 to 24, representing about 60% of those in this age group with a disability and effecting three out of five youth (Morris, Fawcett, & Hughes, 2018). Disabilities also often co-occurred with other types of disabilities with the number of disability types increasing with age (Morris, Fawcett,

& Hughes, 2018). Among youth aged 15 to 24 with a disability, 19% reported four or more disability types, with mental health related and learning disabilities co-occurring in about 25% of all youth with disabilities (Morris, Fawcett, & Hughes, 2018).

When speaking about mental health, the topic of suicide cannot be neglected. Although suicide rates are decreasing, approximately 4000 Canadians continue to die by suicide each year (Statistics Canada, 2018). Overall, men were involved in more than 75% of suicides while women attempted suicide three to four times more often (Statistics Canada, 2018). In 2017, among youth aged 15 to 24, suicide accounted for 385 male deaths and 162 female deaths making it the second leading cause of death in this age group, second only to accidents (Statistics Canada, 2019). It is important to note that the rate of suicide among Indigenous youth is 5 to 6 times that of youth of non-Aboriginal descent (Health Canada, 2015). Despite these statistics, in 2016, about 75% of youth aged 15 to 24 felt resilient, hopeful about the future, and happiest while working hard (Statistics Canada, 2018a) and approximately 62% perceived their mental health to be very good or excellent while approximately 11% perceived it to be fair or poor (Statistics Canada, 2018b) .

The foundation for a healthy life is formed through healthy emotional and social development early on in life. Individuals who have mental health problems as children are more likely to develop into adolescents, and eventually into adults, with mental health problems and illnesses (Smetanin, et al., 2011). About 70% of mental health issues start during adolescence or childhood (Government of Canada, 2006) and by the time Canadians reach the age of 25, a fifth of them will have developed a mental illness (Mental Health Commission of Canada, 2019), and by age 30, half of them will have, or have had, a mental illness (Smetanin, et al., 2011). Despite Canada being a wealthy nation, it alarmingly ranked

17th out of 29 countries for overall child well-being, and 26th out of 35 countries for overall child inequality in 2013 (UNICEF Canada, 2016). In 2017, UNICEF's assessment of Canadian children's status compared to 41 other rich countries ranked it 25th for child and youth well-being (UNICEF Canada, 2017). In this 2017 report, Canada was ranked relatively high for indicators for responsible consumption and production, quality education, decent work and economic growth and reduced inequalities (UNICEF Canada, 2017). Canada was placed near the bottom for other indicators in comparison to peer nations, ranking 29th for good health and well-being, 32nd for poverty, 37th for hunger, food security and nutrition, and 37th for peaceful and inclusive society (UNICEF Canada, 2017). Alarmingly high rates of relative income poverty, and violence in children's lives were also identified with Canada having the 5th highest rates of child victims of homicide as well as the 5th highest rates of bullying (UNICEF Canada, 2017). Child poverty produced inequalities impact child development and health which become evident once children begin school, but can also continue to negatively impact them lifelong, particularly in the realms of health and completion of education, which can then translate into differences in earnings during their adult years (UNICEF Canada, 2017; Heckman, Pinto, & Savelyev, 2013). Moreover, the emotional, psychological and/or physical violence involved with bullying is associated with poorer levels of health, self-esteem, and educational outcomes, as well as increased depression, and suicidal ideations (UN Special Representative of the Secretary-General on Violence against Children, 2016). With such alarming rates, it is no wonder that amongst Canadian children and youth, approximately 1.2 million are affected by mental illness (Mental Health Commission of Canada, 2019).

Adolescence and young adulthood are also crucial periods in human development, often involving dramatic physical and social transformations, as well as various life stage complexities and challenges. Given this vulnerable life stage, youth aged 15-24 experienced the highest rates of mood disorders and/or substance use disorders than any other age group in Canada in 2012 (Pearson, Janz, & Ali, 2013). In Canada, 31% of youth aged 15 to 24 reported experiencing a mental health or substance use disorder in 2012, with 19% experiencing it in the last 12 months (Statistics Canada, 2019a). In Ontario, just over a third of students in high school reported moderate-to-serious levels of psychological distress, 14% reported a serious level of psychological distress, 14% reported having seriously contemplated suicide in the last year, and 4% having attempted it (Boak, Jamilton, Adlaf, Henderson, & Mann, 2016). The highest rates of mental health problems or illness occur among adults between the ages of 20 and 30, which is also the age range with the highest rates of mood and anxiety disorders (Mental Health Commission of Canada, 2013). Women's prevalence rates of mood and anxiety disorders are more than double that of men, while men experience almost three times the rate of substance use disorders – both respectively peaking in their 20s (Pearson, Janz, & Ali, 2013; Mental Health Commission of Canada, 2013). The fact that prevalence rates within both males and females peak to about 28% between the ages of 20 and 29 is of particular concern as this life stage often involves transitions into or between post secondary education and/or workforce (Mental Health Commission of Canada, 2013; Shanmuganandapala & Khanlou, 2019). The challenges that individuals face during early adulthood, including those between the ages of 18 and 29, can have major and/or life altering implications, and in some cases, lifelong consequences to their quality of life (Mental Health Commission of Canada, 2013; Shanmuganandapala & Khanlou, 2019). These include criminal justice system involvement (Murphy & Fonagy, 2013), loss of income

and/or productivity, career related delays, and individual and familial distress (Mental Health Commission of Canada, 2013; Shanmuganandapala & Khanlou, 2019).

In this section, I reviewed statistics related to the prevalence of mental health disorders and disabilities within Canada. At the individual level, I reviewed factors from childhood to adulthood including individual experiences of mental health and resilience, statistics related to the prevalence of mental health disorders and disabilities, and differences between males and females. Canada's low ranking for child inequality compared to other similar countries raises the question of how these conditions continue to impact subsequent life stages such as during the emerging adulthood period. As statistically presented in this section, emerging adulthood is a time of high vulnerability to a multitude of mental health illnesses and challenges emphasized by important experiences and transitions. Expanding on the discussion from the introduction related to the experiences of the emerging adulthood period differing from the experiences of this age group from the past, and between cultures, I draw attention to the need to better understand the experiences of this population as it applies within different immigrant, refugee, ethnocultural and racialized (IRER) groups. One way of increasing such an understanding is through my thesis which examines the meanings, beliefs, practices and experiences of mental health and well-being among Tamil emerging adults.

1.1.2 Individual and societal impacts.

As previously discussed, employment and education play critical roles in the lives of individuals in the life stage between 18 and 24 years of age, where the opportunities, challenges and experiences can highly impact the current and future quality of their lives. The following section will focus at the microsystem level on the impact of mental health related disabilities in this population's employment and educational opportunities.

The Canadian Survey on Disability (2017) indicated that in 2012, although most Canadian youth were enrolled at academic institutions, those with mental illnesses were less likely to be high school or university graduates, and had relatively lower levels of educational attainment compared to youth without such illnesses. In addition, around half of adults between 25 and 64 who had a disability during their school years reported that their condition impacted their course and career related decisions (Canadian Survey on Disability, 2017). About a quarter to a third of these individuals reported taking fewer courses, taking longer to complete their education, experiencing long periods of interruptions in their education and/or discontinuing their studies (Canadian Survey on Disability, 2017). In addition to the negative impacts in the academic world for those with disabilities, differences in the workforce presents yet another challenge. A longitudinal study found significant associations between individuals between 18 and 25 with a psychiatric disorder and decreased employment, income and living standards at age 30 (Gibb, Fergusson, & Horwood, 2010). In 2017, employment rates for persons with disabilities (59%) were lower than employment rates of persons without disabilities (80%) (Canadian Survey on Disability, 2018).

Stigmatization includes negative social responses to mental illnesses and can result in prejudice, discrimination and social exclusion of individuals with mental illness (Patten, et al., 2016). Over the past five years, mental illness related stigma has decreased, mental health related awareness has increased, and attitudes surrounding mental health have improved overall, yet stigma continues to be a barrier for many (Bell Canada, 2015). Approximately 40% of individuals aged 25-64, who had a disability during school attendance, reported others avoiding or excluding them in school, while 27% experienced bullying (Canadian Survey on Disability, 2017). Furthermore, in relation to employment challenges, about 50% of Canadians who were

employed with a mental health-related disability expressed that their condition presented difficulties related to changes or advancement in their career, and a quarter of this half attributed the reason to be a result of stigma or discrimination (Canadian Survey on Disability, 2019). Other challenges and barriers included not disclosing mental health problems to managers at work, where a quarter of persons with disabilities who held employment reported that their employer was not aware of their work limitation (Canadian Survey on Disability, 2017) while others were concerned about the impact on work if a colleague was affected by a mental illness (Canadian Medical Association, 2008). Youth who were not employed, or in school were most vulnerable. Youth who are not in employment, education, or training are at higher risk for depression and at being socially excluded (Brunet, 2018). The mental health related public and self-stigma resulting from these experiences are further heightened for those belonging to an IRER group, and unfortunately impacts their openness to seeking help, and thorough participation in treatment (Gary, 2005). At this particular life stage, the major impacts occur in relation to youth's education and employment, which are important considerations to the strongest determinant of health -their current and future incomes.

Youth with a mental health related and/or a learning disability often experience challenges in both obtaining education and employment. In fact, according to the 2017 Canadian Survey on Disability, 90% of youth who were neither enrolled in school nor employed had a mental health related disability and/or a learning disability (Morris, Fawcett, & Hughes, 2018). Furthermore, out of the total 108 790 youth with disabilities who did not attend school or hold employment in 2017, 83 400 of them were identified to have the potential to work, with 84% of them having a mental health-related and/or learning disability, and women having more potential to work than men (Morris, Fawcett, & Hughes, 2018). The combined challenges in the areas of

employment and academics ultimately impacts the overall health of individuals with disabilities through income, a key social determinant of health. Individuals with disabilities were more likely to be living in poverty, with the severity of their disability, living alone, and living in a lone parent home increasing this likelihood (Morris, Fawcett, & Hughes, 2018). Those aged 25-64 with a disability had a lower median income compared to individuals without disabilities (Morris, Fawcett, & Hughes, 2018). There were also notable differences between the sexes with women outnumbering men within the population with disabilities, but also among the population that were unemployed but with potential to work (Morris, Fawcett, & Hughes, 2018). In addition, more women were single parents, living alone, living in poverty, had lower levels of income and lower rates of employment compared to men (Morris, Fawcett, & Hughes, 2018). On the other hand, young women were more likely than men to be employed while completing school, regardless of the severity of disability (Morris, Fawcett, & Hughes, 2018).

Positive mental health contributes to positive social functioning through a decreased probability of education abandonment, and increased levels of resilience, achievement, and higher income potential (Jané-Llopis & Braddick, 2008); therefore, influencing positive mental health through prevention and early intervention may lead to better mental health outcomes. By analyzing the meanings, beliefs, practices and experiences of Tamil emerging adults of Sri Lankan origin, my thesis will identify the challenges and opportunities as it pertains to influencing positive mental health. It will further offer recommendations to increase positive mental health through prevention and early intervention for this population and similar populations.

1.1.3 The Canadian mental health system and economic impacts.

In recent years, perhaps as a result of anti-stigma campaigns, there has been a considerable increase in demand for mental health care and services. Despite improvement in the last ten years (HQO, 2018), the demands are not being met due to systemic issues formed by a fragmented system, lack of resources in the community, long wait times for care, and services that are not culturally competent (Government of Canada, 2019; Shanmuganandapala & Khanlou, 2019). The following section will focus at the mesosystem level on Canada's mental health care system and services, its challenges, and economic impacts. It will also discuss the current action being taken by the Canadian government to address the challenges within this system to improve the quality and accessibility of mental health care.

Physician-delivered counselling and psychotherapy services for individuals aged 5 to 24 have increased 10% between 2007 and 2012 (Canadian Institute for Health Information, 2015), agencies serving children are experiencing increased use, and the use of professional counselling such as through the phone, text or online have also increased (Kids Help Phone, 2017; Kids Help Phone, 2018). Although these statistics signal an increase in the use of mental health services, studies show that the prevalence of mental illnesses among children and youth has not changed over time (Canadian Institute for Health Information, 2018). Furthermore, there is a significant portion of the Canadian population that is not receiving the help they need, when they need it. In 2012, a third of Canadians over the age of 15 with mental health care needs in the past year reported that their needs were not fully met (Sunderland & Findlay, 2013). According to the 2017 Canadian Survey on Disability, about a quarter of over a million Canadians with a mental health-related disability did not receive the counselling services they required, and half of those who did receive it, reported requiring more (Canadian Survey on Disability, 2019).

Despite the increasing demand for mental health services, the government of Ontario was found to have failed in making the necessary changes to service-delivery methods to address this increased demand (Office of the Auditor General of Ontario, 2016). The result of a lack of action to address increased demands for mental health services also presents another accessibility challenge by way of increased wait times, and further risks to deterioration of health during this period (Shanmuganandapala & Khanlou, 2019). For children and youth in Ontario, wait times up to six months for counselling and therapy are common (Office of the Auditor General of Ontario, 2016). During this period, deterioration of health can proceed to the point of crisis and can be especially harmful for children and youth due to their developmental stage (Wait Time Alliance, 2014). Aside from the impact on health, individuals and their families are also impacted from an economic perspective. The waiting period can result in potential loss of income from the illness, and further deterioration during this time can extend time the required for recovery causing additional loss of income (Wait Time Alliance, 2014).

In due course, those who are unable to receive the help they need in the community in a timely manner, are increasingly landing in the rooms of emergency departments (EDs) and hospitals. More than 41% of individuals under the age of 24 in 2016 had not received care from a family doctor, pediatrician or psychiatrist in the last two years before their ED visit for mental illness or addiction (Health Quality Ontario, 2018). The Canadian Institute for Health Information (2018) noted that since 2006/07, visits to the ED by children and youth with mental disorders had increased 66% and their hospitalizations had increased 55%. Similarly, the Office of the Auditor General of Ontario's (2016) report found that since 2008/09, hospital emergency-room visits and in-patient hospitalizations for children and youth with mental-health problems had increased more than 50%. These factors are increasing wait times in EDs by adding further

strain to an already strained system. As a matter of fact, in comparison to eleven other countries, Canada was found to have the highest proportion of patients waiting four or more hours during a visit to the ED (Canadian Institute for Health Information, 2017). Furthermore, those over the age of 16 who were discharged after being hospitalized for a mental illness or addiction are also not being followed up by doctors in the community more than half the time in Ontario (Health Quality Ontario, 2018). This limits smooth transitions and prevention of re-hospitalization or return to the ED for these individuals. The increases in ED visits and hospitalizations may be a result of fragmented or limited services at upstream levels where youth are experiencing challenges in accessing timely and appropriate care (Canadian Institute for Health Information, 2011; Canadian Institute for Health Information, 2015). These findings are concerning as early interventions, such as services at home and in communities, have found to be the most effective in serving this population (Mental Health Commission of Canada, 2016).

The impact of mental health issues and wait times are not isolated to the affected individuals and families and ultimately have major economic impacts to society (Shanmuganandapala & Khanlou, 2019). ED visits and inpatient stays related to mental illness cost double those related to other reasons (Canadian Institute for Health Information, 2015). Furthermore, the cost of treating patients in specialty psychiatric hospitals is more expensive than treatment in community or other hospital settings (Office of the Auditor General of Ontario, 2016). Children and youth accessing these services for mental health reasons significantly contribute to this cost as they are more likely to have repeated visits and hospitalizations than those using it for other reasons (Canadian Institute for Health Information, 2015). In 2003, the total economic burden of mental health, including, medical resource use, work loss, and reductions in health-related quality of life, was estimated to be $51 billion (Lim, Jacobs,

Ohinmaa, Schopflocher, & Dewa, 2008). The economic burden only continues to grow given the increasing ED visits and inpatient hospitalizations for mental disorders (Canadian Institute for Health Information, 2018).

In Canada, mental illness has been identified as one of the top three types of disability claims in workplaces (Mental Health Commission of Canada, 2013). As previously mentioned, workplaces are highly impacted as mental health problems and illnesses effect 21% of the working age population (Mental Health Commission of Canada, 2013). By 2030, mental illness is predicted to be the leading cause of disability in high income countries (Mathers & Loncar, 2006) and the Mental Health Commission of Canada (2013) estimates that with cost predictions for treatment, care, and support services, this burden will reach over $2.5 trillion in the next 30 years. These realities are reasons why improving mental health services and supports is currently a high priority for both the Canadian federal government, and the Ontario provincial government.

Evidence suggests that promotion, prevention, and early interventions targeted at children and families, including parent education and family support, are effective and economical solutions to address these challenges (Mental Health Commission of Canada, 2013). However, delivery and effectiveness of such interventions can differ between cultures, communities and families, and the current research on IRER populations is limited. I seek to fill this gap in research and identify the best approach for the Tamil community through the findings of this thesis. In the long run, I hope this information contributes to directing funding and services for similar communities in order to increase the quality and accessibility of our mental health care system and decrease its negative economic impact.

Current Canadian action.

In 2017, the Government of Canada took action to respond to the increased demands of Canadians and address the required improvements to home and community care, and mental health and addiction services through an investment of $11 billion over ten years (Government of Canada, 2019a). All Canadian provinces and territories accepted The Common Statement of Principles on Shared Health Priorities, a statement guided by the principles of collaboration, innovation, and accountability, outlining collective priorities in line with this commitment (Government of Canada, 2019a). These priorities included increasing access to mental health and addiction services and supports especially for children, youth, and those with complex health needs by addressing gaps in the system by expanding access to community-based services which recognizes the effectiveness of early interventions, and availability of evidence based, integrated, and culturally-appropriate interventions (Government of Canada, 2017). Other priorities in The Common Statement included working with Indigenous populations to address their identified health priorities while promoting respect and reconciliation, and the collection and annual reporting of outcomes to assess the impact of the shared health priorities (Government of Canada, 2017).

Beginning in 2017, Ontario is to receive a total of $2.3 billion for home and community care and $1.9 billion for mental health and addictions over a ten-year period as per the Canada-Ontario Home and Community Care and Mental Health and Addictions Services Funding Agreement (Government of Canada, 2017; Government of Canada, 2019b). So far in 2017-2018, Ontario was provided $57.07 million to expand access to home care, and $20 million for caregiver supports. Notional allocations (subject to annual adjustment based on a per capita basis for each Fiscal year) of $211.99 million to expand access to home care

and $20 million for caregiver supports have been made for 2018-2019 (Government of Canada, 2019). This agreement, to be renewed in 2021-2022, acknowledges issues in the mental health and addictions system including high wait times, limited service capacity, barriers to access, uneven service quality, lack of data, and a fragmented system (Government of Canada, 2019). Difficulty navigating the system as a result of lack of transparency and poor coordination of services and gaps in critical services were also identified (Government of Canada, 2019). The bilateral agreement outlines Ontario's five-year investment plan for approximately $1.9 billion which includes supporting child and youth mental health services by increasing access to community-based mental health and addiction services and supports, increasing funding for postsecondary institutions to create integrated supports for students, and increasing services for priority populations such as IRER, French-speaking and LGBTQ2S populations (Government of Canada, 2019). Health services have a low usage by individuals with mental health problems or illness within IRER populations; however, as this group may be accessing higher intensity services such as those at hospitals (Mental Health Commission of Canada, 2016), increasing research on this population would be helpful in informing services, and decreasing economic impact. These increased investments into mental health care and services are long awaited. It is a step in the right direction as the strongest evidence for return on investment of mental health resources are programs and interventions targeted towards children and adolescents (Canadian Institute for Health Information, 2011), and the key to addressing mental health lies in health promotion, illness prevention and early intervention within this population (Canadian Institute for Health Information, 2015).

In section 1.2, I applied a systems perspective from the individual to the mesosystem level and provided an overview of the mental health status of overall Canadian youth, the resulting societal impacts and the current state of the Canadian mental health system and services. However, considering that Canada is a multicultural nation, it raises questions about the role that this aspect plays at a macrosystem level on youths' experiences, if any. I address these questions in the next section I highlight the significance of the current research by discussing the changing dynamics of the youth population in Canada. I further discuss why an understanding and analysis of the familial, societal, cultural, and institutional contexts in which IRER populations in Canada live is an important consideration in informing the mental health services that are provided to them.

1.2 Significance of the Research

Culture, ethnic origin, age, pre- and post- migration factors, and immigration status all influence mental health-related beliefs, manifestations, descriptions, interpretation of symptoms, behaviours, help seeking, and treatment expectations (Srivastava, 2007; Hansson, Tuck, Lurie, & McKenzie, 2012) and have major impacts on health status, outcomes, and quality of care (Mental Health Commission of Canada, 2016). Unfortunately, the current mental health system has not been designed with these considerations in mind (Hansson, Tuck, Lurie, & McKenzie, 2012). The mosaic of Canada hosts a growing IRER population largely represented by South Asians in many areas. The presence and growth of this population, which includes a large population of Tamils of Sri Lankan origin, simultaneously necessitates a focus on their health, mental health, and well-being. With the current increase in funding from the federal and provincial governments to address health equity, and plans to address the needs of IRER populations,

research is required to support evidence-informed approaches and decision making (Mental Health Commission of Canada, 2016).

The current research is a step in meeting this requirement, and I hope to fill the gap in existing research by discerning the multitude of mental health differences and needs within IRER youth, and between different generations in relation to their health and mental health (Mental Health Commission of Canada, 2016). More specifically, this study seeks to recognize Tamil youth of Sri Lankan origin's perspectives, meanings, beliefs, and approaches to, and experiences with health, well-being, and mental health. I hope to inform services by examining the different pre- and post-migration experiences of this population, and the ways in which these experiences can lead to differences in their mental health (Beiser, 2005) by addressing the intersections of gender, race, ethnicity, culture, and class, within the individual, familial, community, and societal levels. The findings and recommendations of this study can then be used to compare with the needs and challenges of other populations, specifically those with similar experiences. The following quote concisely summarizes why such a study is important in advancing health equity and social justice.

"Assessing health equity requires comparing health and its social determinants between more and less advantaged social groups. These comparisons are essential to assess whether national and international policies are leading toward or away from greater social justice in health" (Braveman & Gruskin, 2003, p. 254).

1.2.1 Evolving mosaic: Majority South Asians within the IRER population.

Over time, the multiple languages, cultures, and religions of various immigrants along with the birth of their subsequent generations in Canada have contributed to the diverse make-up of Canada's population. Canada's population now encompasses more than 250 reported ethnic

origins (Statistics Canada, 2017). The 2016 census revealed that more than one fifth (22.3%) of the nation belonged to a visible minority population, with a third of them having been born in Canada (Statistics Canada, 2017). This population is predicted to continue to increase up to 36% by 2036 (Statistics Canada, 2017). Of the current 7.7 million individuals who identified as a visible minority, 25.1% of them identified as South Asian (i.e. 'East Indian,' 'Pakistani,' 'Sri Lankan,' etc.), representing 5.6% of the national population, and rendering them the largest visible minority group in Canada followed by Chinese and Black IRER groups representing 20.5% and 15.6% respectively (Statistics Canada, 2017).

The 2016 census also revealed that 21.9%, signifying more than one in five Canadians, were or had ever been, a landed immigrant or permanent resident in Canada (Statistics Canada, 2017). This is one of the highest proportions of immigrants in the country's history and is attributable to an increase in the number of admitted immigrants each year complemented by a steady increase in the number of deaths and relatively low fertility levels (Statistics Canada, 2017). From 2011 to 2016, over 1.2 million new immigrants, who now represent 3.5% of Canada's total population, were accepted into the country (Statistics Canada, 2017). These immigrants were mainly admitted under the economic category (with most entering through the skilled workers program) while others were admitted under the family class or as refugees, with Syrian refugees specifically accounting for an increase in the number of immigrants admitted between January 1 and May 10, 2016 (Statistics Canada, 2017). The top source continent for recent immigrants in 2016 was Asia, with over half (62%) of newcomers, and almost half (48.1%) of the overall Canadian population being Asian-born (including the Middle East) (Statistics Canada, 2017).

Although there has been an increase in the number of immigrants settling in the Prairies, and Atlantic provinces, most immigrants settled in Ontario or in Quebec, and over half of the total immigrant population specifically select the metropolitan areas of Toronto, Vancouver, and Montreal to settle/live (Statistics Canada, 2017). As I focus on a demographic in the Greater Toronto Area, it is important to note that it has an even higher portion of visible minorities than the overall Canadian population. Fifty-one percent of Toronto's population identifies as visible minorities with the largest group of visible minorities also identifying as South Asians, at about 12.59% of the total population, followed by Chinese 11.13% and Black 8.91% (Statistics Canada, 2017a). Besides Toronto, more than half the respondents in the municipalities of Markham, Brampton, Mississauga, Richmond Hill, and Ajax also identify as belonging to a visible minority group, with the highest percentage being reported in Markham at 78% (Statistics Canada, 2017a).

1.2.2 The young and growing IRER and South Asian population.

The future of a country's health, economics and overall growth heavily depends on the younger generations. The trends in immigration are reflected in the diversity of this young population along with intergenerational aspects such as exposure and adoption of their parents' heritage, language, and culture (Statistics Canada, 2017b). According to the 2016 census, approximately 17% of the total population in Canada are children aged 0 to 14 years, and 12% are aged 15 to 24 (Statistics Canada, 2017a). In terms of children, 37.5% of the population were either foreign-born (first generation) or had at least one foreign-born parent (second generation) in 2016, with 3 in 10 of these children falling into the latter category (Statistics Canada, 2017b). This differentiated them from the adult population in which the adult population encompassed a higher percentage of first generation and lower percentage of second-generation individuals

(Statistics Canada, 2017b). If the existing trends in immigration continue in Canada, by 2036 children with an immigrant background could increase up to 49% of the total population of children under the age of 15 with Canadian children born to two foreign parents probably experiencing the most significant increase (Statistics Canada, 2017b).

To be more ethnically specific, in 2016, almost half of those with an immigrant background up to the age of 34 had originated from an Asian country (Statistics Canada, 2017b). Respondents between the ages of 15 and 24 who specifically identified as being South Asian totaled 271 935 in Canada, 166 265 in Ontario, and 138 590 in Toronto (Statistics Canada, 2016). Similar to the overall population in these areas, South Asians were the largest visible minority group represented in this age group as well (Statistics Canada, 2016). In 2016, 13% of the population in Toronto identified as being of South Asian origins, with the second and third largest subgroups within this ethnic category being Sri Lankan (2.2%) and Tamil (0.8%), and the largest sub group being East Indian (7.5%) (Statistics Canada, 2017a). The total population of those who selected Sri Lanka and/or Tamil as their ethnic origin was 167,030 people in Ontario, and 78,530 in Toronto (Statistics Canada, 2017a). In terms of gender, the total number of males and females between 18-24 living in Toronto who identified as Tamil and/or Sri Lankan was almost equivalent.

In such contexts of immigration, consideration should be given to the elements of culture, language and heritage which may be adopted, practiced, or integrated in various ways such as intergenerationally through their home environments (Statistics Canada, 2017b). For example, it was found that at least three generations lived in the households of 15% of the children with immigrant backgrounds. In terms of language, more children (33%) spoke only an official language at home, compared with less than 10% of their parents who additionally spoke other

languages (Statistics Canada, 2017b). With South Asian youth being one of the largest and fastest growing IRER groups in Canada, the key to ensuring future positive outcomes for these younger generations is to understand their individual, familial, cultural, and group experiences to inform health promotion. Therefore, my thesis will seek to understand these aspects as it pertains to Tamil youth of Sri Lankan origin living in Toronto and their mental health and well-being.

In the next section, I discuss the current state of healthy equity and social justice for IRER populations as it pertains to risks, needs, gaps in the literature, and current action and recommendations.

1.2.3 Health equity and social justice for IRER populations.

Despite the spotlight starting to illuminate the multiple challenges faced by immigrant, refugee, ethnocultural and radicalized children and youth in Canada, there is surprisingly little research into their mental health and addictions problems (Guruge & Butt, 2015; Hansson, Tuck, Lurie, & McKenzie, 2012). Furthermore, within the limited literature that does exist, a scarce amount of literature disaggregates youth of immigrant groups to asses these issues within these individual groups (Guruge & Butt, 2015; Hansson, Tuck, Lurie, & McKenzie, 2012). A literature review of the rate of mental illness and suicidality in the very few IRER groups that had been investigated in Canada, indicated differences in rate, risks, and needs between generations, and by national origin, age, and status (Hansson, Tuck, Lurie, & McKenzie, 2012). Differing needs and risks within different IRER groups, and even within different generations of the same group has clinical implications for the way that mental health is addressed within these populations (Hansson, Tuck, Lurie, & McKenzie, 2012). The lack of information on rates of mental illness in most IRER groups as well as the lack of research on nonimmigrant populations that are culturally diverse poses concerns regarding how equitable the mental health services in Canada

are to these populations (Hansson, Tuck, Lurie, & McKenzie, 2012). A commonly used definition by Whitehead (1991) described health inequities as "differences in health which are not only unnecessary and avoidable, but in addition are considered unfair and unjust" based on WHO documents. Braveman and Gruskin (2003) expanded on the term of equity identifying it as an ethical principle, equivalent to social justice and consistent with human rights. They operationalized it as "the right to the highest attainable standard of health as indicated by the health status of the most socially advantaged group" (Braveman & Gruskin, 2003, p. 254).

Increased interest in health equity by health organizations at the national and international levels (Braveman & Gruskin, 2003) has contributed to the recognition of differences in underlying social advantages/disadvantages amongst different groups of people and encouraged them to take steps towards addressing the need for research on the mental health of racialized populations. One such step was with the Government of Canada's implementation of The Mental Health Commission of Canada (MHCC) in 2007 to address the mental health of Canadians and the mental health system. In 2012, the MHCC (2012) launched a Mental Health Strategy for Canada including six strategic directions of which one was increasing cultural competence of organizations and health professionals informed by social disparities and intersectionality, to improve services and supports for immigrants, refugees, ethnocultural and racialized groups (IRER). Some of their recommendations included the evaluation of mental health interventions rooted in the heritage of ethnic groups and the increase of access to those that were effective, as well as collaboration and involvement of IRER groups (Mental Health Commission of Canada, 2012).

The focus on these populations was further expanded in 2016, when MHCC released their report named The Case for Diversity: Building the Case to Improve Mental Health Services

for IRER Populations. This report called attention to the lack of research addressing the understandings of mental health outcomes of those who identified as ethnic minorities as a result of them often being grouped into larger groups (Mental Health Commission of Canada, 2016). Hansson et al.'s (2012) review of the literature on rates of mental illness and suicidality in IRER groups in Canada noted that studies considered them together as one group or categorised based on area of geographic origin, but rarely sub categorized the group, such as into first or second generation groups, or considered social risk factors as part of their analysis. Although there exists literature on the adult Tamils of Sri Lankan origin population, literature on the youth of this population in relation to mental health exists only within studies focusing on broader groups like 'South Asians'. Broadly conceptualising pan-ethnic group identities, such as South Asians, homogenizes sub-groups identified as belonging to that group, and disregards aspects that may be exclusive to more specific ethnic groups. For example, most South Asians practice Islam, and commonly speak Punjabi, Hindi or Urdu whereas the majority of Tamils practice Hinduism and commonly speak Tamil. In addition, there are differences in dietary practices, migration histories and socioeconomic factors such as educational levels, income, area of residence and levels of acculturation (Anand & Cochrane, 2005). For example, a recent study by Chiu et al. (2018) found that out of Ontario's four major ethnic groups, between 2001 and 2014, South Asians had a lower prevalence of diagnosed mood and anxiety disorders and lifetime suicidal ideation compared to white individuals, but were the second highest ethnic group at 64% to not seek help despite self-reporting poor mental health and the third highest ethnic group to report poor mental health (Chiu, Amartey, Wang, & Kurdyak, 2018). They recommend culturally and ethnically competent mental health care and supports (Chiu, Amartey, Wang, & Kurdyak, 2018) but failed to recognize or acknowledge the unique differences that may exist in prevalence rates within the

sub groups of each of the four major ethnic groups. This lack of identified differences within IRER groups often leads to inaccurate understanding of rates of mental health problems/illness and service needs, help seeking and health behaviours of that group (Guruge & Butt, 2015; Hansson, Tuck, Lurie, & McKenzie, 2012) ; therefore, MHCC (2016; 2019) recommended each province to collect information on each of the IRER groups such as the size, their mental health needs, and differences in outcomes related to country of origin and between generations.

1.2.4 Addressing mental health equity and social justice for Tamil youth.

Enacting the recommendations made by MHCC (2016) requires further breakdown of the large and growing South Asian population. It is important to note that conceptualizations of ethnic origin can differ in the literature and can also differ on an individual basis affecting the way we attempt to categorize and analyze information based on this indicator. As per the Canadian census, ethnic origin refers to the cultural origins of the person's ancestors and responses reflect each respondent's perception of their ethnic ancestry; therefore, a person may have only a single ethnic origin, or may have multiple ethnicities (Statistics Canada, 2017c). For example, the country of Sri Lanka encompasses a majority Sinhalese and other minority populations including the Tamil population, but Tamil people also originate from India and other countries. Sometimes, children are born and/or live briefly in other countries during trans-migration before they come to Canada. The 2016 Canadian Census offered options to identify as Sri Lankan, Tamil, Sinhalese and/or South Asian (an option that captures general responses to this identity as well as specific responses indicating South Asian origins which are not included elsewhere). These interpretations present a problem in accurately being able to identify the size of the population of Tamils of Sri Lankan origin in Canada as individuals may be selecting more than one ethnic identity. For example, Burghers and other minority groups from Sri Lanka could

be identifying themselves in the ethnic category of Sri Lankan, and Tamils from other countries could be identifying as being Tamil.

Amarasingam (2013) argues that as the vast majority of immigrants and refugees to Canada from the island have been Tamil, it is safe to assume that most of those who identified with Sri Lanka as their ethnic origin are Tamil as well. Arguments also exist that census estimates are smaller than what the Tamil community estimates and Wayland (2003) reasons that this may be due to recent immigrants, and as many as half the population according to some Tamil organizations, who simply do not fill out the census forms. In either case, the Sri Lankan Tamil community of Canada has recognized as the largest to be found outside of Sri Lanka, and one of the major subgroups of the large and growing South Asian population. With such a large population, there is a paucity of research focused on the mental health of the ethnocultural population of Tamil Canadians in Toronto, and no current literature focusing on Tamil youth and mental health currently exists. Despite the unique culture, socio-political experiences and war related trauma of this population, they are often grouped into the larger "South Asian" population during research. This study aims to close this gap in knowledge.

1.3 Aims/Purpose

As it is generally accepted that mental health is more than just the absence of mental illness (World Health Organization, 2001), the purpose of this mixed methods research study was to explore, discover, and understand the meanings, beliefs, practices, and experiences of health, well-being, and mental health from the perspective of immigrant Sri Lankan Tamil youth living in Toronto. A convergent parallel design was used in which the qualitative component was the leading arm of the research study and consisted of an interpretive descriptive research design as described by Thorne (2008). The quantitative component drew its data from the

quantitative survey instruments and was included in the larger design study for the purpose of furthering understanding this population's health, mental health and well-being as it relates to self-esteem and engagement in health promoting activities. In this way, the study addressed the intersections of gender, ethnicity, culture, and class, within the individual, familial, community, and societal levels, to increase the understanding and opportunities for nurses to address and promote mental health, health education, practice/service delivery, and further research in relation to this population.

A study by Almutairi, Adlan and Nasim (2017) analyzed 170 Canadian registered nurses' perceptions of critical cultural competence based on critical awareness, critical knowledge, critical skills, and critical empowerment. They concluded that nurses' country of birth and age/experience may influence their perceptions of critical cultural competence as strengthening cultural competence requires knowledge and awareness of different cultures as well as experiences caring for those from diverse cultures and countries (Almutairi, Adlan, & Nasim, 2017). They recommended cultural education programs to strengthen nurses' level of cultural competence to increase quality of care in cross-cultural interactions (Almutairi, Adlan, & Nasim, 2017). In keeping with the College of Nurses of Ontario's (2009) Standards of Care and Registered Nurses' Association of Ontario's (2007) Best Practice Guidelines regarding cultural competence/culturally sensitive care, I hope this research will be used to cultivate tolerant, accepting and culturally competent nurses and other healthcare professionals who can effectively provide culturally appropriate care, services and support to this population and similar populations.

In summary the objectives are as follows:

a. To close the gap in knowledge related to Tamil youth of Sri Lankan origin and their mental health;
b. Respectfully engage the Tamil community to allow opportunities to actively participate in increasing their mental well-being through a health equity and social justice lens;
c. Cultivate informed and accepting service providers who can effectively provide culturally safe care, services and support to meet the needs of this population and similar populations;
d. To increase research on this subgroup of the IRER which can then be used to inform other studies, and support evidence-informed approaches and decision making at a policy level

1.4 Definitions and Conceptualizations

Before addressing the background literature to my thesis, it is important to explicate definitions of key concepts related to the topic. Health related definitions and conceptualizations are social constructions which influence key aspects of understanding health at varying levels of society. Such aspects of health includes people's health behaviours, decisions, demands and expectations at individual and community levels; and health promotion, care systems, policies, practices, and services on a broader level (Marks, Murray, Evans, & Willig, 2000; Flick, 1998; Hughner & Kleine, 2004; Leonardi, 2018). Social constructions are also influenced by culture, thus necessitating the clarification of the definitions and conceptualizations I used. (Hipolito, et al., 2014)

Health – One's state and ability to manage their conditions of illness and physical, mental and social well-being (WHO, 1946; Leonardi, 2018), by competently coping and reacting to

varying environmental events and factors resulting in “desired emotional, cognitive, and behavioural responses and avoiding those undesirable ones” (Leonardi, 2018, p. 742).

Well-being – Includes psychological well-being (PWB) and subjective well-being (SWB). PWB, or eudaimonia, is a protective tool of strength and the capacity of an individual’s perceived ability to handle life’s challenges. This includes factors such as autonomy, self-acceptance, purpose in life, personal growth, positive relationships and environmental mastery (Ryff, 2014). SWB, or hedonia centers on happiness through acquiring pleasure and avoiding pain. It involves one’s cognitive judgement on their level of satisfaction in life and an affective understanding of the balance of their positive emotions compared to their negative ones (Diener, 1984).

Social determinants of health- Conditions shaped by the distribution of power and privilege at different societal levels, in which people are born, grow, live, work and age (World Health Organzation , 2019). They have strong effects upon the health of Canadians, even beyond those associated with behaviours i.e. diet, physical activity, drug use (Mikkonen & Raphael, 2010) and are mostly responsible for health inequities (World Health Organzation , 2019). These determinants include: Income and Income Distribution, Education, Unemployment and Job Security, Employment and Working Conditions, Early Childhood Development, Food Insecurity, Housing, Social Exclusion, Social Safety Network, Health Services, Aboriginal Status, Gender, Race, Disability (Mikkonen & Raphael, 2010).

Mental Health- The World Health Organization (2016) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. Furthermore, “it is a positive sense of emotional and spiritual well-being

that respects the importance of culture, equity, social justice, interconnections and personal dignity" (Government of Canada, 2006).

Mental Illness – Health conditions where one or more changes in emotions, thinking, mood, or behaviour contribute to symptoms and feelings of distress, isolation, sadness, and loneliness and/or the inability to cope with day-to-day life and function in areas such as social, familial or employment contexts (Government of Canada, 2017; American Psychiatric Association, 2018).

Disability - The World Health Organization's International Classification of Functioning, Disability and Health framework is the internationally endorsed standard for describing and measuring health and disability (World Health Organization, 2001b). This framework recognizes that functioning and disability of individuals occurs in a context, including various environmental factors, and defines disability as the relationship between body function and structure, daily activities and social participation (World Health Organization, 2001b). The 2012 and 2017 Canadian Survey on Disability also used a social model of disabilities where disability was identified as a social disadvantage related to the difficulties arising from the interaction between an individual's functional limitations and environmental barriers, including social and physical barriers, in addition to the individual's impairment (Cloutier, Grondin, & Amelie, 2018; Mackenzie, Hurst, & Crompton, 2009; Statistics Canada, 2014)

Resilience – A characteristic of mental health (Schultze-Lutter, Schimmelmann, & Schmidt, 2016) involving the process and capacity to cope by either adjusting/adapting, or successfully overcoming and achieving better functionality, during periods of adversity, significant experiences of stress, difficulties or trauma (Davydov, Stewart, Ritchie, & Chaudieu, 2010; Rutter, 2013; American Psychological Association , 2019). It is established through an

interactive process of environment, genetics, experiences, protective factors and support (Rutter, 2013).

Immigrant – Persons who are, or have ever been, landed immigrants or permanent residents and have been granted the right to live in Canada permanently, including those who have obtained a Canadian citizenship (Statistics Canada, 2016a).

Refugee- As per Article 1 in the Convention relating to the Status of Refugees (1951), a person outside their country of origin who is unable or unwilling to return to that country due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.

Visible minority - 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour,' e.g., South Asians (Statistics Canada, 2016a).

Ethnic origin - The ethnic or cultural origins of an individual's ancestors as identified by the individual, where an ancestor is commonly more distant than a grandparent (Statistics Canada, 2016a).

Tamils of Sri Lankan origin – Individuals whose ethnic origin is from the country of Sri Lanka. In this thesis, reference to the Tamil diaspora will be referring to this population.

First Generation – Individuals born outside of Canada, and usually who currently are, or once were, immigrants to Canada (Statistics Canada, 2016a).

Second Generation – Individuals born in Canada with at least one parent who was born outside Canada, and usually children of immigrants (Statistics Canada, 2016a).

Third Generation (or more) – Individuals born in Canada with parents who were both also born in Canada (Statistics Canada, 2016a).

Youth –The Public Health Agency of Canada (2011) defines youth as individuals between the ages of 12 and 19, and young adults as individuals between the ages of 19 and 24, while the United Nations defines youth as individuals between the ages of 15 and 24 (Secretary-General's Report to the General Assembly, 1985). For this thesis, youth refers to persons between the ages of 18 and 24 where the defined developmental life stage includes late adolescence and young/emerging adulthood.

1.5 Summary

This chapter covered definitions and conceptualizations as it applies within this thesis, background information on mental health and IRER youth in Canada, how I hope to close the gap in knowledge related to Tamil youth and mental health, the significance of this research, and my positionality as a researcher. The next chapter will provide a more focused literature review on the population of interest.

2.0 Chapter Two: Review of the Literature

The following chapter is a literature review that starts off with a deeper dive into the historical background of the Tamils of Sri Lankan origin, followed by their pre/ post-migration experiences, experiences related to gender, and ends with their meanings, beliefs, and practices related to health/well-being. This information on context and background is important because I apply an intersectional lens to view and understand this population's social location. By understanding how historical processes of power and privilege created instances of opportunity and oppression with respect to the interactions of cultural identity, gender, class, life stage, and immigrant status in the past, we can better analyze this group's experiences of social inequities and need for social justice in the present (Crenshaw, 1989; Wesp, et al., 2018).

2.1 Culture of Collectivism

The Tamil culture is traditionally a collectivist and patriarchal culture. In collectivist cultures, individuals are viewed as parts of their collectives and prioritization is placed on the group and group's goals, views and needs over that of each individual (Triandis, 1995). Social behaviours are led by accepted norms, roles and duties instead of pleasure or personal advantage (Triandis, 1995). This includes social behaviours related to cultural norms like arranged marriages, divorces being less common and living with parents until marriage. Children are raised to function as good members of the larger collective with emphasis placed on respecting elders and responsibilities to the family and community (Triandis, 1995). There is a greater orientation toward those who are part of this collective group than those outside of it where common beliefs are shared with the ingroup and there is a willingness to cooperate with ingroup members (Triandis, 1995) i.e. family, religious/ethnic/political group.

Canada contains largely individualistic cultures where there is more detachment of individuals from their collectives (Triandis, 1995). Behaviours in such societies are led by autonomy, maximizing enjoyment and is dependent on each relationship (Triandis, 1995). Personal goals are prioritized over the goals of the collective, social relationships are changed often if the cost is greater than the level of enjoyment from them (Triandis, 1995). Since marriages are based on personal emotions (versus norms, duties and obligations), changes to these emotions over time result in more frequent divorces (Triandis, 1995). Children are raised to be independent from their collectives and freedom from the collective's influence is valued (Triandis, 1995). Intrapersonally, individualists form their self-concept based on personal attributes while collectivists form it based on collective attributes of the groups they belong to (Triandis, 1995).

Collectivism and individualism exist in shades of grey within societies meaning that although one or the other might be the dominating social pattern, it does not mean the opposite social patterns do not exist or that all members follow a certain social pattern. Furthermore, as mentioned in the definition, cultures are always changing and evolving. With globalization and industrialization, traditionally collectivistic cultures are becoming more individualistic to some extent.

2.2 History, Politics, and Human Rights

Sri Lanka is a large island located closely off the Southern tip of India. It is populated mainly by a majority Sinhalese, and a large minority Tamil population as well as other minority ethnic communities including Muslims and Burghers. The Sinhalese population is primarily Buddhist and the Tamil population is primarily Hindu but also encompasses a minority of Muslims and Christians (Leary, 1983). Owed to the island's history related to the Pali canon, the

oldest surviving recorded sayings of the Buddha, it is a major world center of Buddhism. The island was colonized for nearly 450 years first by the Portuguese, then the Dutch and finally, the British (DeVotta, 2009). In the pre-colonial era, it was governed by kingdoms overseeing their respective land and ethnic people, where Tamil and Sinhalese communities generally lived separately (Leary, 1983). In 1505, at the time of Portuguese colonial occupation of the Maritime provinces, there existed an independent Tamil kingdom in the North (Leary, 1983), which was administered separately by the Portuguese and Dutch. British Ceylon was created in 1801, and after bringing the whole island under its control, for the first time, united administration was implemented in 1833 ((Feith, 2010). This united administration was maintained when the Dominion of Ceylon obtained independence from British rule in 1948 (Feith, 2010; Leary, 1983).

There were tense interactions between the Tamils and Sinhalese of Sri Lanka even before the colonial period tracing back to the first century A.D. (Leary, 1983); however, post-colonization differences between the Sinhalese majority government and the Tamil minority ignited a civil war. Cultural revival movements amongst both groups in the nineteenth century aimed to distinguish themselves from the identities imposed on them by the British colonial administration (Feith, 2010). The Sinhalese strengthened identification with Buddhism while Tamils revitalized Hinduism as well as ancient Tamil literature and the antiquity of the language, eventually leading to separate forms of nationalism, and their continued strengthening and polarization through the years (DeVotta, 2009; Feith, 2010). British colonialism's "divide and rule" practices and the uniting of the administration of the island contributed heavily to the formation of ethnic distinctions between the Tamil and Sinhalese identities and nationalism (DeVotta, 2009; Feith, 2010). With the belief that they were compensating for the

disproportionately lower number of Sinhalese in civil positions, and the inferior status of Buddhism and the Sinhalese language, the government implemented policies related to education, language, religion and employment which compromised the social and economic mobility and justice of Tamils through alienation, marginalization and discrimination (Feith, 2010; Office of the High Commissioner for Human Rights, 2015). As it is beyond the scope of this thesis to dive deep into the history and politics of Sri Lanka, a brief summary of key incidents illustrating the experiences of social justice, or lack thereof, related to trauma and oppression of the Tamils under the rule of a chauvinistic majority Sinhalese Sri Lankan government will be discussed.

2.2.1 Rights of minorities.

When the Dominion of Ceylon was granted Dominion status in 1948, it retained the Monarchy of the United Kingdom and implemented the first Constitution of Ceylon, the Soulbury Constitution (Leary, 1983). This constitution remained in force until 1972 and included Section 29 (2) which specifically protected the rights of minorities, with a statement against the creation of laws which gave people of a specific community or religious group a privilege or advantage that is not equally given to another community or religious group (Leary, 1983). Despite this section, in 1949, the government disenfranchised Indian Tamils, who had been brought in from India by the British in the 19th and 20th centuries to work on tea and rubber plantations (Leary, 1983; Feith, 2010). This rendered them stateless and took away their right to vote thereby decreasing the number of Tamil votes and the Tamil people's power in Parliament to question such similar discriminatory policies (Leary, 1983; Feith, 2010).

In the 1950s, nationalism and patriotism of the Sinhalese increased along with a demand for Sinhalese to be the official language instead of English (Feith, 2010). A "Sinhala Only"

campaign by a Sinhalese party rendered overwhelming support from the Sinhalese population eventually leading them to power and following through with the Official Language Act in 1956, which replaced English as the country's official language with Sinhala (Leary, 1983; Feith, 2010). A provision was to be adopted after Tamils peacefully protested; however, an extremist Buddhist group's agitation and strong reaction resulted in its failure to proceed (Leary, 1983). This pattern of winning the majority Sinhalese support during elections through the promotion of Sinhalese nationalism and resulting anti-Tamil sentiments has been an ever-continuing theme (Feith, 2010). The Tamils responded to feelings of their cultural heritage and identity being denied, and the understanding that the policy would function as a language barrier to government employment, by holding peaceful protests; however, they were violently disrupted resulting in rioting (Feith, 2010). Again, in 1958, the first major outbreak of communal violence targeting Tamils occurred where they were raped, killed, and their homes were damaged and burned (Leary, 1983; Roberts, 2007; Feith, 2010). The government was criticized for being delayed in their response to declare a state of emergency. Approximately 300 to 400 deaths occurred, and more than 25 000 Tamil refugees were relocated from Sinhalese areas to Tamil areas in the North for safety (Feith, 2010; Leary, 1983).

2.2.2 Education and employment.

During British colonialism, education became highly emphasized as a means of advancement because schools educating the indigenous population in the English language created avenues for their access to political power and white-collar jobs (Lange, 2011). Such jobs were considered reputable due to their pay, stability and status compared to the country's majority labour based jobs at the time (Lange, 2011). The set-up of missionaries and their provision of English education, particularly in the Northern provinces, where the majority of the

Tamils lived, has been identified as one of the "divide and rule" approaches as this resulted in a disproportionate number of Tamils being admitted into educational institutions for higher education and being employed in civil services (Leary, 1983; Lange, 2011; DeVotta, 2009).

After independence, a drastic increase in the number of newly educated individuals, rapid growth in the overall population, and minimal economic growth, resulted in an overwhelming number of qualified candidates for white collar employment (Lange, 2011). The outcomes for the large number of educated individuals were decreased relative wages and increased unemployment, with the latter issue becoming one of the most influential reasons for ethnonational violence (Lange, 2011). Specifically, among the educated Sinhalese, these issues led to them placing the blame on other advantaged ethnicities, resulting in minor violent incidents against Christians in 1883 and against Muslims in 1915 (Lange, 2011; Jeyawardena, 2004). This stereotyped the Tamils as being privileged economic competitors and resulted in them becoming a target (Lange, 2011). In 1971, the implementation of the discriminatory Universities Act, commonly referred to as the policy of "standardization" yet again created discontent amongst Tamils, who traditionally emphasized education and employment (Leary, 1983). The policy was a racial quota system which based entrance to university faculties on race rather than merit alone (Leary, 1983). Frustrations increased for the Tamils as these policies decreased the number of Tamil votes, placed their language in an inferior position, required them to learn the majority language, curtailed access to higher education, and excluded them from employment in government service; thus, effecting their opportunities for economic advancement (Leary, 1983).

2.2.3 Religion, casteism and nationalism.

The British colonial period brought societal changes to Sri Lanka, namely changes in the dynamics of caste and religion within the Tamil and Sinhalese populations. Attempts to revive cultures and religions led to the strengthening of the mobilization of Sinhalese religious figures who through ethnic mobilization, advocated for caste breakdown in favor of a common Sinhalese Buddhist identity (Biziouras, 2012). On the other hand, the dominant Vellalar caste (land owners) of the Tamils created cultural associations to preserve their heritage through ethnic mobilization; however, they preserved their social hierarchy as they had become more dominant under British rule (Biziouras, 2012). The relationship between the Buddhist religion and Sinhalese nationalism is significantly related to the origins of the ethnic conflict in Sri Lanka (Leary, 1983; Imtiyaz, 2014). In 1972, inhabitants of the island cut ties with colonial Britain, and changed their name to the Republic of Sri Lanka through promulgation of the 1972 Sri Lankan Constitution (Leary, 1983). Chapter *II,* section 6 of this Constitution provided that The Republic of Sri Lanka "shall give to Buddhism the foremost place and accordingly it shall be the duty of the state to protect and foster Buddhism" (Constituent Assembly of the People of Sri Lanka, 1972). Although the Constitution also guaranteed freedom of religion, other religions were not specified (Leary, 1983). This factor further moved Sinhala-Buddhist leaders and politicians to fuel the politicization of the Buddhist religion to gain power, reinforcing the already existent tensions of religion and ethnicity and further alienating the Tamils (Imtiyaz, 2014). The Tamils attempted to negotiate their growing grievances; however, the demands and accusations of the opposition who used extremist Sinhalese chauvinism for political purposes, along with pressure from extremist Sinhalese-Buddhist groups resulted in the failure of these

negotiations and the normalization of the discrimination against Tamils (Feith, 2010; Imtiyaz, 2014).

2.2.4 Tamil youth's uprising.

The Sri Lankan state's institutionalization of discrimination and violence through constitutional provisions most impacted Tamil youth who became increasingly frustrated with the resulting limitations to their rights, education, religion, employment and freedom (Leary, 1983; Imtiyaz, 2014). Beginning in the 1970s this growing frustration resulted in support increasing for a separate state of Tamil Eelam inclusive of the northern and eastern areas of Sri Lanka. In 1971, a state of emergency was declared as a result of growing violence, and emergency powers and draconian security legislation were later introduced (Office of the High Commissioner for Human Rights, 2015). One example was the Prevention of Terrorism Act introduced in 1979, which gave way to measures that were in violation of international human rights, accepted standards of criminal procedure and the Sri Lankan ratified norms of the International Covenant on Civil and Political Rights (Leary, 1983). It resulted in enforced disappearances, arbitrary detention and torture (Office of the High Commissioner for Human Rights, 2015). Specifically, increasing violence by the police and armed forces became prevalent throughout the 1970s with frequent incidents involving the improper detention and maltreatment, specifically of Tamil youth (Office of the High Commissioner for Human Rights, 2015). Tamil youth were arrested and imprisoned for lengthy periods without appropriate legal charges or convictions, while others were taken allegedly for questioning, but were cruelly tortured and harassed while in custody (Leary, 1983; Office of the High Commissioner for Human Rights, 2015). Eventually, unsuccessful attempts at multiple peaceful efforts and political negotiations for Tamil autonomy led Tamil youth to the conclusion that these grievances for justice and

equality required a militant approach (Leary, 1983; O'Neill, 2015; Feith, 2010). This resulted in the formation of multiple separatist organizations in the north of Jaffna, including the Tamil Nation Tigers in 1972 by Vellupillai Prabakaran who later became the leader of The Liberation Tigers of Tamil Eelam (LTTE) created in 1976 (Leary, 1983; O'Neill, 2015; Feith, 2010; Office of the High Commissioner for Human Rights, 2015). Their aim for a separate state from Sri Lanka called Tamil Eelam was based on the view that as an identifiable people with a defined territory of a pre-colonially existing Tamil nation (which was administered separately by successive colonial powers until the British who implemented united administration with the rest of the country), the principle of self-determination under international law entitled them to the restoration of this sovereignty upon the end of British colonial rule in 1972 (Leary, 1983). Rising Tamil militancy further divided the two ethnic communities resulting in countless riots and violent confrontations (Leary, 1983).

2.2.5 Culture.

In 1981, a group of an estimated 100-200 police and security forces went on a rampage in the Tamil city of Jaffna on the nights of May 31-June 1 and June 1-2 (Leary, 1983; Feith, 2010). They burned down the market area, the home of a Tamil member of Parliament, the office of the Tamil newspaper, and the Jaffna Public Library (Leary, 1983; Feith, 2010). The burning of the Jaffna Public Library, which was seen as a monument to learning and culture, was one of the most distressing losses for the Tamils as 100 000 ancient and irreplaceable Tamil manuscripts were destroyed in the fire (Leary, 1983; Feith, 2010) 2010). It is sometimes referred to as a cultural genocide (Somasundaram, 2007). The attack symbolized an attack on the Tamil language, culture, and history and further increased tensions between Tamil people and the Sinhalese police and army (Leary, 1983; Feith, 2010).

2.2.6 War/Genocide.

A violent anti-Tamil pogrom in July 1983, commonly recognized as Black July, drew international attention and concern and marked the beginning of the civil war. Somasundaram (2007) refers to this as the July 1983 ethnic holocaust. Communal violence broke out after an LTTE attack claimed the lives of 13 government soldiers (Office of the High Commissioner for Human Rights, 2015), where Sinhalese mobs systematically targeted and attacked Tamils. During this violence, approximately 3000 Tamils were killed, burning and looting destroyed Tamil homes and approximately 90% of Tamil owned shops/businesses (Feith, 2010; Office of the High Commissioner for Human Rights, 2015; Becker, 2006). The violence continued into other areas lasting for over a month, during which time Tamil civilians were raped, robbed and killed (Feith, 2010). Evidence suggested government (Feith, 2010; Becker, 2006) and Buddhist extremists' (Imtiyaz, 2014) involvement in the riots; furthermore, police did not intervene to protect the Tamils during the riots (Sivarajah, 1996) and the government did not condemn the violence or take appropriate measures to address the perpetrators afterwards (Becker, 2006). The ethnic cleansing effort resulted in 100 000 Tamils in Colombo (Becker, 2006), and thousands of others in other areas being left homeless (Feith, 2010; Imtiyaz, 2014). Thousands of Tamils either fled for safety from the Southern parts of Sri Lanka to the North where Tamils were the majority, or joined Tamil militant groups, both of which further strengthened the movement for a separate state (Imtiyaz, 2014; Feith, 2010). This was also the period in which mass migration of Tamils to other countries took place, with 100 000 of them seeking refuge in Southern India and several thousand others to heading to Western countries such as England, Canada, the USA, Australia, New Zealand, Germany, Switzerland and several other countries in Europe (Imtiyaz, 2014). Black July is recognized by many as the start of the civil war/genocide which was fought

mainly between the Sri Lankan government and the LTTE with brutalities from both sides. As per a study by the Harvard Medical School and the University of Washington, the number of violent war deaths in Sri Lanka from 1975 to 2002 was at least 215,000 (Obermeyer, Murray, & Gakidou, 2008). Between 1983 and 1996, there were 11 513 disappearances (UN High Commissioner for Human Rights, 1999). The war continued to claim an overwhelming number of lives until its catastrophic ending in May 2009. The overall number of deaths is a contested topic due to the Sri Lankan government's unwillingness to cooperate. In early 2019, the experiences of the Tamils of Sri Lankan origin were recognized by the municipalities of Brampton, Toronto and Pickering as a genocide. Currently, Bill 104, an act to proclaim Tamil Genocide Education Week is being discussed at the federal level.

2.2.7 Tsunami.

As if the ongoing civil war had not taken enough lives, in addition to the 390 000 people it had displaced, the Indian Ocean tsunami hit the coastal regions of Sri Lanka in December 2004. It killed over 40 000 Sri Lankans and displaced over half a million more people. The Tamils and Muslims affected by the tsunami in the North and East grieved that they were not receiving adequate assistance as most of the assistance was going to Sinhalese areas (Office of the High Commissioner for Human Rights, 2015).

2.2.8 Final stages of the war/genocide.

The way in which the end of the war unfolded was particularly devastating and traumatizing for the Tamil community both in Sri Lanka and abroad. Between January 20 and February 5, 2009, alone, UN obtained information indicated at least 5000 civilian deaths, of which many were young children, and 3000 injuries (United Nations, 2012). During the final stage of the war, more than 360 000 civilians were trapped in the conflict zone and estimates

during this final phase alone placed civilian deaths at 40 000 and those that were unaccounted for at over 70 000 (United Nations, 2012).

Government forces/military and the LTTE both committed grave violations of international humanitarian law and laws of war (United Nations, 2012). The LTTE forcibly recruited civilians, used them as human shields and prevented them from leaving the conflict zone to seek government assistance (US Department of State, 2009; International Crisis Group, 2010). The government and its military ignored multiple international interventions asking to stop their offensive out of concern for the civilians trapped in the conflict zone on the basis of war crimes and crimes against humanity (Office of the High Commissioner for Human Rights, 2015). While denying so, they deliberately and intensely shelled civilians, hospitals, humanitarian operations, and government designated No-Fire Zones and obstructed the sufficient distribution of available food, clean water, and medical supplies to internally displaced persons and the no fire zones areas (US Department of State, 2009; United Nations, 2012; International Crisis Group, 2010; Office of the High Commissioner for Human Rights, 2015). In addition, they killed those that surrendered, and abducted and killed Tamil civilians, specifically young men and children. At the end of the conflict in 2009, attempting to identify LTTE cadres, security forces detained approximately 250 000 to 300 000 Internally Displaced Persons (IDPs) from the conflict zone in closed internment camps run by the military (Office of the High Commissioner for Human Rights, 2015; US Department of State, 2009). While these camps deprived the IDPs of their liberty and human rights, the government did not allow international organizations and journalists unrestricted access to know the accurate details of what was happening in these camps (US Department of State, 2009). Such details suggest sufficient evidence to indicate war crimes committed by Sri Lankan security forces with top government and military leaders possibly

responsible (International Crisis Group, 2010). Absence of witnesses to the details of the war due to the Sri Lankan government's barring of journalists/media reporters (Somasundaram, 2010), and the absence of aid workers from the conflict zone, led to media outlets coining it as the "war without witness".

2.2.9 Global response.

Before 2009, Tamil diaspora supported the LTTE both politically and financially through transnational networks (Amarasingam, 2013; Wilson , 2000) with Tamil youth playing a large role in political and human rights activism. The goal in supporting the LTTE was for the establishment of Tamil Eelam, a separate Tamil state in Sri Lanka as a way to address the ongoing genocide. Tamil youth organizations existed in many high schools, colleges, and universities as Tamil Student Associations, and other transnational youth organizations such as Tamil Youth Organizations were also deeply involved in political and human rights activism. Many youth took leadership roles in organising and leading protests to bring attention to the injustices taking place in their homeland, where many of their families/extended families remained.

In 2006, following the global "war on terror" movement, the LTTE was listed as a terrorist organization by Canada. Protests and peaceful demonstrations continued throughout the years, but in 2009, extensive protests described as a global outcry by the Tamil Diaspora took place in reaction to the atrocities happening in Sri Lanka. Peaceful demonstrations beginning in January and leading into May took place in the GTA following suit with those happening in the United Kingdom, London, Sydney, and India. These continuous and widespread political demonstrations by thousands of Tamils took place in Toronto and Ottawa with smaller scale ones taking place in Montreal, Vancouver and Calgary. Near the end of the war, some 30 000

individuals took part in continuous demonstrations on Parliament hill as the Government of Sri Lanka's attacks in the North resulted in thousands of civilian causalities, where they appealed to political leaders to take steps to investigate war crimes committed by the state of Sri Lanka and restore the rights of Tamils on the island. On May 10, 2009, in response to mass civilian casualties, protestors entered the Gardiner Expressway, a busy city highway causing it to shut down, as they desperately used the platform to call for a response and plan of action by the Canadian government. The protest continued throughout the night. Extensive media coverage of the "Tamil protests" took place during this time, including many negative reactions to the protest as it took place on Mother's Day, disrupting many of the host country members' plans.

On April 12, 2011, the UN Secretary-General established "Panel of Experts on accountability in Sri Lanka" presented their report advising him on the need for accountability for violations by the parties to the conflict during the final phase of the war in Sri Lanka (United Nations, 2012). In addition, they presented a memorandum with their view that while some UN staff were commendable during the final phase of the war, others had failed to protect people, under-reported violations by the Government and withheld others' reporting efforts. The memorandum stated that the UN "did not adequately invoke principles of human rights that are the foundation of the UN but appeared instead to do what was necessary to avoid confrontation with the government" (United Nations, 2012, p. 4). The memorandum further labelled the inaction by Member States as a failure of the UN (United Nations, 2012). In response, the Secretary-General established an Internal Review Panel on UN actions in Sri Lanka to complete a comprehensive investigation into human rights violations and war crimes between the years of 2002 and 2011 (United Nations, 2012). The findings of the report completed in 2012 further stressed the persistence, magnitude, and significance of the violations of international human rights and

humanitarian law that took place during and prior to the period investigated (United Nations, 2012). Most of the findings had been echoed during protests by the Tamil diaspora.

2.3 Canadian-Tamil Experiences

The Canadian Tamil community's resilience and resourcefulness is one deserving of recognition as they have a long history of sounding alarm bells to bring attention to the mental health needs and lack of supports within their community. The Toronto Star, a major daily newspaper in Toronto, published at least two stories in 1999 including input from a Tamil settlement worker and a Tamil psychiatrist, who both worked extensively with members of the Tamil community (Murray, 1999; Murray, 1999b). It signified a "mental health crisis" in the Tamil community marked by PTSD, depression, and an alarming rate of escalation in suicides and suicidal attempts (Murray, 1999; Murray, 1999b). The community had high levels of unemployment, low levels of income, and was described to be in pain due to the traumatic civil conflict in their homeland (Murray, 1999; Murray, 1999b). The articles noted contributing issues such as males being less likely to seek help, the lack of Tamil-speaking, and culturally-sensitive professionals in the mental health care sector, and the social challenges in the host country such as isolation due to a lack of support from extended family and others in comparison to the social support system that existed in their country of origin (Murray, 1999; Murray, 1999b).

A tragic incident described in one of these stories involved a young Tamil father who leaped to his death in front of a subway platform with one of his children. Following this incident, a group of Tamil community leaders approached Dr. Morton Beiser and his research team and requested research collaboration to investigate the mental health needs, risks, and service use within this community (Beiser, Simich, & Pandalangat, 2003). They wanted to

understand the aspects influencing widespread despair, and the impacts of pre-migration trauma and post-migration discrimination on the community's mental health (Beiser, Simich, & Pandalangat, 2003). This led to a seminal mental health research study which was particularly notable due to the order in which the community requested collaboration with researchers instead of the other way around (Beiser, Simich, & Pandalangat, 2003). Although the initiative taken by the community gained them the title of "Community in Distress" (CID) in articles published from this study, making their distress known speaks to the community's resilience and self - awareness of mental health issues within the Tamil Canadian community. The median length of stay in Canada for the CID study sample was approximately ten years, with the community being predominantly young/middle aged, Hindu, married, and most were living in deep poverty despite being well-educated (Beiser, Simich, & Pandalangat, 2003; Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011). The following literature review includes further information on this study, along with other research focusing on the Tamil Canadian community living in Toronto, and their mental health.

In the following sections I will consider experiences of pre-migration and post-migration at the level of the microsystem and the individual level with respect to the intersections of gender, class, immigrant status and cultural identity.

2.3.1 Pre-migration experiences

The community that wanted to collaborate on the CID research study wanted to understand the factors contributing to the widespread mental health challenges within their community, including the role of pre-migration trauma (Beiser, Simich, & Pandalangat, 2003). The study was initiated in 2003 and explored how the stresses of transit and resettlement contributed to, and/or mitigated the risk of PTSD (Beiser, Simich, Pandalangat, Nowakowski, &

Tian, 2011). It included 1603 participants, one of the largest samples in PTSD literature (Beiser, Simich, & Pandalangat, 2003; Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011).

Almost half of the total participants in the CID study had come to Canada claiming refugee status, and a third of them had come as family class immigrants under sponsorship (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011). Refugees can permanently resettle in Canada through official government selection abroad, or by reaching Canada on their own by other means and claiming refugee status (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011). Claimants are granted permanent resident status if they fit the United Nations convention definition of refugee and have the ability to later sponsor other family members to Canada (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011). Most Tamils who have settled in Canada have through the latter route (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011).

Many participants were from Northern Sri Lanka, rural regions where the ethnic conflict had been most extreme; therefore, they experienced harsh pre-migration experiences with 43% of them having been internally displaced persons, and 17.5% of them having been interned in refugee camps (Beiser, Simich, & Pandalangat, 2003; Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011). During their immigration process 35% were separated from their families, while others experienced physically dangerous situations, were harassed, cheated by travel agents, and/or left with large debts (Beiser, Simich, & Pandalangat, 2003).

George (2013) completed a qualitative study of 22 male and 13 female Sri Lankan Tamil refugees from Toronto, Canada, and a refugee camp in Chennai, India. This more recent study further underscored the amount of distress experienced by this adult population as a result of the civil war and the journey taken to becoming refugees in other settlements (George, 2013). The war had a major impact with 91% of them having experienced violence targeting them or

witnessed it against family members (George, 2013). Themes identified by George (2013) through analysis of participant interviews included army attacks, explosions, being in prison where they were subjected to coercion and interrogation, mass killings, having no support from the law, being separated from family, and wanting to live and not think or explain how bad their situations were. Those who travelled to Canada transmigrated through many other countries with the hope for safety and support of the friends and family who were already there (George, 2013). All of the participants expressed a lack of presence, support and assistance from the United Nations (UN) in response to a question about the influence of the policies of the UN (George, 2013).

Post-traumatic stress disorder.

Post traumatic stress disorder (PTSD) is a condition that occurs in all populations. PTSD concurrently occurs with disorders such as mood, anxiety, or substance-use disorders more than half the time (Pietrzak, Goldstein, Soutwick, & Grant, 2011). According to the fifth edition of the American Psychiatric Association's (2013) Diagnostic and Statistical Manual of Mental Disorders (DSM-5), PTSD is a disturbance resulting from exposure to actual or threatened death, serious injury, or sexual violation which causes significant distress or impairment to emotional, physical, occupational, and/or social functioning. The exposure can occur from one or more traumatic scenarios such as directly experiencing or witnessing traumatic events, learning of violent/accidental traumatic events that occurred to close family or friends, or repeated/extreme exposure to disturbing details of traumatic events other than through media (unless related to work) (American Psychiatric Association, 2013). The trauma of the unexpected death of someone close, sexual assault, and seeing another seriously injured or killed contributed most to PTSD in Canada (Van Ameringen, Mancini, Patterson, & Boyle, 2008).Symptoms of intense

distress can be triggered by stimuli related to the traumatic event and includes re-experiencing trauma(s) through intrusive memories, nightmares, and flashbacks (American Psychiatric Association, 2013). Persistent avoidance of stimuli associated with the event(s), sleep disturbances, difficulty with concentration, hyper-alertness, and negative changes in thinking, moods, emotional states and arousal can occur for those with PTSD (American Psychiatric Association, 2013). Further symptoms include impaired regulation of emotions such as irritability, anger, aggression, and reckless or self-destructive behaviour (American Psychiatric Association, 2013).

The prevalence rates of lifetime PTSD in the general population is 2% (The ESEmeD/MHEDEA 2000 Investigators, 2004), with Canada estimated to have a higher rate of 9.2% (Van Ameringen, Mancini, Patterson, & Boyle, 2008). Unsurprisingly, higher rates occur in refugee populations as a result of a combination of pre and post-migration adversities (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011). There was a 12% prevalence rate of lifetime PTSD found within the CID population, which was high (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011) but comparable to similar rates of 10-12% reported among other refugee populations in high income countries of resettlement as identified in a systematic review (Fazel, Wheeler, & Danesh, 2005; Beiser M. , 2014). A third of the respondents in the CID study reported past traumatic events such as physical assault, rape or witnessing combat, with women reporting more such incidents than men (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011; Beiser, Simich, & Pandalangat, 2003). In spite of this, PTSD rates were lower than the rates of experiencing traumatic events (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011) with only about a third of those with traumatic experiences meeting the criteria for a diagnosis of PTSD (Beiser, Simich, & Pandalangat, 2003). The personal characteristics and

stressful events that most contributed to the occurrence of PTSD in the CID study were sex, the number of pre-migratory stresses of passage, and experiences of prejudice (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011). Perceived quality of life decreased probability of PTSD and nonfamilial, as opposed to familial social support, was a significant protective factor (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011).

The implications of the prevalence rate of PTSD within this population is concerning. Prevalence rates tend to be lower within larger sample sizes (Fazel, Wheeler, & Danesh, 2005), yet within this study which had one of the largest sample sizes in the PTSD literature, the prevalence rates remained high (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011; Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015). The literature also indicates that the non-participating population of the study tends to be at higher risk for psychopathology, presaging that the high prevalence rates of PTSD found in the study might be an underestimation of actual overall rates in this population (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011; Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015). A notable limitation in the CID study was that the cross-sectional study made it difficult to determine directionality related to the function of PTSD so it may be a pre or post-migration indicator (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011).

2.3.2 Post-migration experiences

Tamil community leaders identified post-migration experiences of discrimination expressed as an “anti-Tamil sentiment” in Canada to be of concern and something that they wanted to learn more about (Beiser, Simich, & Pandalangat, 2003). Aside from the pressure of integrating psychosocially and culturally into a new society, this population was also presented with the challenges of economic integration. The following section looks at this community’s

post-migration experiences, and the ways in which the challenges of integration impacted their meanings, beliefs, and practices, of health, mental health and well-being.

Identity, integration and belonging.

George's study (2013) of 35 Sri Lankan Tamil refugees from Toronto, Canada, and a refugee camp in Chennai, India found that 97% of them were acute refugees meaning they had experienced severe pre-migration trauma and fled their country following a disaster with minimal preparation, with many of them having left Sri Lanka without the documents necessary to apply for refugee status (George, 2013; Stein, 1986). Refugee Board policies influenced participants' experiences creating the belief that Canadians perceived them as liars, and the review board treated them like criminals despite not having done anything wrong (George, 2013). They expressed having come to the country for safety, not as intruders and that extreme interrogation by the review board resulted in increased distress and uncertainty (George, 2013). George (2013) recommended that the assessment of the traumatic experiences of acute refugees, its impact, and response should be integrated into settlement interventions. Furthermore, migration policies and refugee review board members should consider the historical, social, cultural and political contexts of the refugee population to better serve them and prevent their re-traumatization during their post-migration process (George, 2013; Rousseau, Crepeau, Foxen, & Houle, 2002).

Discrimination was experienced through some Canadians who questioned the legitimacy of the ways in which Tamils had obtained refugee status, and their concerns about terrorist activities related to the Tamil Tigers (LTTE) in Sri Lanka (Beiser, Simich, & Pandalangat, 2003). This issue initially began in 1986 when two overcrowded lifeboats carrying Tamil men, women and children reached the shores of the east coast of Newfoundland. These refugees were

welcomed with feelings of sympathy, but these feelings changed to anger with the knowledge that the refugees had paid smugglers to bring them from Sri Lanka through Germany (Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011). Canada naming the LTTE as a terrorist organization in 2006 further marginalized Tamils of Sri Lanka, particularly refugees, with the public labelling them as bogus and/or terrorists (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015).

Social resources are a source of resilience as they can increase positive mental health and provide protection from stress (Beiser M. , 2014). Despite the hardships of pre and post-migration, a majority of refugees are not affected by mental illness due to the interaction of differing protective and risk factors at the personal and social levels (Beiser M. , 2014). According to the CID study, 87% of participants had family or friends that they felt they could count on in Toronto when they arrived (Beiser, Simich, & Pandalangat, 2003). Yet, many of the seniors expressed feelings of distress as a result of assigned child care responsibilities, the need to be dependent on their children, not being able to communicate with their grandchildren, and feeling lonely (Beiser, Simich, & Pandalangat, 2003).

Using data obtained through the CID study, Beiser et al. (2015) further specifically examined Tamil refugees' predictability of psychosocial integration, and economic integration through the contributing factors of pre-migration challenges, human capital, mental health/PTSD and social resources. Social integration was conceptualized as satisfaction with social life, quantity of Tamil/non-Tamil friends, and involvement, sense of belonging, and positive view of Canadian society and their local community (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015). They found that 80% of participants placed importance on participating in Canadian society and 73% felt a sense of belonging here (Beiser, Goodwill, Albanese, McShane,

& Kanthasamy, 2015). More than 90% were content with their social lives (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015). Increased length of time in Canada, education, religiosity, and being male versus female, were predictors of positive psychosocial integration (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015). On the other hand, increased age at arrival and pre-migration challenges had an adverse effect while PTSD did not affect psychosocial integration (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015). Although participants had more Tamil than non-Tamil friends, the latter connections increased their sense of belonging, and support from non-family members was a predictor of positive psychosocial integration while support from family had no effect on integration (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015).

Education, income and employment.

As per intersectionality lens, class is one of the key social constructs that contributes to social location and ultimately social inequities (Crenshaw, 1989). As per the social determinants of health, education, income and employment impact health inequities with income playing the most important role (Mikkonen & Raphael, 2010). Therefore, this section examines these aspects in relation to Tamils of Sri Lankan origin. Due to the disruption of war and limited access to higher levels of education, most Tamil immigrants did not bring professional skills and most arrived as refugees (Guruge, Khanlou, & Gastaldo, 2010). In comparison to native born Canadians and other immigrant populations, Tamil refugees were less educated with only 13% having college or university degrees (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015). Lacking English skills and opportunities to utilize their training from their country of origin proved to be barriers to employment for this population. Many of the participants in the CID study were living in deep poverty despite being well-educated (Beiser, Simich, Pandalangat,

Nowakowski, & Tian, 2011). Approximately 13% were unemployed with unemployment rates higher amongst women (Beiser, Simich, & Pandalangat, 2003; Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011). Among participants with teaching or nursing training, there was a 70% unemployment rate (Beiser, Simich, & Pandalangat, 2003). Approximately one third of the participants could only speak fair or poor English, and the unemployment rate within this group was 75% (Beiser, Simich, & Pandalangat, 2003).

In Beiser et al.'s (2015) study, economic integration was conceptualized as employment, owning vs. renting a home, welfare status, and satisfaction with material and occupational aspects. Tamil refugees in this study were found to have higher rates of unemployment and poverty than the general population in the CID study with 45% being unemployed, and 37% living in poverty (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015). More than 25% were not satisfied with their employment or material well-being (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015); in spite of this, about half of the sample owned versus rented their home, and 85% were not on welfare (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015). PTSD and religiosity were found to work against economic integration while perceiving the health care system positively and being married were predictors of positive economic integration (Beiser, Goodwill, Albanese, McShane, & Kanthasamy, 2015).

2.3.3 Gender

A study by Guruge et al. (2010) explored the intersectionality of migration, culture, gender, race, and class as it applies to intimate male partner violence (IMPV) within the Sri Lankan Tamil immigrant population. They found that the production of post-migration IMPV involved: exposure to war and trauma in the pre-migration and border crossing contexts (resulting in the perceived low tolerance of stress, distrust in others, and symptoms of anxiety

and depression); gender inequity within the marriage and within the marital society; decreased social supports in the post-migration context; as well as changes in socioeconomic status, power and privilege (Guruge, Khanlou, & Gastaldo, 2010). This study highlighted the need to consider the multiple aspects that encompass the complexity of immigrants' lives in diaspora and displacement (Guruge, Khanlou, & Gastaldo, 2010).

Females.

Hyman et al. (2011) completed a study by conducting eight focus groups with Sri Lankan Tamil immigrant women living in Canada to explore their perceptions on the post-migration factors that contribute to interpersonal violence (IPV). Focus groups included Tamil women of varying ages, with two groups of participants that were married or in common-law relationships, two groups of women over 65 years of age who were formerly or currently married, or in common law relationships, and two groups of women who had received IPV counseling services (Hyman, et al., 2011). The majority of the participants were first generation immigrants and Hindu, the younger women were all attending post-secondary school, and the majority of the middle-age and senior women had no post-secondary education (Hyman, et al., 2011). Major themes that were identified in the study were post-migration stress and conflict, gender norms and expected behaviours rooted in patriarchy, and individual male characteristics and actions (Hyman, et al., 2011). The participants also acknowledged the role of gender inequality and financial dependence as aspects that influenced IPV, and the part that women played in maintaining the marriage (Hyman, et al., 2011).

The major stressors that were identified were employment, income and the lack of social support (Hyman, et al., 2011). In the participants' native country, women's gender

roles and expectations were mainly to care for the children and attend to the housework while men functioned as breadwinners (Hyman, et al., 2011). In Canada, although the need and opportunities for women in employment were higher, and women were able to contribute to the household income through employment, the lack of a strong social support which previously existed in their native country led to increased responsibilities inside and outside the home (Hyman, et al., 2011). The required division of household tasks and changes in gender roles/expectations created stress between couples (Hyman, et al., 2011). Furthermore, disagreements about child-rearing practices (specifically between parents about the extent to which their children should be raised traditionally or as per the culture in the Canadian society), involvement of older in-laws (with differing value systems compared to the younger couples), and harsh criticism of daughters-in law by parents-in-law were notable contributors to family conflict (Hyman, et al., 2011).

Individual male characteristics and behaviours such as mental illness, anger management, infidelity, and alcohol issues were also recognized by participants as being responsible for IPV; however, women also perceived that they played a significant role in mitigating conflict within the marriage, and felt that they were sometimes responsible for triggering men's violent behaviour (Hyman, et al., 2011). They imparted that to avoid provocation/abuse and maintain family harmony, women were expected to conform to social and gender-appropriate norms (Hyman, et al., 2011). They further revealed strategies to avoid such violence/conflict including choosing the "right" times to discuss problems, choosing to let males think they are right, not looking too attractive, not spending too much time outside the house, being quiet, being unobtrusive, avoiding friendships with other men, and avoiding any behaviours that were disliked by the males (Hyman, et al., 2011).

Although gender inequality and male domination were identified as factors contributing to IPV, there were differences in opinion related to how Tamil women's autonomy and nonconformity added to incidences of IPV (Hyman, et al., 2011). Some expressed increased financial independence as being related to IPV while others felt it was related to a reduction in IPV (Hyman, et al., 2011). Several participants with experiences of IPV expressed that confrontation of the rigid gender roles and responsibilities early on in their relationship could have helped to prevent the abuse (Hyman, et al., 2011). Others felt those raised with the concept of equal rights between men and women may experiences less IPV, but this contradicted the finding that women conformed to gender roles to avoid provocation of males (Hyman, et al., 2011). As a result, changes in power dynamics through gender equality and financial independence were both connected to the occurrence of IPV and significant to preventative strategies (Hyman, et al., 2011).

This study analyzed the community as being in a "state of acculturative flux" between different cultures and regardless of whether women conformed to traditional gender roles or not, they were held to high standards (Hyman, et al., 2011). This indicates a double standard as it relates to expectations and possibilities where unequal status contributes to IPV, as does their role in failing to prevent it (Hyman, et al., 2011). The study highlighted the importance of pre and post-migration factors in beliefs about contributing factors to IPV, and the need to consider them in the prevention of IPV within newcomer communities (Hyman, et al., 2011).

Males.

Affleck et al. (2018) conducted qualitative interviews using a participatory action research design in a study with 33 Sri Lankan Tamil refugee males living in Canada. Affleck et al. (2018) considered the intersections of war, migration, resettlement, and mental health

specifically in relation to cultural conceptions of masculinity. In their study, they found that gender played a role in the type of war trauma experienced with men often having experienced interrogations involving torture and detainment including rape and sexual abuse (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). Males felt a sense of helplessness, and ongoing rumination as a result of not being able to protect their loved ones from suffering or death during the war rather than as a result of their direct experiences of war trauma (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). As the head of the family, men's inability to physically protect and provide emotional support to their family caused suffering and negative judgement by others and themselves (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). Symptoms of PTSD were commonly reported by participants and included distrust of others, emotional detachment, and increased anger and rage (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018).

The main form of psychosocial suffering expressed were related to negative impacts to concentration, awareness, memory, and the retention of information which all considerably hindered their daily functioning in employment, travelling, and social interactions (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). These symptoms negatively impacted their ability to fulfill their masculine role, particularly within their family (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). Furthermore, they often felt unable to fulfill the typical masculine duties that were culturally and socially expected of them such as supporting their family due to the stress experienced before and after migration, or being a provider, due to employment issues (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). The blame they placed upon themselves for these failures and their family's suffering

contributed to mental health problems (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018).

Post-migration, the cultural differences between Sri Lanka and Canada resulted in men feeling that their masculine role and responsibilities had become redundant (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). Their beliefs did not coincide with those being followed by their wives and children in Canada, they were no longer the main source of income, and cultural duties belonging to men in areas such as marriages and funerals had become redundant, as had their leadership and helping roles in their community (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). This loss of multiple roles depleted their masculine identity and made them feel unimportant and unnecessary (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018).

Lastly, men were distressed by their spouses who reminded them of their failures and through the practice of shaming, attempted to spur them to achieve more (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). Shaming began internally within the household, and if the tactic was unsuccessful at achieving the desired outcome of a more prestigious job or more income, progressed in front of other family and neighbors and eventually ejection from the household, and claims to the community that the man was not competent enough, which was a source of great disgrace for men (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). As many of the men had poor English skills and no relevant job experiences, the goals that their wives wanted them to achieve were difficult and their inability to fulfil their expected roles left them feeling guilty, inadequate, and emasculated (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). This type of shaming was associated by the participants with mental health problems including alcoholism, depression, social isolation and

suicidal ideation, and negative impacts on intimate/spousal relationships including verbal and physical violence (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). This shaming was a primary trauma and exacerbating stressor as it contributed to already prevalent negative feelings of masculinity (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018).

Irrespective of the kind of trauma or daily stresses they experienced, these experiences at the individual, familial and societal levels emphasized their failure to meet the cultural expectations of masculine behaviour and achievement, cumulatively resulting in a state of "depleted masculinity" (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). This emotional and psychological state was one where their masculine self-concept and self-worth were so negatively impacted that their masculine identity was either diminished or lost entirely, and resulted in various emotional, behavioural, and mental health problems including depression, social isolation, alcoholism and suicidal ideation (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). Affleck et al. (2018) suggest a need to review and rebuild masculine identity with this ethnic population by highlighting the dangers of ideal gender norms to support the mental health, and increasing opportunities for meaningful societal participation, and leadership.

Knowledge of mental health-related beliefs, practices and experiences of this population is important in critically examining and understanding their strengths and needs related to mental health. Although the existing literature presented in the literature review is based on the adult population of Tamils of Sri Lankan origin, it is informative in providing a basis for understanding the family, community and culture that the youth of this population belong to. The findings of the study in chapter four are organized and presented in part with the same headings to allow for comparison and analysis. Knowledge of this population's mental health related beliefs, practices and experiences is helpful in identifying specific opportunities at the individual,

micro, meso and macro system levels so that informed, tailored, culturally safe mental health interventions and services can be provided.

2.4 Meanings of Mental Health and Well-being

A qualitative study (Pandalangat, Rummens, Williams, & Seeman, 2013) examined conceptualizations and perceptions of health and illness in 16 Sri Lankan Tamil immigrants in Toronto, who self-identified with a diagnosis of depression, and compared these conceptualizations to those of eight care providers who served this community. Although this study focused on the Sri Lankan Tamil population, it was focused specifically on recent immigrants with a diagnosis of depression (Pandalangat, Rummens, Williams, & Seeman, 2013). The participants were adults who had been in Canada 10 years or less (Pandalangat, Rummens, Williams, & Seeman, 2013). Findings revealed that this population highlighted meaningful social functioning, specifically the aspects of family-centrism, achievement in education, and positive social relationships with enhanced positive communication (especially with family) (Pandalangat, Rummens, Williams, & Seeman, 2013).

Social functioning was also perceived to be fundamentally related to health and illness, and participants linked depression to a breakdown in social functioning (Pandalangat, Rummens, Williams, & Seeman, 2013). Men identified the ability to accomplish their social role through employment to fulfill their role of primary provider and ensure the education of their children as especially important (Pandalangat, Rummens, Williams, & Seeman, 2013). Tamil women on the other hand expressed maintaining healthy familial and marital relationships as important factors (Pandalangat, Rummens, Williams, & Seeman, 2013).

Aside from the social elements, participants held an integrated/holistic concept of health overall, inclusive of the social, physical, and mental elements (Pandalangat, Rummens,

Williams, & Seeman, 2013). One participant referred to the health of "manam", which was interpreted by the study as mind, being essential for good health (Pandalangat, Rummens, Williams, & Seeman, 2013). This cultural understanding was not reflected by most service providers (Pandalangat, Rummens, Williams, & Seeman, 2013).

The community conceptualized disease prevention and health promoting interventions as functioning along social dimensions, and service providers correspondingly recognized that return to social functioning was an important aspect to recovery for this population (Pandalangat, Rummens, Williams, & Seeman, 2013). Pandalangat et al. (2013) recommended considering the aspects of social and support services in culturally competent care including focusing on employment, and family dynamics. As the social aspects were foundational to the meanings associated with mental health by this community, Pandalangat et al. (2013) also recommended the incorporation of social support and vocation services to address mental health within this population. Therefore, I will explore mental health related meanings within the Tamil youth of Sri Lankan origin population because there is a lack of literature on this topic.

2.5 Beliefs of Mental Health and Well-being

As previously noted, literature pertaining specifically to the ethnocultural population of Tamil Canadian youth and their meanings and beliefs about mental health is nonexistent. A search of meanings and beliefs about mental health and mental illness from other youth in other cultures however, proved interesting. An ethnonursing study conducted by Suttharangsee (1998) focused on mental health from the perspective of Thai adolescents found that this population identified having good social supports, a good mood, being worry-free and practicing positive thinking as characteristics of a mentally healthy person. Methods identified by this population in maintaining mental health included expressing feelings through actions and words, distracting

themselves from problems, seeking help, using a cognitive strategy, and religious practices (Suttharangsee, 1998). Protective factors for mental health identified by this population included peers, family, school, mass media, religion, physical environment, economics, and physical health (Suttharangsee, 1998).

In the CID study, participants reported using rituals, traditional herbal remedies, and religious stones/bracelets and astrologers to cope with past experiences (Beiser, Simich, & Pandalangat, 2003). The study by Pandalangat et al. (2013) on the other hand found a change in the way that the community didn't hold a strong belief of mental illness being caused by the supernatural, an understanding dually expressed by the service providers and attributed to mental health education efforts within the community. This move away from the former Tamil beliefs and traditions indicated how the culture has shifted and continues to do so requiring therapeutic interventions to evolve with it to maintain its relevancy.

Pandalangat et al. (2013) found that the community had a limited understanding of the preventative and rehabilitative roles of the Western medical system, including the role of medication. Service providers' perspective in relation to the topic of medication however was that the community did not consider medication and counselling/psychotherapy as stand-alone treatments, with a preference, and less resistance than other communities to medication (Pandalangat, Rummens, Williams, & Seeman, 2013). Pandalangat et al, (2013) recommended that this requires primary care physicians and psychiatrists to educate individuals on the roles of social service providers and make appropriate referrals to them. They also recommended increasing health literacy around concepts of preventive health and health maintenance within the Western medical system including the role of medication in these aspects (Pandalangat, Rummens, Williams, & Seeman, 2013). Therefore, I will explore mental health related beliefs

within the Tamil youth of Sri Lankan origin population because there is a current lack of literature on this topic.

2.6 Practices of Mental Health and Well-being

Multiple barriers to help seeking existed in this community including lack of mental health literacy, unfamiliarity with the healthcare system, lack of culturally competent care, and mistrust of the healthcare system. The CID study found that more than 50% were unlikely to seek help for psychological problems, whereas almost all of them would seek help for physical problems (Beiser, Simich, & Pandalangat, 2003). Of those with traumatic experiences, 36.2% qualified for a diagnosis of PTSD, but only one out of ten of those who qualified for the diagnosis had received any treatment for it (Beiser, Simich, & Pandalangat, 2003). Although 70% received care from their family physician in the last 12 months, less than 1% received services from a mental health professional (Beiser, Simich, & Pandalangat, 2003).

The Tamil culture's emphasis on not requiring medication as an indication of good health, resulted in participants associating medications with ill health, reduction of medications as an indication of recovery, and the role of medication only recognized in the acute stages of mental illness (Pandalangat, Rummens, Williams, & Seeman, 2013). The desire to reduce or avoid medication impacted the health behaviour of this community in that rather than seeking help for preventative or rehabilitative reasons, they resorted to traditional help seeking practices such as seeking help from friends and relatives instead of mental health workers, and avoided seeking medical help until their illness became acute (Pandalangat, Rummens, Williams, & Seeman, 2013). Non-adherence to prescribed medications resulting in incomplete recovery from depression (such as stopping medication as soon as there is a relief of acute symptoms) were

other challenges presented as a result of their beliefs around the role of medications (Pandalangat, Rummens, Williams, & Seeman, 2013).

Higher levels of personal stigma and being a male have been associated with increasingly negative attitudes towards help seeking for mental health challenges (Arora, Metz, & Carlson, 2016; Pandalangat, 2011). This may be due to the role of traditional male gender expectations where expressions of pain and emotions are discouraged and self-reliance is encouraged (Connell, 2005) and cultural beliefs which highlight the importance of achievement and honouring the family (Das & Kemp, 1997; Durvasula & Mylvaganam, 1994). Males did however use other coping mechanisms. A quarter of the males in the study by Affleck et al. (2018). engaged in coping activities to calm their body and mind such as long baths, meditation, yoga and engagement in religious activities (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). They also attempted to follow through with meeting their masculine duties in relation to their families and communities by adopting leadership roles in community organizations and doing community work as a coping mechanism to actively rebuild their masculine identity, which fostered resiliency (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018).

The CID study found that a barrier to seeking mental health services for most who were interested in seeking help was not knowing where to go. Counselling and psychotherapy were not often utilized, possibly because the community was unfamiliar with such services due to the differences in the health care system in their country of origin (Pandalangat, Rummens, Williams, & Seeman, 2013). In Sri Lanka, such services were not as prevalent or utilized. Those who provided therapy also felt that they were not as valued or respected compared to medical practitioners when dealing with mental illness (Pandalangat, Rummens, Williams, & Seeman, 2013). Some participants did not seek help because they felt there would be a lack of culturally

competent care, while others did not do so because of the lack of healthcare personnel from their ethnic background (Beiser, Simich, & Pandalangat, 2003). More than half the population preferred a service provider who spoke Tamil, particularly those with poor English skills, weaker sense of belonging and shorter periods of residence in Canada (Beiser, Simich, & Pandalangat, 2003). On the other hand, ethnicity was not of importance to approximately 40%; particularly, those with an increased sense of belonging, fluency in English and length of residence in Canada disregarded ethnicity (Beiser, Simich, & Pandalangat, 2003).

The CID study also revealed other barriers to seeking mental health services for most included linguistic and transportation barriers, specifically for women and seniors, believing the problem would resolve on its own, preference to solve the issue themselves, and feeling that it would still not help (Beiser, Simich, & Pandalangat, 2003). Although less frequently cited, other deterrents to help seeking were stigma related to what others might think, and to the condition itself, and the belief that it was astrologically unfavorable timing for help seeking (Beiser, Simich, & Pandalangat, 2003). Mistrust of the healthcare system existed due to past experiences of racial discrimination or unmet needs (Beiser, Simich, & Pandalangat, 2003). Fear of forced hospitalization and violations of confidentiality also prevented others from seeking help (Beiser, Simich, & Pandalangat, 2003). Therefore, I will explore mental health related beliefs within the Tamil youth of Sri Lankan origin population because there is a current lack of literature on this topic.

2.7 Summary

The Tamil youth of Sri Lankan origin are a population with a complex historical, cultural, religious, and political background, which includes what is starting to be recognized as genocide. This population consists of youth that may have arrived as refugees, or immigrants; however, as

with most of the population, they may have also arrived as sponsored family class immigrants but still have experiences similar to those of refugees. The literature on this youth population is limited, in some cases dated, with the existing literature on the Tamil population and mental health focusing mainly on adults. Increasing social justice and health equity for this population requires recognition of these factors and further research into this subject, which is why the current research is necessary.

3.0 Chapter Three: Methodology

In the following chapter, I will cover the theoretical perspective, research design/methods, research questions, research methodology, study timeline, study rigor and ethics as I have applied them in this study.

3.1 Theoretical Perspective

Wesp et al. (2018) recognized that nurses practice in ever complex sociopolitical climates, and care for marginalized communities where health inequities continue to exist; yet, these complex factors are not sufficiently considered in how cultural competency is currently approached in nursing. As social justice and quality of care are central to nursing practice and healthcare in general, adequately addressing these aspects compels questioning and critically examining structures and processes of power to recognize and understand the specific needs of a population (Wesp, et al., 2018). Failure to do so can result in unconscious/implicit bias and/or overt discrimination in healthcare which can further contribute to health disparities for marginalized populations (Wesp, et al., 2018). The current study applies Wesp et al.'s (2018) emancipatory approach to cultural competency which is informed by critical race, postcolonial feminist and intersectionality theories. This approach offers a way to acknowledge diversity, question and analyze processes of power, and explore interventions to combat implicit bias in healthcare professions including nursing.

3.1.1 Critical race theory

Critical race theory recognizes that although racism is an everyday experience, the failure to acknowledge it past the narrowly defined view at the level of personal interactions versus within a systematic and widespread context makes it challenging to address (Wesp, et al., 2018; Delgado & Stefancic, 2017; Bonilla-Silva, 2017). Furthermore, race is socially constructed and

mainly controlled by the non-racialized dominant (white) group who maintain power among themselves, and subject other groups to categorization and stratification through these social constructions of power (Delgado & Stefancic, 2017; Wesp, et al., 2018). As this majority group benefits from these social constructions in terms of psychological and economical power, there is a lack of motivation to eradicate racism (Bell, 1991; Wesp, et al., 2018).

3.1.2 Post-colonial feminism

Post-colonial feminism is an amalgamation of post-colonial and feminist theories which materialized from challenging the portrayal of women from low income nations as lacking knowledge or ability, and victims of patriarchal societies and culture (Anderson & McCann, 2002; Wesp, et al., 2018; Mohanty, 1988). It recognizes the ways in which women are oppressed politically, economically and socially including the ways in which processes and policies related to colonization continue to have current impacts of power and oppression in the post-colonial era (Anderson & McCann, 2002; Wesp, et al., 2018). This theory challenges the view/knowledge of the majority group which has contributed to structural differences in power between dominant and nondominant groups, and aims to broaden the discourse to include historical perspectives and context, while challenging those that are essentializing and culturalist (Anderson & McCann, 2002; Wesp, et al., 2018). It further highlights the creation of culture (which includes domination and resistance) as being one of continuous negotiation shaped by differing power relations between the colonizer and colonized (Anderson & McCann, 2002; Wesp, et al., 2018).

3.1.3 Intersectionality

Crenshaw's (1989) seminal work on intersectionality defines it as a way of viewing and understanding social location with respect to the interaction of systems of race, gender and class (Crenshaw, 1989). The intersectional approach acknowledges the unique amalgam of multiple

identities and conditions of a person as opposed to a mutually exclusive approach (Crenshaw, 1989). Crenshaw (1989) also highlights that these varying identities and conditions are located within structures of power and privilege where intersecting identities can create instances of both opportunity and oppression. Crenshaw's work has since stemmed a great deal of literature dedicated to the topic and application of the intersectional approach. Considering this is an exploratory study, the social constructs selected to be included were the key social constructs of gender and class as identified by Crenshaw (1989), along with culture as ethnic identity, life stage, and immigrant status, which are constructs identified in the inclusion criteria. A "both/and" strategy was utilized, as this strategy concurrently recognizes distinct master categories and emergent effects at intersections (Bowleg, 2008; Risman, 2004). The importance of these aspects is exemplified in a study by Ramaswami Mahalingam et al. (2008) which examined the intersectionality of immigrant status and gender within Asian communities. This study noted that idealized patriarchal beliefs in relation to femininity/masculinity were positively related to ethnic pride and resilience as women in the communities identified patriarchal identity constructions as honouring their culture and challenging values of the West (Mahalingam, Balan, & Haritatos, 2008).

In *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada* (Mental Health Commission, 2009), cultural identity was noted to be "a potential source of resilience, meaning and value." Factors that influence psychosocial integration include formation of identity at the individual level, migrant status and racialization at the societal level, and socio-political factors at even broader levels (Khanlou & Gonsalves, 2011). First and second-generation youth often must navigate between identities; including that of their parents and that of the country they migrated to (Khanlou & Gonsalves, 2011). Experiencing racism or

discrimination in their host countries can also affect their identity and integration (Khanlou & Gonsalves, 2011). As the life stage of adolescence is a crucial period of identity development, it adds further complexities to the intersection of racialized status and immigrant status (Khanlou & Gonsalves, 2011). Gender and class, the most omnipresent and codified constructs further present unique instances of power and privilege while intersecting with youths' other identities. Also, as gender is a socially constructed category, it cannot be presumed to be static (Khanlou & Gonsalves, 2011; Shields, 2008). Khanlou and Gonsalves (2011) argue for applying an intersectionality lens in in examining youth cultural identities and psychosocial integration and re-visioning youth mental health promotion (MHP) in immigrant-receiving pluralistic societies. They conclude that "intersectionality can position us to understand how agency (or resiliency and resourcefulness within the MHP approach) is negotiated within the structures of host society" (p. 177). The quality and efficiency of mental health promotion, policies and initiatives depend on appropriately addressing the multiple identities that immigrant youth have, and their intersectionalities, including gender, life stage, migrant and racialized status (Khanlou & Crawford, 2006).

In this study, an intersectional approach was applied to the social determinants of health and viewed through the theoretical perspective of Wesp et al.'s (2018) emancipatory approach to cultural competency. This theoretical perspective offered a way to analyze how the social constructions of power and privilege manifest at both the micro level, i.e., between individuals, as well as at the macro level, i.e. in the form of policies, rules or laws, and to examine how this multi-axial social construction produces mental health inequities for Tamil immigrant youth (Caiola, Docherty, Relf, & Barroso, 2014). Using a broad and comprehensive approach that is multi-disciplinary and multi-sectorial at the individual, family, community, and society levels

can increase the comprehension of, and opportunities to address and promote mental health appropriately and effectively. By further framing social inequities and seeking social justice, this theoretical perspective will contribute to the development of nursing knowledge and practise in better serving this specific population's mental health needs.

3.2 Positionality

Epistemology is the study of knowledge, which includes the nature, possibilities, sources and limitations of what we know and understand. As such, the theoretical perspective described above renders the need to reflect on where you, the reader, and I, the writer, are located within this complex interplay of continuous negotiations of power. Such a reflection will in turn maximize the way in which this thesis is contextualized and understood. This further requires sharing on my part as the writer on a multitude of factors including my social determinants of health (including gender, class, race, culture), life stage, identity and immigrant status and the ways in which these factors along with the processes and policies affected by colonization influence diversity, biases, power, and oppression. Clarifying my positionality in such a way critically situates my knowledges and gaps of the research within the politics of power, agency and knowledge production (Rose, 1997). It also, I hope, adds to the rigor of my study.

To clarify my positionality related to this research, it is important to note that I, the primary investigator (PI), am a young adult, and I identify as a cisgender woman. I am a Canadian citizen, and a first-generation Tamil immigrant of Sri Lankan origin, who arrived in Canada at the age of five. Similar to the majority of Tamils of Sri Lankan origin, my father arrived in Canada as a refugee, and later sponsored the rest of my family and I. Having lived through the war/genocide, I've participated in human rights activism pertaining to the war, and I took part in the 2009 large scale protests in Toronto to call attention to war crimes and human

rights violations alongside my community. The Tamil Genocide was recognized by some municipalities in Toronto during the completion of this thesis. My interest in this topic stemmed from my experiences and observations of stigma related to mental health and mental illness, as well as the loss of multiple youth to suicide in the Tamil community. I currently practice as a Registered Nurse and have experience in the specialties of mental health, community nursing, and compliance/inspections.

This research utilizes a subjective epistemology standpoint where my knowledge/positionality has been shaped by both my own social and political experiences as well as the social and political experiences of the Tamil community. A general review of the current literature on Tamils of Sri Lankan origin, whether it be related to mental health or politics, evidenced a huge lack in allowing individuals from this group to lead the analysis of their own community and personal experiences and often represented voices belonging to the dominant group culture. This situation fails to be inclusive of the varying standpoints of members belonging to this group. It also fails to allow opportunities to challenge the status quo led by the dominant group, which further marginalizes and/or oppresses the voices and experiences of this group. As a member of the Tamil community, an immigrant who is bilingual (Tamil and English), and a healthcare professional, I hold an "insider perspective" in relation to this research topic in multiple ways. The resulting "outsider-within" phenomenon placed me in a unique position where I was able to utilize "insider" knowledge in my analysis which would otherwise remain unrecognized by the dominant group culture. This in turn also allowed me to challenge the status quo. Further discussion on the experience and meaning of being in such a positionality throughout this thesis work, and its advantages and limitations will be discussed at the end of this thesis.

Despite the Tamil community having some similar experiences, it remains important to recognize the differences and diversity within this group. As I, the primary investigator, am a first-generation Tamil immigrant with a preconceived awareness of the community, I remained cognizant of the historical and contextual aspects of distinct identity categories, and aware of my own perceptions through self-reflection, and completed journal entries to record my thoughts, feelings and reflections. In using this approach, I acknowledged Tamil youth's social constructions of difference including historical, cultural and political contexts (Caiola, Docherty, Relf, & Barroso, 2014), and analyzed the relations between the selected identities and the structural systems of society that maintain them (Collins, 1990; Stewart & McDermott, 2004) including historical, cultural, and developmental contexts, and the acts and policies that work together to create social location (Warner, 2008).

3.3 Research Design and Methods

A convergent parallel mixed methods research design (Creswell & Clark, 2011) was used in this study. A mixed methods study uses both a qualitative strand and a quantitative strand where the strands can be part of the design equally or one can be the leading arm over the other (Creswell & Clark, 2011). It combines the data obtained from the different strands at different points to enhance understanding of an area of interest (Creswell & Clark, 2011). In this study, the qualitative strand was the leading arm and consisted of an interpretive descriptive research design as described by Thorne (2008), while the quantitative strand drew its data from the quantitative survey instruments. The point of interface between the quantitative and qualitative strands occurred at the point of data collection, analysis and interpretation including connecting through the sampling frame (Creswell & Clark, 2011). Data collection of both sets of data were completed concurrently from the same sample of participants followed by separate analysis of

each data set. Both sets of data were also then merged together and analysed to produce descriptive and interpretive results to enhance understanding of the qualitative results to inform ways to improve mental health care for the population of interest (Creswell & Clark, 2011).

This method was selected to help in developing comprehensive and deep insights into the complex organizational and social phenomena of health, well-being and mental health, which cannot be as completely understood using a quantitative or a qualitative method on its own (Venkatesh, Brown, & Bala, 2013). This convergent parallel mixed methods design addresses the different research questions that need to be answered, of which each requires different types of data and reflects the paradigm of pragmatism by assessing the relationship, if any between the qualitative data and quantitative data (Creswell & Clark, 2011). Teddlie and Tashakkori (2003; 2009) identify the value of mixed methods research as including the ability to concurrently address exploratory and confirmatory research questions and counterbalance the disadvantages that an individual method has on its own. Other values Teddlie and Tashakkori (2003; 2009) identified were that it offers a variety of contradictory and/or corresponding views and provides stronger inferences than those that would be made with any individual method.

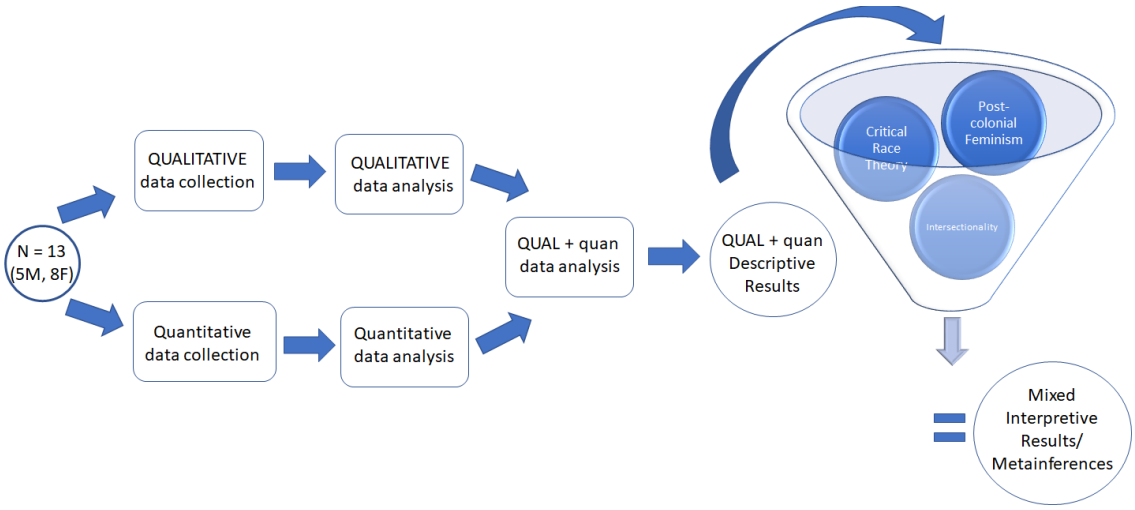

Figure 1: Convergent Parallel Design. Adapted from Creswell & Plano, 2011

I maintained inference quality/validity in this thesis through explicit discussion of meta-inferences, assessments of the integration of qualitative and quantitative findings, and the quality of this integration (Teddlie & Tashakkori, 2003; Teddlie & Tashakkori, 2009). I also closely followed what is recommended in pertinent literature on mixed methods research (Teddlie & Tashakkori, 2003; Teddlie & Tashakkori, 2009). Data quality and the extent to which collected data met the criteria of quality to be considered valid and reliable, were also ensured (Teddlie & Tashakkori, 2003; Teddlie & Tashakkori, 2009). This was done through data collection of both data strands from the same sample, using the weaving approach and quotes to jointly display data from both strands on selected constructs i.e. self esteem, health practices, reporting disconfirming evidence, addressing the mixed methods research question and interpreting the mixed method results through a social justice lens. Any potential limitations were also discussed.

3.4 Research Questions

The qualitative research question for this study was: What are the meanings, beliefs, practices, and experiences of health, well-being, and mental health from the perspectives of Toronto-residing, first and second-generation Tamil youth of Sri Lankan origin?

The quantitative research question for this study was: What is the youth's current self-esteem based on their feelings towards themselves in the past week, and what is their level of engagement in leisure activities that promote or maintain mental health and well-being?

The mixed method research question was: How does the quantitative data provide an enhanced understanding of the qualitative findings in order to explore opportunities for nurses and service providers to improve mental health care for this population?

3.5 Research Methodology

A cross sectional, convergent parallel mixed methods study based on an interpretive descriptive approach was used to explore Tamil youths' meanings, beliefs, practices and experiences of health, well-being, and mental health. The interpretive descriptive research approach expands "beyond mere description and into the domain of the 'so what' that drives all applied disciplines" (Thorne, 2008, p. 33) including nursing. As recommended by Guthrie and Low (2006), I drew out emergent information during interviews, including participants' definitions which showed "fluidity and dynamicity of categories". Open ended and exploratory questions about these different intersections were included in the interview guide while the quantitative survey instruments assessed health promoting activities they engaged in and their current self-esteem. This methodology fits with Wesp et al.'s (2018) emancipatory approach to cultural competency by means of recognizing individuals' unique social locations created by the overlapping experiences and realities of class, race and gender, and in relation to structures of

power and privilege. In this way, it allowed me to inquire further into its impact on participant's perceptions, practices and experiences of health, well-being, and mental health.

A key aspect of Thorne's (2008) approach is to produce new qualitative evidence that can be applied to practice, such as in the health or nursing fields. I used this mixed methods study design based on an interpretive descriptive approach with the goal of helping nurses and other health professionals inform their ways of approaching, engaging and providing mental health care to this population. I analyzed and emphasized changes required at the individual level of this community's members, as well as changes required at the micro, meso and macro systems that serve this population. I make critical reflections on how this information can be used to increase quality of care and services provided to this population.

3.5.1 Ethics

The study was submitted for approval and monitoring by the Research Ethics Board at York University. Participants were ethically recruited with full disclosure of the study through written and verbal information and were informed of their ability to withdraw from the study, if desired, at any time. Appropriate informed consent procedures were completed prior to any data collection, at the initial face-to-face meeting. This procedure further ensured ethical authorization for participation in the research and the audiotaping of the interview process. Participants received and demonstrated comprehension of the information provided. In order to protect participant confidentiality, the PI and the research mentor were required to sign confidentiality forms. Any identifiable information such as names were removed from data and only de-identified and password protected data were used in the study. Collected data was securely stored in a locked drawer in my research office and used solely by myself and my supervisor for the purpose stated in the consent form. The data will be stored for two years and

then it will be archived at York University. None of the interviews or processes during the study caused undue stress to participants. Information on general mental health providers/services, and mental health education where appropriate was provided to all participants. De-briefing time was provided to all participants at the end of the interviews where questions were answered, and concerns were addressed. More specific information based on assessed needs was provided to three participants as this skill is within my scope of practice as a Registered Nurse. One specific situation shared by a participant presented an ethical problem where my professional action was required. As the details are of a confidential nature, specifics cannot be discussed; however, processes as required by the College of Nurses of Ontario (CNO) were followed closely and safety and care of the participant was ensured.

3.5.2 Sampling strategy.

A two-part sampling method was used. Snowball sampling was used during the first stage to recruit participants, followed by purposive sampling in the second stage to ensure a wide range of variation in terms of age, gender, and class. The inclusion criteria for this study required participants to be between the ages of 18 to 24 years old, self-report that they are a first or second generation Sri Lankan Tamil immigrant, speak and understand English, be willing and able to share information and knowledge related to their perceptions of health, well-being, and mental health, and agree to be interviewed by me for approximately one to one and a half hours. Data saturation was considered as a component to finalize the sample size, and based on similar studies in other ethnic populations, the sample size was estimated to be in the range between 10 and 15 participants. The final sample size was 13, with 8 female and 5 male participants, who participated in the study before saturation was reached.

In the first stage, the snowball sampling stage, participants were recruited through referrals by friends and colleagues, and with posts shared on social media (i.e. Instagram and Facebook). Several community organizations assisted with recruitment by sharing the online recruitment poster and referring participants to me. A ten-dollar gift card was offered as an incentive for participating. Images used on social media for recruitment can be found in Appendix A. As part of this first stage, interested participants were asked to undergo a screening phase where they completed an online form/screening questionnaire outlined in Appendix B, which was designed as a tool to ensure interested participants met the inclusion criteria. This questionnaire included online informed consent (of which the content can be found in Appendix C) and required between five to ten minutes to complete. Recruitment was completed in two waves with the first being May to September 2017, and then the second being October 2017 to January 2018. On March 6, 2018, the online questionnaire was noted to have received 36 responses; however, recruitment was difficult with many participants who completed the screening questionnaire not responding when contacted. Nevertheless, the number of responses indicates a high level of interest in this topic within this community. Online respondents of the screening questionnaire were mostly aged 23 and 24 (58.4%), followed by those aged 21 and 22 (22%). Most were female (58.3% females and 41.7% males) and identified as second generation (66.7% second generation and 30.6% first generation). In the second stage, the purposive sampling technique was used in relation to the inclusion criteria where participants from the first stage were screened and those who met the inclusion criteria were invited to an interview.

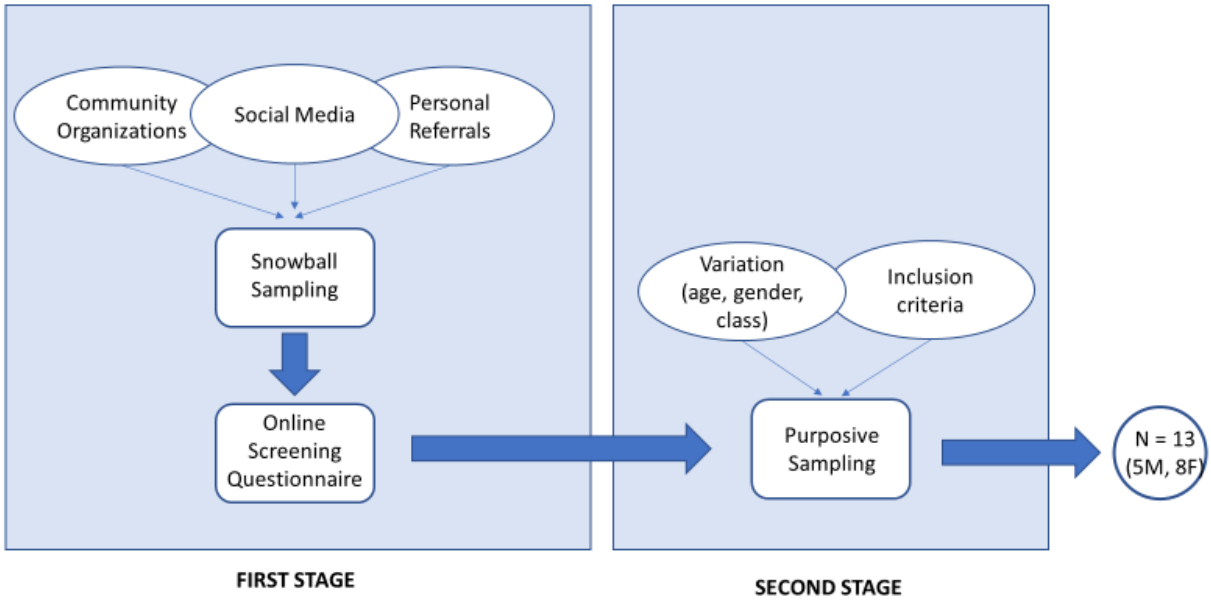

Figure 2: Sampling strategy used

3.5.3 Concurrent data collection.

I, a registered nurse, completed face-to-face interviews with participants who responded to the invite following the screening phase. All the interviews were in the English language and conducted in a private setting. At the time of interview, participants signed a consent form (which can be found in Appendix C) after they were provided with information on details of the study, what will be made of the data, who will see the data, and benefits/risks of participating in the study. They were further assured of confidentiality and given an opportunity to ask questions or clarify any concerns.

Quantitative measures.

The participants then completed the individual questionnaire which can be found in Appendix D. The individual questionnaire included demographic questions on the individual

and their family, the Health Promoting Activities Scale (HPAS), originally developed by Helen Bourke-Taylor, Mary Law, Linsey Howie, and Julie Pallant (2013), and The Current Self-Esteem Instrument developed by Nazilla Khanlou (2004).

The HPAS was chosen as it measures the informant's estimate of how often they engage in leisure activities that promote or maintain health and well-being, with a specific focus on mental health (Bourke-Taylor, Law, Howie, & Pallant, 2013). This scale has a good internal consistency with a Cronbach's alpha of 0.78 (Bourke-Taylor, Lalor, Farnworth, & Pallant, 2014). The Current Self-Esteem Instrument was also chosen to be included in the individual questionnaire to measure informant's feelings about themselves over the course of the past week (Khanou, 2004). This instrument contains an analog scale numbered from one ten to rate positive feelings toward self (Khanou, 2004). It also contains three open-ended questions to assess a participant's feelings toward themselves, promoting or challenging influences on their self-esteem, and their suggested strategies to promote their self-esteem (Khanou, 2004).

Qualitative guides.

Either following completion or before beginning the individual questionnaire, I asked the participants what interested them in participating in the study and all of them expressed the desire to contribute to the development of knowledge and research on mental health within the Tamil Canadian community. They expressed their concerns related to the number of suicides in the community and the number of individuals suffering with mental health challenges, some included themselves. Upon participants completing the individual questionnaire, I quickly reviewed it to gather a sense of understanding of the participant and ensure its completion. I then proceeded to questions from the interview guide which consisted of open-ended and semi-structured questions, to complete in-depth interviews. The interview guide can be found in

Appendix E. All the interviews were in the English language and audiotaped from the beginning to the end of the interview guide. Each interview progressed differently as I took more of a conversational approach to the interview guide. I asked questions in the order that felt most natural to each unfolding conversation. I probed and expanded on certain topics to gain more information from the participants, at times using information from the demographic/individual questionnaire. The participants became more comfortable with disclosing information on their own as the interviews progressed.

Recorded interviews lasted between approximately 20 to 60 minutes, and each meeting took approximately 60 to 90 minutes. Time was allowed at the end of the interview for debriefing, to reduce the impact of any unpleasant emotions that surfaced during the interview. Many of the participants provided feedback stating that they felt open to talking as they felt they were not being judged. A few participants expressed concerns about the confidentiality of the interviews but were provided reassurance and were referred to information provided on the consent form.

Mental health resources were provided to all participants and can be found in Appendix F. Specialized information was provided based on indications of emotional distress and/or upon request. Audiotaped data and field notes were then transcribed verbatim and saved onto a password protected computer hard drive. I completed a researcher's field log to keep a record of additional information including observational notes that described what was observed in terms of actions, dialogue and context of the interview; theoretical notes that documented my thoughts about how to make sense of what was going on; methodological notes that recorded reflections about observational strategies, effective strategies and potential new approaches; and personal

notes to capture my feelings and reflections (Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, 2008).

3.5.4 Data analysis

As previously mentioned, data analysis was one of the ways that integration of the qualitative and quantitative components of this study occurred (Creswell & Clark, 2011). Analyses of the qualitative and quantitative strands were first conducted separately and then mixed so that the quantitative results were used to enhance understanding of the qualitative results in how it can improve mental health care for the population of interest (Creswell & Clark, 2011). Onwuegbuzie and Teddlie's (2003) framework for mixed methods data analysis was employed, including data reduction (summarizing qualitative data), data display (reducing data to tables and charts), data transformation (transforming one data type to another), data correlation (making associations between data types), data consolidation (blending data types to create new data), data comparison (comparing data) and data integration (amalgamation of all data).

Quantitative data.

Quantitative data was analyzed using quantitative analysis procedures including, frequency distribution, and percent distribution. Descriptive analysis was applied to the data collected from the HPAS (Bourke-Taylor, Law, Howie, & Pallant, 2013) and The Current Self-Esteem Instrument (Khanou, 2004) to generate means and frequencies. The resulting inferences were then incorporated into the descriptive presentation of the results and grouped along with the quantitative results under the headings of individual practices and experiences in order to answer the second/quantitative research question. Inferences are conclusions drawn from separate

qualitative and quantitative strands of a study (Teddlie & Tashakkori, Foundations of Mixed Methods Research, 2009).

Qualitative data.

Qualitative data was analyzed using a qualitative interpretive descriptive approach. The level at which the themes were identified was first at the descriptive level in chapter four, and then at the interpretive level in chapter five, but analyses was ongoing and iterative (Thorne, Kirkham, & MacDonald-Emes, 1997). I tactically engaged in periods of data collection, and engagement with data collected, with the intention of honing the inquiry (Thorne, Kirkham, & MacDonald-Emes, 1997). Recruitment was completed in two waves with the first being May to September 2017, and then the second being October 2017 to January 2018, and feedback was sought from Dr Nazilla Khanlou, my supervisor, between these recruitment periods. Based on the feedback, I improved the quality of my field notes to include detailed observations and information obtained outside the interview guide. I also allowed for more moments of silence when needed during interviews to allow participants to reflect and respond.

As the data collected yielded a large amount of rich data, I repeatedly immersed myself in the data collected through interview transcripts and field notes, carefully examining them to understand and become familiar with the data (Thorne, Kirkham, & MacDonald-Emes, 1997). This was done during the transcription of the interviews as I completed them on my own. I first listened to the recordings, then listened again as I transcribed them, and then listened once more to confirm that the transcriptions completed were accurate. I combined all the transcripts and during this process, I also began to highlight and withdraw quotes from the participants that may be relevant into a separate document.

A thematic analytic approach informed by interpretive description was then utilized, including data tabulation where the data was sorted into themes/patterns, coded, tested for relationships and connections, and conceptualized into findings (Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, 2008). I first created participant codes for all participants to represent whether they were male or female and assigned them a number as an identifier i.e. Participant #M003. After the first wave of recruitment, I started identifying, reviewing and re-identifying qualitative themes/patterns repeated between four participants' transcripts using Microsoft Word's (a word processing software) comments feature. From this, I created an initial emergent codes list. I reviewed this list and the codes I had identified with my supervisor who had also independently reviewed the transcripts and identified codes. Based on the insight gained from the discussion and comparison of codes, I completed the analysis for the remainder of the participants' transcripts. Specifically, I highlighted relevant data and created a comment with the name(s) of the code and then employed data reduction by summarizing the relevant information from the interview along with the participant code. By using the search feature on Microsoft Word, I was further able to find similar words/patterns within the transcriptions and complete coding on this document. I will refer to this document as the Coded Transcript Document. I then extracted each coded occurrence of identified themes and their related data (including participant codes) from the Coded Transcript Document and recorded them together under a heading for each identified theme in a new, separate word document which I will refer to as the Summarized Code Document. I was then able to employ data transformation and correlation by tallying the prevalence of identified codes among the participants and making associations between their characteristics i.e. sex, age and the findings. The Coded Transcript Document and the

Summarized Code Document were a work in progress as I revisited them at different stages to gain further insight and make additions/revisions to codes.

I continued the analysis and revision of identified codes informed by the social determinants of health. I also organized them at different points to summarize them into themes and organize them in different ways including within a systems model. I did this by drawing different mind maps and transcribing the themes on cue cards to arrange and group them in different ways. These coding methods were an active process which allowed me to view the data from different angles and perspectives to "appreciate the implications of each of the available options for handling, grouping, and reconstructing pattern within them" (Thorne, 2008, p. 47). Analytic thinking was documented into my notebooks and in the drafts of my analysis documents with analytic memos to refine ideas, seek expansion and clarification, pose questions, identify patterns, organize data and brainstorm ideas and connections (Thorne, 2008).

Mixed analysis.

The data continued to be explored by disaggregating it across different variables and subcategories of variables. I employed data reduction, data display and data transformation by using Microsoft Excel (a spreadsheet software) to analyze the two strands of data. I created three tables. The first table (hereafter referred to as the Demographics Table) analyzed demographic information by tabulating participant codes and their answers to questions one to 17 from the individual questionnaire (which focused on demographics). The second table (hereafter referred to as the Interview Guide Table) tabulated participants' age, gender and birthplace with the data gathered from the interview guide, but I populated the table by summarizing the participants' responses to the interview guide questions. The third table tabulated responses to the HPAS. With these tables, I was able to more easily analyze the data, identify repeating patterns among

the participants, tally answers, summarize information, and transform qualitative data into quantitative data as discussed below.

I further engaged in data correlation, consolidation and comparison by merging information from the Demographics Table and the Interview Guide Table with the Summarized Code Document into one document. The steps I took to do this was to first create a word document using the Interview Guide Table by extracting each question and list of each participant's summarized answers along with their participant codes. I merged this document with the Summarized Code Document and organized the information and codes under different levels based on the systems model. The answers to the question on definitions/conceptualizations from the interview guide were organized separately in the document. The information that was tallied and summarized from the Demographics Table was later included in this document as well. I was then able to start summarizing findings. I continued to create documents that extracted relevant data for me to examine and summarize. These documents provided better visibility for continued analysis of the data. Analysis of the data was ongoing, where I referenced and clarified my summaries and documents by referring to previous documents to ensure that the accuracy of the information was maintained. Data analyzed included responses to interviews as well as field notes and journal entries to ensure contextualization of the data. I also continued to collect and revise the relevant quotes used from the transcripts in the presentation of findings.

Participants were invited during the data analysis stage to confirm, validate, and refine data patterns, thematic extractions and inferences; however, only two participants responded, and as their availabilities did not coincide, the focus group could not be completed. However, research dissemination opportunities, described in Chapter 6, presented instances for learning

with health care providers, service providers, parents and youth both within and outside the Tamil community and contributed to thorough analysis of the data.

Integration.

As a representation of the continued analysis and comparison, the findings are presented in a semi-combined way at a descriptive level in chapter four, and a combined way at an interpretive level in chapter five (Fetters, Curry, & Creswell, 2013). Chapter four answers the qualitative and quantitative research questions and chapter five answers the mixed methods research question. In this chapter, the descriptive findings are presented under headings related to the main questions that my thesis, and the first/qualitative research question sought to answer. The headings are the meanings, beliefs, social/individual practices and experiences, in order to answer the first/qualitative research question. The chapter begins with a descriptive analysis of the demographic information and ends with a summary of the participants' recommendations. As the qualitative and quantitative strands mixed during this stage of analysis, findings from the HPAS is merged under the heading of Individual Practices of Mental Health and Well-Being (presented in section 4.6.1), and findings from the Current Self-Esteem Instrument is merged under the heading Experiences of Mental Health and Well-Being (presented in section 4.7.9). These sections answer the second/quantitative research question. Chapter four presents the findings through the weaving approach where both quantitative and qualitative findings are jointly written together (Fetters, Curry, & Creswell, 2013), allowing for comparison of the two data sets.

The resulting inferences from the quantitative data, including engagement in health promoting activities and self-esteem, were compared and analyzed with the inferences from the qualitative data to enhance understanding and gain deeper insights into the qualitative data which

resulted in high quality meta-inferences in chapter five (Venkatesh, Brown, & Bala, 2013; Fetters, Curry, & Creswell, 2013). Enhanced and precise inferences, referred to as meta-inferences are key elements of mixed methods research (Tashakkori & Teddlie, 2008) and are defined as "the theoretical statements, narratives, or a story inferred from an integration of findings from quantitative and qualitative strands of mixed methods research" (Venkatesh, Brown, & Bala, 2013, p. 38). The meta-inferences in chapter five were made by analyzing the mixed data through Wesp et al.'s (2018) emancipatory approach to cultural competency. Findings were also compared with similar studies on mental health, to draw similarities and differences, including studies on Tamils in Sri Lanka, and other communities with similar experiences as the Tamil community. The data was then amalgamated, theorized, and contextualized for the application to practice (Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, 2008). The phenomenon under study was then illuminated in a new and meaningful manner through recommendations to practice.

3.5.5 Study rigor

I ensured rigor in this research study in multiple ways by ensuring epistemological integrity, transferability, confirmability, analytic logic, creation of an audit trail, and use of thick description. Epistemological integrity was maintained as the research questions were consistent with the stated subjective epistemology standpoint, and the interpretation of data and interpretative strategies flowed soundly from these questions (Thorne, 2008). Transferability occurred as the interpretations of the cultural meanings, beliefs, practices of, and experiences with, health, well-being, and mental health may be transferred to other Tamil immigrant cultural contexts, and possibly other South Asian immigrant youth populations. It can also be transferred to other immigrant/refugee populations with similar experiences of war, trauma, genocide, and

discrimination. Creating an audit trail by maintaining and systematically documenting data to ensure that findings can be traced to actual data collected further enhanced these aspects (Thorne, 2008). Thick description was used, including verbatim accounts from the data to ground interpretive claims (Thorne, 2008).

Representative credibility and trustworthiness were achieved using triangulation approaches (Thorne, 2008) including data collected from interviews, field notes, observations, and interviewer's reflective journals. In addition, during the analysis stage, my supervisor and I analyzed the first four transcripts separately then compared the emerging codes. Based on the discussion, I applied and elaborated on the remainder of the transcripts for the study. My supervisor and I also met regularly to discuss emerging codes and throughout the study.

My reflective journals also increased trustworthiness and explicated interpretive authority by facilitating the expression of possible bias and accounting for the reactivity that occurs in the research process (Thorne, 2008; Paterson, 1994). As previously mentioned, I, the PI, have lived in Canada for over 20 years, am a first-generation Sri Lankan Tamil immigrant, practicing nursing as a mental health nurse, and am familiar with many aspects of health and life for Tamil immigrants in Canada leading to my role as a potential insider. Padgett (1998) stated that while it is not mandatory to dispense of personal feelings and biases, it is crucial to become conscious of them and their impact on the study. Therefore, I remained aware of my positionality, analytically and reflexively reviewed my emotions, perceptions, and reactions to the data throughout the research and kept a reflective journal describing and interpreting my own experiences, feelings, thoughts, and reactions at various stages of the study. This process ensured reflexivity, which furthered the rigor of this research study.

3.6 Summary

This chapter discussed the theoretical perspective of how and why the intersectional approach was applied to the social determinants of health and viewed through the theoretical perspective of Wesp et al.'s (2018) emancipatory approach to cultural competency. My positionality, and the research design and methods, and questions were stated, and the research methodology was described. Lastly, it shared an overview of the study timeline, how study rigor was maintained and how ethical requirements were met. The next chapter brings this chapter and all the previous chapters together to present the descriptive results of the study.

4.0 Chapter Four: Descriptive Results

An abundant amount of rich information was gained during this study. This may have been due to the participants' age, their insightfulness or educational background and/or a result of me, the PI, being an insider to the community in question allowing for deeper analysis. In any case, in order to maintain inference quality/validity of this convergent parallel mixed methods study as discussed in chapter 3.3, the current chapter presents the descriptive results of the study and chapter five presents the interpretive results. Findings gained from thematic analysis are presented with supplementation of descriptive quantitative data of the study sample in this chapter. This chapter aids in answering the qualitative and qualitative research questions for this study.

Presented in this way, the reader is provided an opportunity to be informed in chapter four on how the quantitative and qualitative data were analyzed concurrently, then follow the thought process presented into chapter five where the interpretive results are discussed. Of course, there exists a strong appreciation that this is just one way of grouping and constructing patterns with this data (Thorne, 2008), and the results presented in this way offers an opportunity for the reader to engage with the data in different ways than I, the researcher.

4.1 Demographic Information

Presented below is the demographic information of the study participants and their families including their age, gender, country of origin, place of birth, age at arrival, status upon arrival, current status, mother tongue and primary language. Summarized information can be found in Tables 1 and 2.

4.1.1 Age and gender.

As per the study's inclusion criteria, all participants were between the ages of 18 and 24, including eight female participants and five male participants. Most of the participants were 21 and older, with the majority (five females and two males) aged 22 -23 years old. The youngest participants were both males aged 18 and 19, while the oldest participants were a male and a female, both aged 24 years old. It is to be noted that recruitment of males for participation in the study proved to be difficult despite the number of attempts, and various recruitment methods employed.

Table 1. *Basic Demographic Profile of Participants*

	Female		**Male**		**Total**	
	n	**%**	**n**	**%**	**n**	**%**
	8	61.5	5	38.5	13	100
Age						
18-21	2	15.4	2	15.4	4	30.8
22-24	6	46.1	3	23.1	9	69.2

4.1.2 Place of birth, origin, immigration and status.

All the participants' parents were born in Sri Lanka and had immigrated, or trans-migrated via European countries to Canada. Two participants (15%) were born in European countries, and two others (15%) were born in Sri Lanka, but most, nine participants (69%), were born in Canada. The two participants born in European countries immigrated to Canada as infants, while the two born in Sri Lanka immigrated to Canada at preschool age. As such, the majority of the sample are second generation Canadians, who have been in Canada for over 18 years, and are currently Canadian citizens, as are their parents.

Table 2. *Origin, Birth, and Immigration of Participants*

	Female		Male		Total	
	n	**%**	**n**	**%**	**n**	**%**
Country of Origin[1]						
Sri Lanka					13	100
Place of Birth						
Canada	6	46.2	3	23.1	9	69.2
Sri Lanka	1	7.7	1	7.7	2	15.4
Europe	1	7.7	1	7.7	2	15.4
Age at Arrival						
0-2	1	7.7	1	7.7	2	15.4
3-5	1	7.7	1	7.7	2	15.4
Status Upon Arrival						
Immigrant	2	15.4	2	15.4	4	30.2
Current Status						
Canadian Citizen					13	100

[1]Place of their parents' birth

4.1.3 Language.

All the participants identified Tamil as their mother tongue, but English as their primary language. All the interviews were conducted in English with no translation required.

4.2 Socio-economic Information

The information presented below covers participants' area of residency, adjusted household incomes, employment status, student status, relationship status, highest level of education, family structure, parents' pre and most migration employment, and parents' language and literacy levels. Summarized information can be found in Table 3 below.

Table 3. *Socio-economic Profile of Participants*

	Female		Male		Total	
	n	**%**	**n**	**%**	**n**	**%**
Household Income						
I don't know	0	0	3	23.1	3	23.1
$20,000 - $49,999	0	0	1	7.7	1	7.7
$50,000 - $79,999	5	38.4	1	7.7	6	46.1
$80,000+	3	23.1	0	0	3	23.1
Relationship Status						
Single	4	30.2	3	23.1	7	53.9
In a Relationship	4	30.2	2	15.4	6	46.1
Highest Level of Education						
High School	1	7.7	2	15.4	3	23.1
College Diploma	1	7.7	1	7.7	2	15.4
Undergraduate	6	46.1	2	15.4	8	61.5
Student Status						
Part-Time	4	30.2	1	7.7	5	38.4
Full-Time	1	7.7	0	0	1	7.7
N/A	3	23.1	4	30.2	7	53.9
Employment						
Full-Time	5[1]	38.4	2	15.4	7	53.9
Part-Time	2	15.4	1	7.7	3	23.1
Unemployed	1	7.7	2	15.4	3	23.1

[1] One participant reported working multiple part time jobs

4.2.1 Parents' pre and post-migration employment.

Participants' mothers were mostly either unemployed or students prior to migration and worked general labour jobs post-migration. Prior to migration, nine (69%) participants reported their mother was either a student (five participants' mother or 38%) or not employed (four participants' mother or 31%). Only four participants (31%) reported that their mother had been employed prior to migration. Of those mothers that were reported to be employed, two were teachers, one was an administrative assistant, and another worked "odd jobs". Post-migration, ten mothers (77%) were employed. Six of the participants' mothers (46%) were working as general

laborers and four (31%) were employed in other positions with two of them holding management level positions. One of these participant's mother were reported to be working two different jobs. Only one participant's mother worked in a related position pre and post-migration. The remaining two mothers (15%) were reported to be either unemployed or had not been reported on by the participants (question was left unanswered), but these same mothers were noted to have been unemployed pre-migration as well.

Compared to participants' mothers, their fathers were more likely to have been employed pre- and post- migration, and like the mothers, the fathers were also employed general labour positions. Descriptive statistics concerning fathers was based on the answers of 12 participants. Prior to migration, seven of the participants (58%) reported that their father was employed in varying jobs/professions. Two participants reported that their father had been a student (17%). Three of the participants (25%) did not answer this question. Post-migration, all the fathers were employed in various jobs/professions, of which five (42%) were in general laborer positions, and three (25%) were in jobs requiring professional training. Only two fathers (17%) remained employed in the same occupation pre and post-migration. One of the participants expressed frustration related to not being able to have the same kind of support and opportunities to advance in her career as others in her field had as a result of their parents being educated and working in the same fields and her own parents not being able to offer similar advantages.

4.2.2 Parent's language and literacy level.

Three participants (23%) mentioned that due to their parents' language barrier, they held responsibility of translating or speaking on behalf of their parents during interactions with healthcare providers, through legal proceedings, and payments of bills. One participant

highlighted that due to their parents' lack/level of education, they lacked support during their own education.

4.2.3 Family structure and housing.

When asked about the number of members living in their household including themselves, six participants (46%) reported this number to be three to four persons, and seven participants (54%) reported it to be five to seven persons. All but one participant (92%) had one to two siblings, and all those who had siblings lived with them except for one participant. All participants except one (92%) indicated their household was a nuclear family including a mother and a father. One participant reported a single mother household.

In terms of extended family members living with participants, three participants (23%) reported that they currently lived with grandparent(s), and two of these participants (15%) reported that extended family members such as a cousin or uncle also lived with them. An additional two participants (15%) mentioned during their interviews that they at some previous point had extended family living with them i.e. uncles, aunts. One of these participants also reported having lived with ten others at one point and being witness to a lot of conflict between the members of the household, causing the participant to dread going home after school.

4.2.4 Area of residency.

Participants resided in various parts of the Greater Toronto Area including Markham, Scarborough, Etobicoke, Mississauga, Brampton, and Whitby. Six participants (46%) resided in Markham, another four (31%) resided in Etobicoke or Scarborough and the rest resided in Mississauga, Brampton or Whitby.

4.2.5 Adjusted household incomes.

Information on household income was gathered from participants; however, an adjustment is required to understand its implications as the number of members in each household differs between participants. The method most commonly used by Statistics Canada to determine low-income rate in census metropolitan areas is the low-income cut-off (LICO) approach, a well-defined methodology classified by family size and size of area of residence, which distinguishes those who are considerably worse off than average (Heisz & McLeod, 2004). In this approach, family income is compared with a predetermined low-income threshold inferred from an analysis of expenditure patterns, and if the family's income falls below this threshold, then they are considered to have low income (Heisz & McLeod, 2004). It is important to note that three participants did not report their household income as they did not know what it was. Based on this methodology, participants' reported household incomes and family sizes were compared to the most recent cut offs identified in 2017 by Statistics Canada (Statistics Canada, 2019b). One participant indicates low income, and another participant indicates the possibility (as a range was provided) of their household being low income as well.

4.2.6 Employment status.

Most participants (10 participants, 77%) were working full time or in school full time while juggling part time work. Out of the five participants (38%) who reported that they were attending university or college full time, four reported that they were also working part time. Six participants (46%) reported working full time, and one of these participants reported attending college part time. Only two (15%) participants reported that they were neither working or enrolled in school, with one of them reporting that they had just graduated and currently job searching.

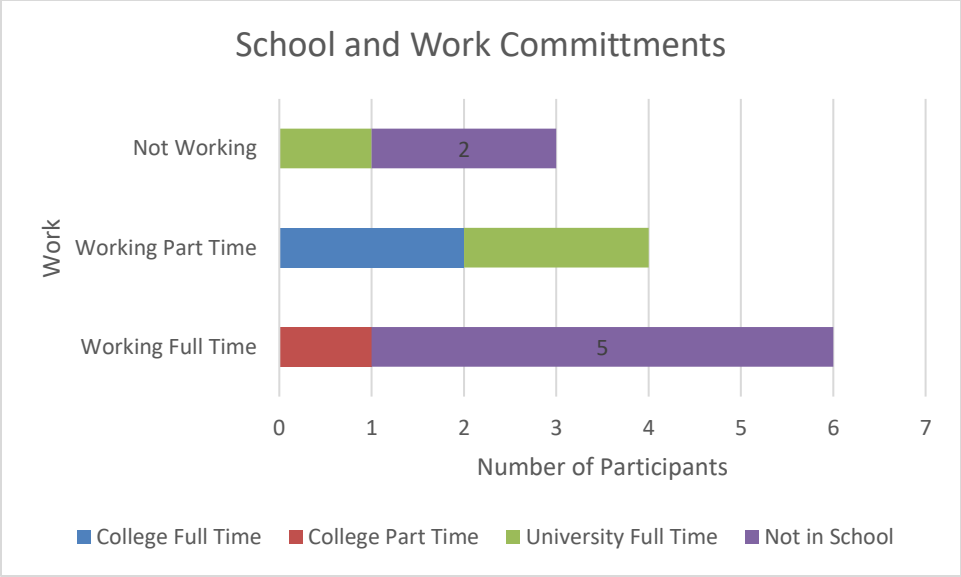

Figure 3: Participants' School and Work Balance

4.2.7 Education.

The participant group was highly educated. The highest level of education reported was undergraduate degree by eight participants (62%), college diploma by two participants (15%), and high school diploma by three (23%) participants. Females had higher levels of education than males overall, and two female participants (15%) reported that they were pursuing further education with one being at a graduate level. Interestingly, six (46%) participants were noted to be enrolled in or have completed programs in the social sciences i.e. global health, social work, human resources, recreation and leisure studies, nursing, and community work.

4.3 Definitions of Mental Health and Well-being

4.3.1 Health.

In defining the concept of health, aspects of both physical and mental health were correctly specified in eight participants' (62%) definitions. In contrast, the physical component

alone was indicated in two participants' answers (15%), and the mental component alone was specified in two participants' (15%) definitions.

Many participants may hold a misleading idea that health is equivalent to the absence of disease as six participants (46%) stated health is about managing stress, being mentally and physically fit, and not having any illnesses. They further believed that all areas of health must be actively worked on to have good health because if one area of health was not well, your overall health could suffer. There was a lack of understanding that one could be healthy overall despite one aspect of health not being optimal.

In comparison to males, females held a more holistic view of health as four (50%) of the eight female participants included social or spiritual health, and six of the eight participants (75%) that mentioned both physical and mental components in their definition of health were females. In comparison, only two (40%) of the total of five males specified both physical and mental health components in their definition, while two focused only on either physical health or mental health, and the remaining individual stated he did not know how to define it. None of the males mentioned any other aspects of health in their definition such as social or spiritual health.

4.3.2 Mental health.

When describing their definition of mental health, ten participants (77%) did not recognize all aspects of mental health including that it lies on a spectrum, can be dynamic, and is inclusive of behaviours, thoughts and emotions. Mental health was seen as more of a dichotomy versus a spectrum by most of the participants. Their definitions, as specified by 8 participants (62%) which included all 5 males (100%) and three of eight (38%) females, solely focused on either mental illness, coping and help seeking, or having healthy thoughts and being in the "right state of mind". Mental illnesses, being mentally unwell, coping strategies and help seeking

behaviours were the sole focus of six (46%) of the participants' definitions of mental health. Mental health was defined as behaviours such as having the appropriate tools, resources, and coping strategies to overcome life's challenges by four participants (31%), of which one was male and three were females. Another two participants (15%) who were both males, defined mental health solely focused on mental illnesses such as depression and anxiety.

> *Participant #M013: It's like to fix people with depression and stuff like that, like not really even fix but to spread awareness of other mental illnesses, not only depression, like anxiety, etc. I have many friends who have anxiety.*

Positive mental health such as healthy/positive thoughts, being in the right state of mind, and healthy living were solely focused on in three (23%) of the participants' answers, which included two males and one female. Another female participant's definition only focused on emotions and thought process e.g. how you feel and process what is happening around you.

> *Participant #F002: I think it depends on whether you are happy or not. That's very subjective, but I find that it's something, like if you're diagnosed with something like depression, I feel like it's something that you fight for. It's not easy, it's something that's always there with you, but it's like realizing that like you realize the pattern when you go through it enough times, you realize the patterns and you learn to avoid it. And you learn to take care of yourself, and you start doing things that make you happy and like you work on yourself and I think it's ultimately finding that peace of mind.*

Mental health was more accurately defined as being a dynamic state that can be managed through behaviours, thoughts and emotions by three (23%) of the participants, of which all three happened to be females. They spoke about finding a balance by engaging in positive activities, finding happiness, and practicing gratitude, while recognizing aspects that negatively impact

their mental health and coping/working through those rough times. One of these participants provided this definition in the context of managing a mental illness.

4.3.3 Mental illness.

Mental illness was defined by six (46%) participants as identified mental health diagnoses with one of these participants describing it as something that has been "researched, officialized and labelled". In these definitions, depression was mentioned five times, anxiety and schizophrenia were each mentioned three times, bipolar disorder was mentioned twice, and insomnia and autism were each mentioned once. The word "disease" was mentioned in three participants' (23%) definitions (two males and one female).

Definitions including only specific signs and symptoms, or only specific causes were expressed by six participants (46%). Three participants (two females, one male) described certain aspects in their definitions of mental illness such as it being more chronic and long term, causing you to hurt yourself or others, and constant negative thoughts that prevent you from doing things. Three participants (23%) cited the causes for mental illness as their definition, with a male participant attributing it to chemical imbalances or psychological reasons, and two female participants attributing it to a lack of coping strategies in addition to lacking a support system or failing to use available resources.

Males understood mental illness with more of a negative connotation compared to females. In terms of differences in gender, three of the total males (60%) defined it as specific diagnoses and two (40%) used the word "disease" in their definition. One of these males also stated he was unsure of this definition and that he had never had an issue with mental illness while another stated it means being "not well in your mind" due to scientific or psychological reasons. One of the males who described it being a disease stated the following:

Participant #M010: "To me it's a disease cause that's the only thing that's taking majority of other people's lives right. Just the thoughts of their own, what they go through, is what leads them to harming themselves, killing themselves, like population, with other people yeah…"

On the other hand, about half of the females defined it using a diagnosis, while the other half defined it using examples of symptoms, length of symptoms, and causes such as not talking about emotions, and lacking support systems or coping strategies. One of these female participants stated, "you can get out of it through talking to people about it." Their understanding demonstrated a more accepting and recovery-based understanding of mental illness than that of males.

4.3.4 Resilience.

When asked what resilience means to them, nine participants' (69%) responses included phrases such as the ability to cope, being persistent, not letting things get to you, defeating obstacles, pushing through, coming out stronger, not giving up, and having faith. Two of the participants (15%) either passed, or stated they did not know, and another two (15%) gave different answers including having a barrier to doing something, and awareness of oneself.

Participant #F002: "…you fight something so often, you keep breaking down those walls, and you keep coming back up… It's like every time you fall you get back up and you keep trying, and you keep trying, and you eventually break through. That's what it is- you don't give up."

4.4 Beliefs of Mental Health and Well-being

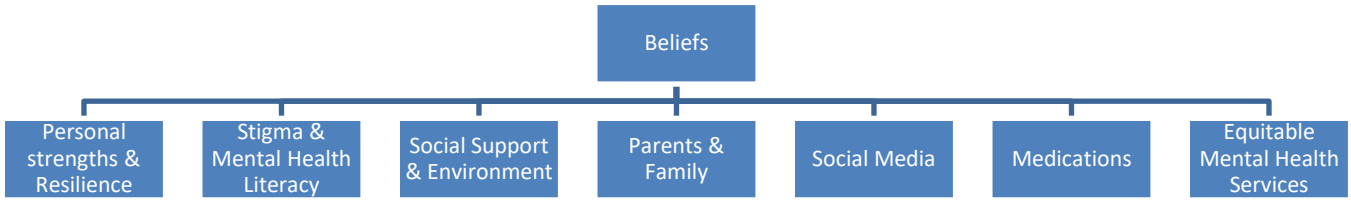

Figure 4*: Beliefs of Mental Health and Well-Being*

4.4.1 Personal strengths and resilience.

When asked about their strengths in relation to mental health, five participants (38%) identified aspects related to their relationships including family, time with friends, positive relationships/feedback from others, and being outspoken/communicating with others. Other strengths identified by five participants (38%) of which only one was a male participant, were understanding how the mind works, recognizing and self-regulating emotions, activating coping mechanisms, recognizing when help is needed, and proactively seeking help when necessary. These participants also believed being aware of their issues and resources, coping with stressors, and staying focused on their goals helped promote mental health. Three participants (23%) referenced their resilience as their strength. These factors included emotional strength and focusing on the positives, the future and their goals. Two participants (15%) identified this to be engaging in activities such as trying new things and working out. Furthermore, two male

participants (15%) identified their strengths as faith and praying. One male participant stated they did not have any mental health strengths at the time of interview.

In total, four participants (31%) considered themselves to be resilient, four (31%) stated they did not, three (23%) stated at times/to a certain extent, and two (15%) stated they did not know or passed. Four (80%) of the males in the study did not identify as being resilient and cited reasons such as lack of self-control, low self-confidence, and not thinking that they had gone through anything "harsh" enough.

> *Participant #M004: "I don't think I've gone through anything to credit myself as being resilient, anything harsh enough. Other people might say I'm resilient, but I don't believe I've gone through anything to deserve the title resiliency."*

> *Participant #M009: "Not a lot of people get to me but as a result of my poor confidence, it's really hard for me to get back up, get back out there…"*

4.4.2 Stigma and mental health literacy.

Five participants (38%) believed a lack of knowledge/understanding and stigma related to mental health was a weakness of the Tamil youth population. One participant believed this stigma was a result of the misperceptions taught by parents to their children. They further stated that those who talked about mental health did it for gossip versus genuine concern and that their age group did not talk about mental health.

Five participants (38%) believed that more open discussions about mental health within their age groups, and younger age groups, and that individuals of the same ethnicity and/or immigration background who share their lived experiences with others and online through social media are aspects that promote mental health in the community.

4.4.3 Social support and environment.

All the participants (100%) believed social support from either friends, family, or others, including being able to communicate/express themselves to someone, make personal connections, and feel a sense of belonging as factors that helped to have and maintain good mental health and well-being. Nine participants (69%) believed that support from friends helped them to have and maintain good mental health, with one participant identifying them helpful only as a distraction, and seven participants (54%) believed family/family support contributed to this function, with one of these participants identifying them as helpful only as a distraction. Other social supports and factors mentioned by participants included coworkers, supervisors, significant others, religious communities, and feedback from others.

The differences in the responses between the genders to the question about what helped to have and maintain good mental health and well-being indicated that males may rely on social support from others more heavily and as a sole source of support compared to females. Three of the five males (60%) compared to one out of eight females (12%) only identified the social aspect of finding distraction, support, or advice from others as their answer. Furthermore, seven out of eight female participants (88%) identified other factors that helped maintain their mental health and well-being in addition to social support.

4.4.4 Parents and family.

Parents were identified as a weakness in relation to mental health of Tamil youth by six (46%) participants as well as a challenge they face in relation to their mental health by three participants (23%). One reason provided was parents' lack of mental health literacy and the stigma they held related to mental health, which in fact was expressed by each of the participants (100%) at some point in during their interview. Participants felt that parents did not have enough

knowledge about mental health and as a result, they feared it, did not know how to recognize symptoms, or know how to address it and/or support children facing mental health challenges. Stigmatizing beliefs/misperceptions held by parents indicating a lack of understanding about mental health as shared by the participants included the belief that mental health concerns/autism are directly related to child rearing, mental health concerns as something that you can "get over"; and using language such as "dumb" and "stupid" in reference to individuals with mental health illnesses. Participants felt that if parents were more open and understanding, children would be more open with them, but that children should also be open to explaining to parents the differences in their experiences, and the stress that comes with living up to their parents' expectations.

4.4.5 Social media.

Three participants (23%) recognized that social media can be used to share information and increase awareness and resilience. One of these participants, a female, stated that the sharing of lived experiences related to mental health through social media promoted mental health in the community. They expressed that they felt empowered and motivated when they were able to connect to the experiences of individuals who were successful despite their mental health experiences as it normalized the experience and their vulnerability. On the other hand, one of these participants stated that social media pages related to mental health for the Tamil population would help but they were not aware of any, and another stated that there are a lot of youth who want to help and attempt to do so by sharing mental health related content on social media to help raise awareness; however, there was an expressed need for more proactive and concrete steps. Please refer to section 4.7.5 for further information on participants' experiences with social media.

4.4.6 Medications.

Four participants (31%) recognized the benefits that medication can have on mental health, while three participants (23%) did not seek help out of fear of being given medications to take for their mental health or did not take recommended medications due to the fear of side effects and dependence.

One male participant had a mother, and another male participant had a non-Tamil friend, who took prescription medications for mental health diagnoses, and both participants recognized that the medications were helpful in supporting their friend/family member's mental health. One female participant expressed the potential benefits medications can have for others while another female participant stated that prescription medications were helpful in managing her depression but found that explaining and gaining the support of her parents in relation to taking the medications was a challenge.

> *Participant #F006: "In terms of the medications, my parents were not for that. It took them a while to get used to it… like anytime I talk about it, they were like so when is your doctor going to cut down your dose? They were like looking towards that, and I'm like all I know right now is that I'm taking the medication and like that's what I'm going to be doing for now and so like I'll let you know when like the doctor thinks it's good for me to like cut down or -they were thinking that I'm going to be taking medication for a while, they weren't thinking or thought of me taking it for the rest of my life…*
>
> *…It definitely has to do with the stigma attached to like- just you know like someone on medication, like they're crazy or they didn't really know how the medication would support… it took a lot of like research and like talking to doctors and doctors providing information on the medication and what exactly it does".*

Of the two participants, one male and one female, who stated they had declined/not taken medications that had been prescribed or recommended to them to support them in managing their mental health, both expressed a reason to be out of fear of side effects including mood changes, weight changes and dependence from taking the medications. The male participant further stated that he did not "believe in medications". Another female participant expressed "being against taking medications" may have been the reason why she hasn't seen a doctor, or sought a diagnosis related to her mental health concerns. She expressed wanting to help herself without medications. Interestingly, this participant had a mother with a mental illness who took medications.

> *Participant #M010: "They tried to give me like pills and stuff just so I don't really… feel attacked, but I didn't really believe in- I don't believe in medication…*
>
> *… I don't believe it because for example, if it's tablets or pills, I believe that it would get me more sick than for me to be healthier. It's not even a healthy- some work but like to me I don't think it's healthy because once you take those pills then extends… like the doctor would prescribe it for like 2 weeks, and then you would have to take it for more than 2 weeks. You would start to gain weight or lose weight, like it really messes up your -how your body works."*

4.4.7 Equitable mental health services.

Eleven participants (85%) believed that it is necessary to ensure equitable and appropriate access to services for Tamil youth in Toronto. Twelve participants (92%) did not feel that organizations have the necessary resources to support Tamil youth, and twelve participants (92%) believed that individualized gender-sensitive and culturally sensitive approaches are needed for easier access to Mental Health Services for Tamil youth.

One participant believed that those who were accessing resources based on her observations in waiting rooms of mostly middle-aged white people, services were tailored more towards an older demographic and that services were either not targeting younger people or younger people were not aware of these services and programs. More than half the participants did not believe that mental health services were easily accessible and more than half of those who did believe that they were accessible had not ever accessed these services themselves. Specifically, seven participants (54%) believed that mental health services were not easily accessible and five participants (38%) believed they were; however, over half (60%) of the latter group hadn't actually ever accessed these services themselves.

When asked whether mental health services are accessible to both male and female Tamil youth, eight participants (62%) said yes as services existed and were available to both genders; however, three female participants stated that services were either more targeted towards females or more used by females. One female stated that she felt an advantage being a female seeking services as she knew of many male youth were struggling or have struggled, and who have died by suicide, and that males experience more challenges when seeking services and with their family.

B: Do you think it's necessary to ensure equitable and appropriate access to services for Tamil youth in Toronto?

Participant #F008: Yeah I think it's really crucial cause it's the next generation of people who are gonna have another generation people so like it's really important for us to realize like we're put in the situation where you know, our parents might have not been talking about it or not going through it but I think it's our duty to talk about it and you know, to improve like the mental health of people in the future and even ourselves, it's

crucial for us to talk about these issues because it could just be like a downward spiral of like you know, having our parent's views on these things resonate with us, and us continuing that negative downfall of mental health.

4.5 Social Practices of Mental Health and Well-being

Figure 5*: Social Practices of Mental Health and Well-Being*

4.5.1 Social support and help seeking.

Participants saw their friends more than they saw their extended family. Six participants (46%) specifically noted spending time with their friends to be positive. Nine participants (69%) saw their friends one to three times a week, two participants (15%) saw them one to two times a month, and two participants (15%) saw them once every three months. All of the participants had extended family in the GTA, and four participants (31%) saw their extended family one to seven times a week, four participants (31%) saw them one to three times a month, four participants (31%) saw them one to four times a year, and one of them (7%) never saw them. Out of the five

participants (38%) that saw their extended family zero to four times a year, two of them (15%) attributed this to family conflict.

When specifically asked if they thought they had friends they could turn to for support, all thirteen participants (100%) responded yes. On the other hand, although nine participants (69%) described some level of support from family in their interviews, only five participants (38%) thought they could turn to their family for support when directly asked. Eight participants (62%) responded they could not or could maybe turn to their family for support. Reasons that participants felt that they could not turn to their family for support included viewing them as more of a distraction from their problems rather than someone to talk to about their problems and finding it difficult to find time to spend with family due to odd work and school schedules. One participant expressed that some youth did not have a support system as both parents were too busy working. Two participants mentioned lack of support due to not being able to talk to family about being in a relationship and having to hide this relationship from their family.

Participants were asked who they would seek help from if they were experiencing problems with their mental health, and all their responses were noted. Seven participants' answers (54%) included that they would seek help from their friend(s), or significant other while six participants' answers (46%) included that they would seek help from their family, mainly their parents. Friend(s) and/or significant others were the sole choice for four participants (31%) and parents were the sole choice for two participants (15%), with two other participants stating their parents might be a latter choice to their partner, sister, or friends. Others each stated they would approach their yoga instructor, religious leader, or no one for help. Only one participant stated they would approach their family doctor for help.

4.5.2 Professional help seeking

Nine participants (69%) stated they were not using any mental health services; however, two of these who were male participants mentioned during a different part of their interview to have partially or fully completed an anger management program in the past. Participants who confirmed access of mental health services were all females. Four female participants (31%) stated they had accessed mental health services in the past or were currently accessing them. Two participants (15%) percent stated they had accessed counselling services in the past, with one of them currently on a waitlist for counselling, and two participants (15%) stated they were currently utilizing mental health services, with one participant receiving counselling; the other had accessed a psychiatrist in the past and was currently accessing mental health services through their family doctor and therapist.

Nine participants (69%) identified advantages of accessing mental health services to include receiving needed help and support, having someone to talk to who can offer different perspectives, assistance in identifying core issues, and a start to wellness. When specifically questioned whether they would seek help for mental health related problems from a professional, just over half of them were willing to seek help from a professional with females more willing to do so in comparison to males. Seven participants (54%) stated they would; three participants (23%) said they would not, and three participants (23%) said it would depend on the severity of the mental health problem. This included if it was preventing them from functioning the way they wanted to, and/or whether they really needed the help.

Only one female out of the total females (12%) stated they would not seek professional help, attributing this to cost, and two females (25%) stated they would do so based on need/severity. On the other hand, two of the five males (40%) stated they would not and one

male (20%) stated they would, based on severity. In addition, one of the males that responded that they would seek help, also recognized a mental health concern within themselves during the interview but disclosed they had not sought professional help due to shame. The males who responded they would not seek professional help stated it was due to potential cost, a negative past experience where their parents became involved, and concerns related to confidentiality.

4.5.3 Help seeking barriers: Stigma, confidentiality and gender.

All off the participants (100%) spoke about stigma being a concern related to mental health. When asked about the key challenges participants experienced in accessing mental health services, eleven participants (85%) identified shame and stigma as a key factor. Furthermore, judgement/stigma was identified by seven participants (54%) as a barrier to accessing mental health services with six of them (46%) identifying it as the most significant barrier and one of them identifying it as a disadvantage to accessing mental health services.

They specified judgement/stigma held by family, and people not talking about mental health, and/or gossiping about it. Participants referred to a family member/friend with mental health challenges being treated differently by others. One participant stated that people used the Tamil word *paithiyum*, meaning crazy, to describe their friend who had a mental illness. They further feared being embarrassed, and people who were unsupportive or discouraging. They also stated that if they sought help, they were concerned of what others would think, or feared that there would be something "on file". One participant stated that she would not access services if there was a possibility that friends/family would find out about it. Other fears included those related to being judged and fears related to confidentiality, especially if help is sought from someone of the same ethnicity, as the community is tight knit and "Tamil people talk". When asked how they felt they interacted with health service providers, two male participants spoke

about not going or avoiding the doctors. One of these males stated due to confidentiality concerns, even if he saw a doctor, he would hide any concerns by saying that everything was fine, while the other male participant stated he just never went to doctors.

Of the total participants, five participants (38%), which encompassed four of the five males (80%), stated a key challenge they experienced in accessing mental health services was them wanting to help themselves without it. Reasons included not wanting to rely on medications, questioning whether the help was needed, and feeling like they should have the willpower to handle it on their own. Other challenges identified by participants included not wanting to burden anyone, finding it difficult to open up to others, and fear of overreacting i.e. fear of making a fool of themselves and questioning whether the help was needed. Two participants (one male, and one female) even stated that they themselves were their *most significant* barrier to accessing mental health services. Two male participants stated that the person may be unwilling to go, and one of them specified that it depends on the person if they want to seek help or not and that if they would like to fix the issues themselves, they wouldn't access the services.

> *Participant #M012: "I feel like if I – I feel ashamed if I go. I'm like yo, I don't have the willpower to do it myself. Why do I need help, is there something – there's people who like smoke for years and then they're like I'm not going to smoke anymore and then they do it, so they have will power, so why can't someone like this you know. I already know okay, what's- how to improve but why am I not taking the steps? So, it's basically on me right so."*

Participant #M013: "I feel like it's an issue you have to solve yourself. I feel like anger management is kind of useless cause I kind of had to fix up myself if I wanna do good in life. I feel like other people telling me wasn't going to help me because I feel like you're kind of telling me, like I do have anger issues, and it's like I don't want to hear that. I want to solve that myself. For me, I'm the type of guy, I try solving my own problems." "…it depends on the personality, like if people do know – like for me, anger issues, whatever, I knew I had anger issues, but I didn't want to go to counseling and something, like some people would be willing to go right. They do need help from others to fix their issues. So, it personally depends on people…"

Gender barrier.

Males expressed more shame and experiences of stigma related to mental health and help seeking. Shame prevented them from seeking help as described by one male participant who felt that they should have the willpower to overcome their mental health concern on their own. When asked whether they could turn to family for support, one male participant stated that they viewed themselves as the support rather than the person seeking support from others as they were the eldest and most successful in the family.

One male participant stated they would turn to their girlfriend but not his male friends for support while another male participant stated that mental health wasn't something discussed among his groups of friends, and that they would not talk about mental health issues or participate in mental health programs in a group. He did however state mental health was something that could be discussed one to one with selected individuals depending on their maturity and their relationship and referred to an experience where another male friend had shared a traumatic event with a male group, but the group focused on the event rather than the

expressed trauma. It is interesting to also note that even during interviews, males tended to require re-assurance about the confidential nature of the study while females did not.

Females noted that they felt it was easier to express feelings and seek support as a female but knew of Tamil males who are struggling or have struggled. Furthermore, they expressed that there was more openness towards females with mental health concerns as females were more open and serious about such issues, and seeking help, and that they felt that services are more targeted towards them for this reason. They noted that it was more surprising to hear about males with mental health concerns as males don't feel the need to seek help, laugh it off, or make fun of it, but that males should be more sensitive towards mental health issues and seek help when necessary instead of being "manly".

4.5.4 Mental health role modelling and mentors.

Three participants (23%) spoke about a lack of healthy mental health role modelling by family members and parents. They referred to their father displaying unhealthy coping strategies when dealing with stress, not having someone to look up to as they had grown up with a single mother who was always working, and parents not promoting/teaching them how to make healthy coping choices.

When specifically asked about the most significant barriers for Tamil immigrant youth accessing mental health services, two participants (15%) stated a lack of mentors that have gone through similar experiences. These female participants highlighted the importance of knowing others with similar backgrounds and/or similar ages, who have dealt with mental health challenges for relatability, motivation, and empowerment, but it was difficult to find such people to relate to. On the other hand, a female participant conveyed that she had been positively influenced by an Instagram celebrity, of the same ethnicity, culture, and gender, who had openly

talked about her mental health experience. One participant stated the most significant barrier for them accessing mental health services was questioning themselves whether the help was really needed. They further explained this was as a result of mental health and help seeking not being talked about when they were growing up.

> *Participant #F002: "It's nice when people… you look up to… open up and they tell you something … that they're vulnerable about and it makes you realize, it's ok, they're human just like us. And it's ok to have a mental illness, because you can still be successful and have a mental illness. I think a lot of people think that those two don't go hand in hand and it doesn't work like that. Ye, but I think the more people come out, and they open up and they share their story, a lot more people are um…I think it helps people as they're going through it. Like it feels better knowing that you're not the only one"*
>
> *Participant #F002: I think the barrier, so my barrier would be like ok, do I need this right now? ; time, would this really help me because growing up like we never talked about it, so like obviously I know the right thing is to like, if I'm ever feeling like I have a mental illness, I should go to access the service but if I like… I know like I should do that but like I feel like you know, my thought process would be like "do I really need this" because growing up, we never …we'd just be like get over it, it'll be ok, which I know is unhealthy, but I know that if I ever do go through a mental illness, it's important for me to be like I need to go see a professional.*

Parents and family.

All thirteen (100%) participants talked about parents playing an important role in influencing their meanings, beliefs, practices, and experiences of health and mental health. Participants voiced that children/youth take a lot of advice from their parents to satisfy their

wishes. Possible reasons mentioned for this compliance included culture, parents being strict, and/or out of fear of their parents.

Participants experienced feelings of shame and stigma and lacked confidence that their parents would be able to support them, which prevented them from disclosing their mental health challenges to their parents and seeking help from them or others. Four participants (31%) expressed fear of disappointing, hurting, distressing, or worrying their parents if they were to be open about their mental health challenges. Participants also expressed being hesitant to open up, or not opening up at all to their parents and family about issues related to mental health due to the beliefs and misperceptions held by parents, and the existing stigma and lack of understanding related to mental health. Participants further stated that most children are afraid to disclose such issues to their parents because of how they would respond, and the potential for parents to "overreact" to disclosures because of their lack of mental health literacy.

Perceptions held by their parents, and the lack of healthy conversations around mental health also impacted participants' mental health practices and their readiness in seeking help elsewhere. Participants expressed questioning the need to seek mental health help as a result of the lack of cultural conditioning when growing up to seek mental health help when needed and being told to "get over it", and having to learn about the importance of taking care of one's mental health on their own due to the lack of healthy mental health role modelling by parents.

> *Participant #F008: I think the barrier, so my barrier would be like ok, do I need this right now? … would this really help me because growing up like we never talked about it, so like obviously I know the right thing is to like, if I'm ever feeling like I have a mental illness, I should go to access the service but if I like… I know like I should do that but like I feel like you know, my thought process would be like "do I really need this" because*

growing up, we never …we'd just be like get over it, it'll be ok, which I know is unhealthy…

Participant #F011: I feel like a lot of the times, because my parents understanding of mental health, I really had to teach myself to take my own mental health seriously. From before, I would just try to deal with things on my own. It wasn't until I got into the healthcare profession and it wasn't until schooling that I realized that mental health is something that I need to actively take care of, and I need to you know, deal with now before it gets worse and worse.

4.6 Individual practices of Mental Health and Well-being

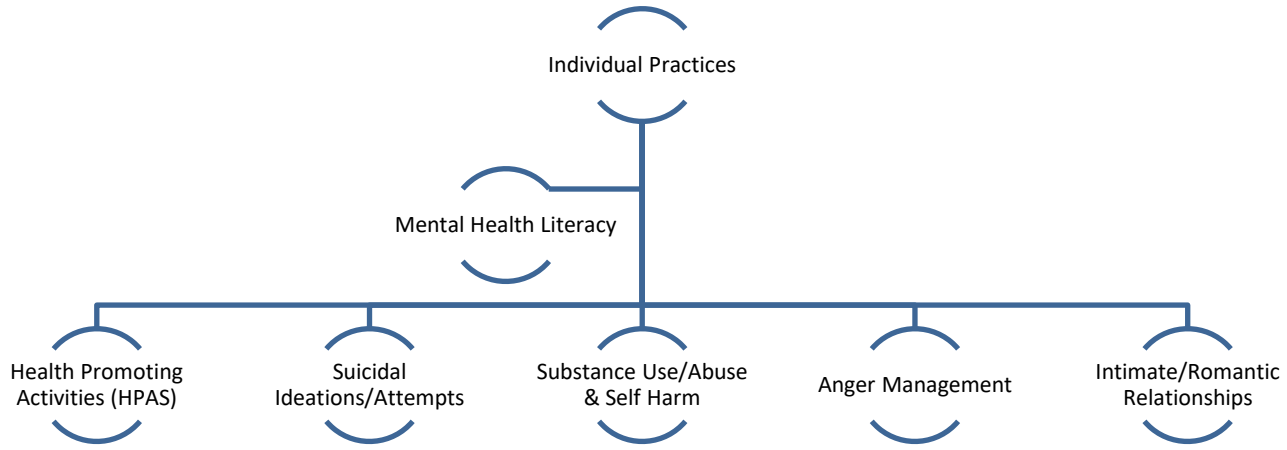

Figure 6*: Individual Practices of Mental Health and Well-Being*

When asked what helps to have and maintain good mental health and well-being, participants mentioned a variety of factors. Seven participants (54%) mentioned exercise/physical activity including running, dancing, working out, and hot yoga. Six participants

(46%) mentioned other coping/ self-care activities that they liked and found to be helpful such as reading, going out, engaging in a hobby, having “me time”, making a future plan to look forward to, playing with pets, and working on self-development/internal motivation/positive thoughts. Four participants (31%) believed spirituality/religion including praying, yoga, and meditation helped. Formal mental health interventions such as therapy was mentioned by three participants (23%) who were all females, and medication was also mentioned by one female participant.

> *Participant #F001: It's so surprising how even just one session later or a couple sessions later … or if you're on medication I'm sure it helps, like so much more and you never expect it to.*

One female participant mentioned using a mobile application called Daylio to document her daily activities and moods in order to identify what helps and what doesn’t.

> *Participant #F007: Yeah, I got this app called Daylio, and I use it to track my moods and stuff, so that kind of gives me motivation, so I know that going to the gym helps me like feel more happy, feel more better about myself.*

Five participants (38%) stated that having and maintaining their mental health and well-being involved being mindful/conscious of thoughts, feelings and actions, recognizing stress and patterns, knowing how to self-regulate emotions, and take required actions to care for self/cope to maintain balance. For example, dealing with things one at a time without being overwhelmed. Yet, eight participants (62%) stated that having and maintaining healthy coping skills were challenges they faced in relation to mental health. Participants expressed the need for balancing the multiple aspects of life including school, work, finances, social life and health; knowing their triggers and recognizing when they are not coping well; and intervening with appropriate interventions such as seeking help. Participants mentioned some of the ways they coped included

negative self-talk, overthinking, thinking they were overreacting, bottling things up, neglecting self-care, going to sleep when feeling down, and substance use. Not having healthy coping skills resulted in the build-up of stress, poor decisions, self-harm, substance abuse, and even suicidal ideations.

4.6.1 Health Promoting Activities Scale.

The HPAS allowed participants to estimate and record the frequency in which they engaged in self-selected leisure activities that promote or maintain their health and well-being. According to the scores analyzed from responses, females engaged in such activities more frequently than males. Males scored an average of 32, and a median of 35; however, one male participant did not answer one of the questions. Females scored an average of 39 and a median of 40. The highest attainable score on the scale is 56. Twelve participants (92%) took part in spiritual or rejuvenating personal time, and 46% specified yoga/meditation. Some females recognized such activities as part of a holistic definition of health while males did not.

4.6.2 Mental health literacy.

One of the key challenges experienced by seven of the participants (54%) in accessing mental health services was their lack of knowledge of where and how to find services and how to navigate them. Participants expressed a lack of knowledge and awareness about where to continue receiving help after high school, cost and affordability of services, non-age restricted hotlines besides Kids Help Phone such as Good to Talk, and where to get help if their family doctor was unhelpful. They also voiced that navigation of such services could be difficult for someone having mental health issues.

Participants identified word of mouth/others, school, online resources, posters/advertisements and organizations in the Tamil community as sources where they learned

about mental health services. Online resources, social connections, and schools were the main sources identified. Specifically, six participants (46%) identified their source to include online resources such as social media (Twitter, Instagram, Facebook, BellLetsTalk hashtag, trending items, and group chats), school website, and search engines such as Google with the majority identifying this as their sole resource. Five participants (38%) identified learning about it from word of mouth/others, and most of them identified this as their sole resource. School was identified by five participants (38%) as their source of information including their school program, and posters/announcements, with two participants identifying this as their sole source. Organizations in the Tamil community such as online through Aadhya and CANTYD workshops were identified by three participants (23%) who were all males. Lastly, two participants (15%) identified posters and advertisements on TV and through the radio to be effective in informing them about mental health services.

4.6.3 Suicidal ideations/attempts and self-harm.

Out of the total participants, five (38%) had self-harmed, attempted suicide, and/or experienced suicidal ideations. This total encompassed three (38%) of the total females, and two (40%) of total males. Another participant mentioned being assessed for suicidal ideations and being immediately referred for mental health services in the past.

More specifically, four (31%) out of the total participants had either self-harmed (cutting) or attempted suicide, of which two were males and two were females. Reasons provided were to cope with voices, stress/anxiety, and emotions, and due to interpersonal conflict with a significant other, with one participant requiring emergency care and stitches. Three (23%) out of the total participants (two of whom had self-harmed and/or attempted suicide) expressed past

suicidal ideations. Reasons provided for self-harm included being unable to cope with voices in their head, elevated levels of stress/anxiety, and issues in a relationship with a significant other.

4.6.4 Substance use/abuse.

One participant stated that drugs/substances are used by Tamil youth to cope with their problems rather than trying to resolve the issue. Another female participant mentioned that her brother who had immigrated to Canada with her family at the age of 10, had also used drugs in high school. Questions related to drug use were not a formal component of the questionnaire or interview in this study; however, during the interview process, out of the total of five male participants, three (60%) disclosed that they use/ had used drugs i.e. alcohol, cigarettes, marijuana.

One participant stated that he used marijuana frequently. The other two male participants specifically stated that they used these drugs as a coping mechanism, and both cited problems/breakup in a relationship with a significant other as being one of the triggers. One of these participants declined to disclose the amount and frequency of his alcohol intake, but acknowledged that he had an alcohol dependency, and stated that he had not sought professional help due to shame. He further stated that he used to smoke cigarettes to deal with stress, but currently only smokes in social settings. The other participant described frequent use of all three drugs (drinking every other day, smoking more than three cigarettes a day and marijuana three times a week), but stated that he had quit everything except for social drinking and now resorted to fitness instead. It is important to note both male participants started using all three drugs while under the age of 18.

Participant #M012: I used to be social, now I only have a handful of friends that I lean towards or substance. I have a little bit of issue with that.

...I was kind of underage, and whenever I had problems, I had someone to get it for me basically. That was a problem."

"...I talk to my ...my best friend and I share things with, and then he tells me ways to ... lean off it, not always go towards it. I don't think it's working but sometimes in my mind I'm like okay, you know, I should seek a healthy choice, not go to that, you know, then it becomes a pattern and then if you keep- the longer you do it, the harder it is to stop. And yeah so I know what I'm doing but then I don't."

"...it's just that guys that are my age, when back in like when you're in high-school when we chill, we play sports, we go out. Now they say chill, it's mostly like drinking, even when you want to play pool, you get a beer or something right. Or they'd be like let's go out to eat, and there's choices there at the restaurant."

4.6.5 Anger management.

Three participants (23%) who were all males stated that they have or have had anger management issues. Two of them attended anger management classes, of which one was court-mandated, and another referred from his high school principal, but both participants stated that they did not find the classes helpful. The participant who was court-mandated to attend the classes stated that he had lost control of his anger and vandalized the house as result of losing control of his anger. The participant who had been sent from school stated his anger was caused by racism, choice of living, and how he was brought up, and that he did not end up completing the classes out of fear that his parents might find out about it. One female participant also stated that when her older brother was in high school, he was very aggressive and violent and had been arrested a few times. She also stated that her father has anger management issues as he does not have good coping strategies when it comes to dealing with stress.

4.6.6 Intimate/romantic relationships.

Almost half (46%) of the participants reported being in a relationship. Two female participants mentioned having to hide their relationship from their parents; thus, could not go to their parents with relationship problems. One female found coping with a breakup difficult, while two males also expressed that coping with breakups (of a romantic/intimate nature) was difficult for them and others, with one specifically citing it as a weakness of the Tamil youth population in relation to mental health. They further stated that such a breakup, or unstable relationship could trigger strong emotions including anger, and had led them to experience suicidal ideations anxiety, and self-harm and both males expressed using drugs i.e. alcohol to cope. One of the males further stated that females have also told him that they take medications for depression and anxiety caused by a breakup.

4.7 Experiences of Mental Health and Well-being

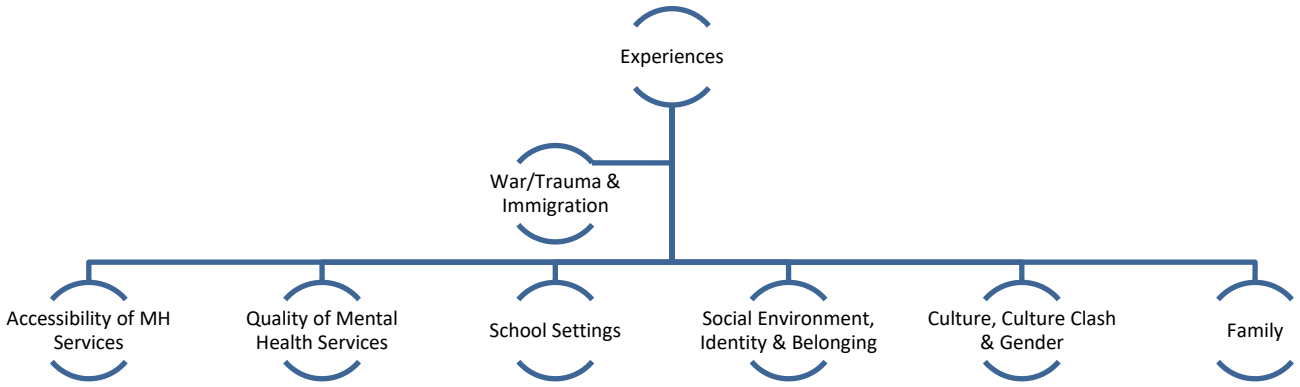

Figure 7: Experiences of Mental Health and Well-Being

Figure 8: Systemic Experiences of Mental Health and Well-Being

When directly asked if participants' experiences were the same or different from those of other youth, eleven participants (85%) responded they were different. Of these participants, three stated that they were similar to those of other immigrant youth/families, i.e. South Asian immigrant families. Only one participant stated their experiences were the same as other youth.

4.7.1 War/trauma and immigration.

Participants that stated their experiences were similar to other immigrant families' experiences cited similarities including family dynamics where the mother is expected to raise the children and the father is expected to be the sole provider. Those that stated that their experiences were different, mentioned specific experiences including a lack of understanding of their own history, issues with self-identity, and experiences of culture clash. Some participants spoke about the pressures that come with being a first generation Canadian including the longing to be accepted and the desire to build upon the foundation set by their parents. Others

additionally mentioned the pressure to contribute to the family financially and/or through being a translator, due to their parents' language barrier so that appropriate services could be accessed/received i.e. health services, legal services, paying bills.

Three participants (23%) referred to the war in Sri Lanka and its impact on them and their family. One participant expressed that Tamils have had a distinctive experience by means of having been through a civil war and genocide which can influence their state of mind. He stated that these difficult experiences may be harder to address as health care practitioners are not able to be as empathetic because they are not able to relate to these distinctive experiences of their cultural history. Another participant expressed that she wished there had been more support for her parents upon arrival to Canada, such as someone to talk to about their experiences of leaving their homes and families, as this may have helped them overall, but also would have helped them to understand mental health better. In relation to help-seeking, one participant stated that since their parents came from being in "survival mode" from Sri Lanka, it makes it harder to open up to them because they have the "you have nothing to worry about here" mentality based on their own experiences.

One of the participants also expressed frustration related to the war and the experiences of Tamils not being given as much importance as other countries e.g. Syria. She felt that there was not enough attention or media coverage, and when there was, it was of a negative nature. In addition, she stated that the experiences of Tamils and the reason for their protests were not understood by others as their perception was that Tamils were just blocking the streets and causing traffic.

4.7.2 Accessibility of mental health services

When directly asked if they thought mental health services were accessible, seven participants (54%) stated they were, and five (38%) stated they were not. Interestingly, six participants (46%), which included four of the five male participants (80%), did not have personal experiences of accessing mental health services but expressed positive views about them. They stated that they are readily available, easily accessible, and confidential, with a variety of types of services to choose from such as hotlines, centers, and social media. Some participants stated that advantages included being able to access services online and through the phone.

On the other hand, six participants (46%) also mentioned that lack of accessibility of mental health services were a concern including cost, lack of transparency of available resources, and lack of physical accessibility due to location and transportation needs. Two of them (15%) stated that not being aware of available resources and help not being in the open were disadvantages of accessing mental health services. One participant stated there was a need for more public/free services as the services were currently expensive with no accommodations made even for students. Three participants spoke to the lack of physical accessibility and transportation due to locations of programs mostly centered in Toronto and not as available in other areas and having to figure out your own transportation to such services if you were not able to disclose your experiences to your parents. One of the participants was a healthcare provider themselves, and they described that based on their experiences, it was difficult to ensure that patients' mental health needs were met while in the hospital for physical health needs as referrals for mental health would be made, but it was difficult to ensure that those services ended up being provided to the patient.

Wait times.

Seven participants (54%) had negative experiences accessing mental health services related to wait times. Three participants (23%) identified wait times to be a key challenge they experienced in accessing mental health services and two participants (15%) stated waiting times/lists were a disadvantage of accessing mental health services. One participant expressed frustration due to currently being on a wait list and another stated that without private insurance, wait times for counselling could be a six to eight month wait.

One of the participants described waiting 11 hours in the ED to access care for an immediate mental health need involving suicidal ideations, and another participant stated that they waited 24 hours in the ED before their mother's mental health concerns were addressed. One participant described a visit to the ED for mental health needs but ended up leaving before seeing the physician due to the wait time. Three participants (23%) who were all females described their difficulty accessing mental health services through their academic institutions. One of them stated it took two to three months to see a counsellor, and another stated that they'd heard about three to four months wait times from a friend who'd accessed services at school, which then became a deterrent to seeking help for themselves. Another participant stated there was an improvement as it took two weeks for them to see a counsellor whereas it used to take two to three months before.

> *Participant #F007: "being on the waitlist like frustrating you know, like if you're really in need of help, like they're not willing to like you know "come in today we'll figure something out", like nothing like that I was just kind of like you know you're on the waitlist and I'll call you back when we get a spot for you, which was frustrating…"*

4.7.3 Quality of mental health services.

When directly asked how they felt they interacted with health service providers (HCPs), six participants (46%) stated that it was fine, positive, or with no issues. One of them believed this was because they were a student in the field. Two of these participants, who were all females described that they had found their therapist/social worker to be helpful for their mental health. An additional participant described during their interview a visit to the ED where he found the healthcare providers to be kind and that they understood that he needed help, and even tried to talk his mother about it.

On the other hand, four participants (31%) expressed that they did not interact well with family doctors, especially "brown" doctors or doctors who were also Tamil when asked how they felt they interacted with health care providers. These experiences along with other experiences with primary physicians are discussed in more detail in the section below. In addition, two female participants expressed finding counselling unhelpful with one of them having tired two different therapists, and the other continuing to seek help from a second service provider. Other challenges expressed by two female participants included a lack of information or supports provided by healthcare providers. In one case, a physician (of Indian origin) at a walk-in clinic only focused on the physical issues and did not offer mental health supports to their friend who had experienced sexual assault/rape. In another case, a lack of information was provided about a treatment recommended by a psychiatrist to a participant resulting in them searching it on the internet and finding misleading information. Another participant identified the challenge of the lack of continuity with accessing counselling over the phone as a result of having to repeat their story each time to someone different.

When asked how HCPs interact with them and their family, five participants (38%) stated there were no concerns with their interactions, and three participants (23%) identified a language barrier and/or a lack of cultural competence to be challenges they experienced. One participant stated that the providers still interacted with their parents fine despite the language barrier while the other participant noted a difference with the way they interacted with her in a positive way versus more negatively with her parents with the language barrier. Three participants, which included one male and two females, expressed feeling uncomfortable and/or holding back on sharing information when with healthcare providers when assessments were completed, or questions were asked in the presence of their parents. Another participant stated that they found that the health system dealt with her parents well, but she experienced challenges with the school system while navigating her mental health.

Emergency department.

Three participants (23%), one female and two males, had personal experiences in the ED for their mental health needs. Two of these participants found the wait time to be difficult due to their symptoms, while another ended up leaving before seeing the physician. One of them waited eleven hours before being able to speak to anyone about not feeling safe due to their suicidal ideations, and then had to speak to five different health care providers and advocate for their own needs before being able to receive an intervention they felt they needed. They also stated that security guards in the department were making insensitive remarks within earshot in the halls about patients with suicidal ideations. This participant felt they were only able to receive this help as they were in the field themselves and knew how to advocate for themselves. Another participant described a visit to the ED after self-harming where they received stitches, and then was told to wait a couple of hours to see the physician. The participant promised the staff they

would not self-harm again and that they needed to be somewhere the next day, so they were allowed to leave after providing their contact information. When the ED staff contacted them the next day, the participant didn't pick up the call. The third participant who was brought to the department by their school guidance counsellor as a result of experiencing symptoms of mental illness found the wait to be difficult with their symptoms, and also found the environment where they were made to wait (a room with no windows) was unhelpful. Both males described that the staff in the department to be helpful and that they insisted that the participants stay in the hospital for further assessment; however, both ended up leaving. One of them stated that their mother was extremely upset and convinced him to tell the staff he was ok, and although he was upset with his mother for not understanding, he listened to her and left. He stated that she was talking in Tamil, and the staff attempted to speak to his mother, but no translator was present. The other male participant found it helpful when the staff asked his mother to leave the room when they spoke to him; however, during a meeting before discharge, his mother remained in the room and he found this uncomfortable. Furthermore, because of her presence, he answered their questions differently than he would have and made statements so that he could leave.

> *Participant #012: Good thing was she made my mom leave before she talked to me. So that was a good thing. At the same time, another instance where I think someone came to do a psych analysis before they let me go kind of thing. I think my mom was there at that time so that was a little uncomfortable for me.*
>
> *B: Did you answer the questions the same way you would have if she had not been in the room?*

012: The thing is all I did was promise, ok I'm not gonna do it again, I'm not gonna do it again, just let me go, like I don't want to be here right. Like I think I would have answered differently…"

Doctors and mental health services.

In Canada, family doctors are often referred to as the "gate keepers" to healthcare as they are often the first point of contact when seeking healthcare. They are also the ones that make referrals to needed services such as mental health services. Two participants (15%) identified that Tamil people often have family doctors of the same ethnicity as parents feel comfortable and helpful to speak to them in Tamil. Four participants (32%) disclosed they had doctors/family doctors who were Tamil and of Sri Lankan origin. Four participants (32%) stated their family doctor also cared for their other family members, and all but one of them was Tamil and of Sri Lankan origin. Some participants had positive experiences with their family doctor, while many did not, especially when the family doctor happened to be of the same ethnicity (Tamil).

In fact, four participants (31%) felt that they could not talk about mental health to their doctors who were of the same origin (Tamil). Two participants stated that their family doctor had a close relationship or was a family friend of their family/parents. As a result, they did not feel comfortable talking to them about mental health related issues out of concerns about confidentiality and feeling embarrassed or that they were being judged. One participant feared that they may disclose what they share to their parents, so they sought help from a walk-in clinic and expressed frustration from this experience as it was a longer process to find help. The other participant stated that their family doctor would often ask them to bring their parents to their appointments, and that the doctor also disclosed personal health information without their consent to their parents which led to the participant seeking a different doctor. One participant

stated that they were never able to talk to their family doctor (whom they shared with their family) about mental health because their family doctor never opened up this topic with them. The participant further felt that it was a necessary dialogue that doctors should have with their patients and complete assessments for. One participant stated they do not tell their doctor much "because they are Tamil" and did not want them to advise them to stop hurting their body.

Three participants (23%) expressed positive experiences with their family doctors, with two of them (15%) having personal experiences with them related to mental health. One male participant expressed that a disadvantage to accessing mental health services was that there is a negative perception of Tamil health care practitioners in the community; however, they stated that their own experiences had been positive. A female participant described that their Tamil family doctor was helpful in maintaining confidentiality and informing her parents about her experiences with consent from her as per her wishes. Another female participant also described that her mother had encouraged her to access services and supported her to seek help from their family doctor (who was of Indian origin), who was able to make appropriate referrals to get her the help she needed.

> *Participant #F003: I feel like when it comes to doctors and stuff you feel like you're being judged or you can't ask and be open cause I feel like there's no really patient doctor confidentiality when it's a brown doctor cause they feel comfortable telling your mom so…*

Lack of culturally competent care.

Ten participants (77%) referred to the lack of cultural competence/sensitivity/ safety that was available to the Tamil community. Participants described challenges to include not being able to connect/relate to the service provider, feeling like they weren't being understood, lack of

access to a service provider of the same ethnicity, resources that were not specifically catered to them or culturally appropriate/sensitive. When asked whether Tamil immigrant youth were able to utilize culturally and linguistically appropriate services, seven participants (54%) stated that they did not know of any, and two of them described services were most often accessed by white people based on their observations at such services. Four participants (31%) stated a challenge they faced in relation to mental health was cultural competence/sensitivity/ safety, and four participants (31%) identified this issue and a lack of services being available specifically for Tamils of Sri Lankan origin to be a key challenge they experienced in accessing mental health services. Three participants (23%) specifically feared the disadvantage of accessing mental health services to be if they were not understood, or if the service providers could not connect/relate, or help.

Participants experienced difficulties in explaining their feelings due to cultural differences, such as having to explain to service providers about restrictions resulting from their relationship with their parents. They also stated that there was a lack of understanding about immigrant families and how they function related to mental health. One participant stated that their situation is not the norm for health care providers and that the service providers "fake it like it they understand" but they don't understand "the grey". They further stated that they would have continued accessing mental health services if they felt the counsellor was able to culturally relate to her. Others felt that service providers lacked relatability to the community's past trauma. One participant stated that it is difficult when the health care provider is not able to be empathetic to experiences of their cultural history, genocide, and civil war because they can't relate to it. Another participant described an experience where during an assessment, the health care provider asked whether they were hallucinating and the example they provided was

hallucinating that they were a Tamil Tiger (LTTE). The participant felt that this was mentioned just because they were Tamil and felt that it wasn't culturally sensitive. One participant stated that only once in about ten times dealing with a health care provider had someone asked (from a questionnaire) if there was anything they needed to know in terms of cultural sensitivity, but it made her happy to know it was being considered at that time. Participants expressed that culturally sensitive services would help the whole community and encourage people to be more willing and comfortable to access services.

Participants expressed a need for more services catered specifically towards the Tamil population, language and culture, and a need for more service providers of the same ethnicity, as there was currently a lack of both. One participant stated that they often hear about a high number of suicides at Waterloo University, but there were no organizations in the Tamil community to address this issue. They stated there was a need for counselors within already existing organizations (such as CANTYD) to make them accessible. Participants expressed a need for funding to increase service providers of the same ethnicity, Tamils of Sri Lankan origin pursuing careers in mental health to increase the diversity of mental health teams and having more people of color working in the field, would all make it easier to relate to service providers. They described that having service providers who have gone through similar experiences, and who were able to understand their family dynamic would promote mental health in the Tamil youth population as they wouldn't have to seek help from someone who may not understand what they are going through and would prevent them from feeling like they have to explain everything. Linguistically appropriate services were also emphasized for the overall community, but it was less emphasized than culturally appropriate services for youth with one reason being that participants felt that most youth were able to speak and understand the English language.

One participant who was a healthcare provider themselves stated that due to language barriers, it was difficult at times to communicate and execute services for Tamils in their healthcare setting.

> *Participant #F003: "I also think that like Race Matters. And I know this sounds bad but it's like I can't go to someone who's not like brown and expect them to understand something that I'm going through because they don't- I feel like it's hard to go to someone who-where like our situation is not the norm for them you know. Or like things are different for them and it's more black and white and not so much gray and…and it's hard to talk to someone who's just kind of looking at you like oh yeah, I get it like they're so faking it! Do you know what I mean? …And I feel like people it's like maybe this is a bad comparison but it's like makeup artists. Many makeup artists they only learn how to work with certain shades of colors. So, when a brown person goes in and they don't know how to help you find the right shade and they don't understand undertones and stuff and I feel like that's the same thing with like these counselors like they learn everyone learns something that they're only able to apply these things to a certain group of people not everyone. Cause that same tactic doesn't work for everyone right it just works maybe for not even certain race, maybe it just works for certain people going through a certain thing, but I feel like mental health is very like diverse and people experience so many different things so…"*

4.7.4 School settings

Experiences related to school/academics as well as the role of schools in addressing participants' mental health and mental health challenges/concerns were also discussed by the participants. As mentioned earlier, long wait times were an identified challenge in accessing mental health services in post secondary institutions with one participant identifying a two to

three month wait, and another stating that hearing about such a wait deterred them from seeking help through their school resources; however, one of the participants identified a recent improvement in waiting times. Two of these participants (15%) further identified that they experienced difficulties in accessing these resources/appointments/recommended workshops through their postsecondary school due to school breaks, semester changes, cancellations from the provider's side, being busy with coursework/placements, and with juggling their jobs. Yet, two participants (15%) found that accessing resources and obtaining help in post secondary school was easier compared to in high school. One participant also stated that professors were often understanding of their experiences and they were able to seek and obtain extensions when needed.

A few participants also identified that some of the services they were able to access, such as those provided by their school social worker, were helpful, or helpful to some extent. On the other hand, participants also found the school (both post secondary and high school) counsellors to lack cultural competence/sensitivity, and that they lacked a connection with them. One participant felt that a service provider was "going by the books" as they were reading off questions and writing, and they didn't feel that the provider was talking to them one on one. Another participant shared that they were assigned a counsellor in high school based on their last name but felt they could not express themselves to their assigned counsellor; however, another counsellor who was understanding and supportive would often check in on them. Two participants (15%) identified that high school counsellors were not as helpful because they thought the students had nothing to be sad or upset about, whereas the counsellors in post secondary school were more helpful as they were taken more seriously. Another participant stated that they were advised to get a doctor's note in high school during a difficult experience

related to mental health, but the purpose was not so that they could get help, but rather to provide documentation. Furthermore, they stated that despite the school's vice principal (who happened to be Tamil of Sri Lankan origin) knowing about their experiences, they were not supportive or empathetic. The vice principal wanted the participant, who was previously performing as a top student, to switch to a different school when their performance and attendance were negatively impacted and told the participant "you're not a role model because you're not coming to school". The participant felt they were spoken down to, and that based on their experience they felt that the school did not put their health or learning at the center. They also felt that there was no support provided to their parents as all the mental health related information and experiences were new to them. They described having to support themselves and their parents through their struggles using information from the internet and identified that it would have been helpful to have someone to assist them through this experience.

Three participants (23%) who were all males identified confidentiality as a concern, and three participants (23%) identified lack of engagement, support and information provided to their parents as a concern based on their experiences with their high school. One of them disclosed to the school social worker that their parents physically disciplined them and was lost their trust with them when the social worker got his parents involved to address this disclosure. (Although it may be decreasing, physical discipline has been a common practice within families of Sri Lankan origin.) The other participant stated that after his parents discovered he was self-harming, they spoke to the school. His principal and guidance counsellor requested to speak with him, so he opened up and shared his experiences with them; however, he described that he was then forced to call his parents and tell them what he had shared with them. He did not feel that his parents were provided any support in relation to this experience. Another participant

described being unexpectedly taken to the ED after disclosing his experiences and stated that this was one of the reasons he would no longer disclose anything to healthcare providers. Furthermore, this participant also described that they left the ED as a result of their mother being upset, and that although their guidance counsellor encouraged them to return to the hospital and seek help, they did not inquire about, engage, or follow up with his mother.

4.7.5 Social environment, identity and belonging.

When asked what challenges participants faced in relation to mental health, seven participants (54%) mentioned their social environment. The way they were treated by the people around them, such as friends, coworkers, and faculty supervisors, were expressed as factors that can impact their mental health by five participants (38%). Female participants expressed how a loss of relationship with a best friend negatively impacted their mental health, lack of validation from friends functioned as a significant barrier to accessing mental health services and stressed that receiving positive feedback from others as important with one of them stating that this is what mainly fueled her internal motivation. One male participant repeatedly spoke about having low confidence throughout the interview but was reluctant to share and expand on the root of this issue. When probed, he stated it was because of being "put down" and "teased" (denied it being bullying or harassment) when he was younger and growing up watching and being traumatized by one of his parent's experience with mental illness. Another male participant communicated that they experienced racism, robbery and trauma by hearing gunshots due to the unsafe physical environment/area they lived in.

Relatability to those around them including their family/parents, social groups, community, and healthcare providers was expressed as important by most participants. One participant expressed that Tamils have more questions about their identity than a "regular

Canadian" would due to the history of Tamils; however, the information on this history is difficult to access and makes them question their identity further. They further felt that having a good sense of identity would contribute to a better sense of community.

Community support.

When asked what promotes youth mental health within the Tamil community, seven participants (54%), of which only one was male, identified Tamil organizations such as Aadhya, ANBU, and CanTYD, doing mental health work, as well as Tamil Students Associations (TSAs), and Tamil sports groups. One participant was unclear about Aadhya's role other than to raise mental health awareness. CanTYD was described as an open space which welcomes all people of any gender, and as a space for youth to hang out, play drop in basketball on Fridays, be themselves and stay out of trouble. Participants felt that organizations like ANBU which catered towards Tamil youth/people were important, and more such organizations were needed. Participants also believed that clubs like TSAs and Tamil sports groups were spaces to connect with others, and make new friends with those similar in age, and with similar experiences that they could relate to.

Discrimination & racism.

Four participants (31%) and/or their parents faced direct or indirect racism/discrimination. One participant described such experiences as being called "Paki" or "Indian" and that racist jokes were at times bothersome, and even contributed to anger management issues in high school. One participant stated that he felt that white people were more superior than him but did not describe any specific experiences of racism. Another participant described their experience with a parent in the ED of a hospital, and how the

interactions between the health care providers and her were different than their interactions with her parent due to the language barrier.

> *Participant #F003: "...with waxing when I got my underarms waxed and like you could see that they're just so like they were like oh so where are you from cause you're like darker-skinned toned and stuff. They're not so comfortable with that..."*

> *Participant #M004: "Nothing to my face. Nothing direct. But there's always I've always sensed undertones of racism at times. I can tell when someone is just being off, and you can't really put a reason as to why they're being the way they are and then the only reason why the explanation ends up being might be cause I'm brown but never directly to my face."*

> *Participant #M012: "...the thing is I feel as if they are a little bit superior than me. The thing is I was going to work at place where I had an interview with two white dudes, and I was- so overwhelmed. I don't know, I was like why it's just an interview, but at the same time, when I had an interview with other people, it wasn't that overwhelming for me, I don't know."*

> *Participant #F003: "...so I feel like when you don't know the language, they just look at you like you're dumb and I feel bad for my dad cause he's not dumb. So, it's annoying when people kind of like when doctors and stuff expect you to or look at you differently just cause you don't know the language or cause of your skin color or something."*

Reputation and respect.

Five participants (38%) emphasized the level of importance that parents/families placed on what others thought/reputation and family respect. Two participants talked about their parents worrying about what to tell others about their children's academics i.e. attending university, choice of program, academic progress. This concern resulted in the parents pressuring their children to do academically well. Another participant provided an example where a sibling was sexually assaulted by an individual; however, the parents did not want to inform the police or take action as they did not want to lose the family's respect and reputation. The participant expressed anger related to this incident and stated that they ended up supporting their sibling through the trauma.

> *Participant #F003: I feel like our parents make so many sacrifices because of what other people are going to say and for their kids cause reputation matters so much… I also think it's important to for us to talk about being happy and the idea of happiness because they're so focused on what other people think and what the community thinks and oh my gosh what are they going to say about this person's daughter or what are they going to say about- because she did this this and that…I have a cousin and she's raised in a very very strict family and now she's super rebellious and super out there and I feel like part of the reason she's how she is now is because of how her parents were and they were so like you can't do this this and that because our family is going to say this and that…There are so many unnecessary problems because they worry too much about what other people think…and we have to stop that and we can stop that if we wanted to by engaging our parents in this type of conversation…*

Participant M012: They're always going to be like what's your son doing and if like my parents, they go to an event or anything, like they'd be ashamed of something, so I think that's why they have a lot of pressure on themselves to make sure their son or daughter (does well).

Participant #M013: she got sexually assaulted…and my parents didn't want to call the police or nothing, because they said our- like her respect would go away to the family and stuff… I was really pissed that day… my parents were acting like everything was fine.

Media.

Two participants (15%) described social media as something that negatively impacted their mental health. It made them compare themselves with others, and made them feel low, especially as they are trying to figure out their own life and they see others who seem to have it all together. Its use as a form of communication made them feel left out/uninformed if they were not utilizing it. They also stated the need for likes and pressure to put on a display of happiness was unhealthy. On other hand, participants also identified that discussions online about mental health, including those on social media, were helpful in promoting and creating awareness. In terms of other media, one participant described learning about mental health (which happened to be inaccurate) from a Tamil movie they had watched and having used it to analyze his symptoms of mental health.

#F007: "Can be a trigger when comparing yourself to others, seeing those you don't have relationship with anymore are happy without you can make you feel low; it's also a form of communication i.e. group chats; if you are not on social media, you don't feel informed and like you don't fit in"

4.7.6 Culture and gender.

Females experienced different challenges than males including those in relation to their appearance, rules, expectations and timelines. They faced body image issues due to experiences of "shadeism," and the cultural norm of others, especially elders, openly commenting on people's physical image such as skin color and body size. They were perceived as being emotional by others, which deterred them from seeking help from mental health services. Females felt left out and a decreased sense of belonging when stricter rules were placed on them by parents including how they were allowed to dress (i.e. no nail polish, can't change earrings, no sleeveless tops, knees covered, no skinny jeans), and the activities they were allowed to engage in (i.e. come home for lunch, limitations on use of social media, no privacy, no sports related activities). Female participants expressed parents encouraged them to focus on academic related activities instead of sports, and faced greater pressure related to timelines for graduation due to their parents worrying about getting them married before the age of 30. One female participant shared that being able to move away from home and her strict parents allowed her to experience new found freedom, but it ended up taking away from school. Females also noted their experiences of cultural gender roles in their own families such as men being the sole provider and not focusing on their children's lives as much as women who took responsibility for child rearing. One participant expressed that if a child experienced issues, the responsibility was placed on the mother and noted as her failure by the community.

Culture clash.

Three participants (23%) spoke about their experiences of culture clash including those related to behaviours, attitudes, values, respect, functioning in relationships, music and apparel. For example, one participant stated that although it didn't impact her experience in school in any

way, she did notice the culture clash in what others wore to school i.e. short skirts versus what she was allowed to wear by her strict and traditional parents i.e. no sleeveless tops, knees covered; however, another participant stated that she struggled to fit in due to the culture clash, while trying to make her parents understand. Another participant stated they felt a sense of disparity between themselves and "long-term Canadians", and described the change in culture as becoming a hybrid culture encompassing the Tamil and Canadian cultures, which they pointed out has its difficulties and benefits.

4.7.7 Family

Family history of mental illness and related stigma.

In total, eight participants (62%) reported that at least one of their immediate or extended family members had a diagnosed or suspected mental illness or mental health problem, and two participants (15%) reported that this family member completed suicide. Of the total participants, five participants (38%) specifically reported the family member to be an immediate family member, such as a grandparent or parent, with two participants (15%) identifying this family member as their mother who had a diagnosed mental health illness, and two participants (15%) identifying more than one family member who fell into this category. This included a grandfather and uncle in one case, and a mother and grandfather in another case. Furthermore, one of the participants reported their boyfriend who was of the same ethnicity lost their father to suicide and another participant shared that their friend lost their mother (who was also of the same ethnicity) to suicide. Interestingly, one of the grandparents was from the maternal side, and the remaining three were from the paternal side, with one of the paternal grandfathers having completed suicide, and one uncle and one aunt were from their paternal side, with the aunt having completed suicide.

The prevalence of mental health issues among participants who had at least one immediate family member with a diagnosed or suspected mental illness or mental health problem was high as 80% reported having a mental health illness or problems themselves. This total encompassed all females, and one male. The female participants expressed experiences of anxiety attacks, self-harm to cope with stress and anxiety, and depression, and one female participant who had a grandfather who had completed suicide, also stated she had past suicidal ideations. The only male participant in this category reported that his grandfather and mother had diagnoses of severe depression, and although he did not directly report mental health problems, he expressed distrust of friends, conflict with immediate and extended family, and a lack of internal motivation and resilience as a result of low self-confidence which he related to the result of growing up with a mother with a mental illness.

The parents of two female participants whose family had a history of mental illness and/or suicide, feared that their children might also attempt suicide or have similar mental health issues. These participants described their parents not knowing how to handle or being fearful of their children's emotions. Another female participant was told by her mother not to share the information about her grandfather's mental illness with others. All three of these participants expressed that their parents' fear and stigma related their family history of mental health issues, in addition to their lack of mental health literacy and not knowing how to cope with mental health concerns, resulted in the participants finding it difficult to share their experiences /feelings related to mental health, and/or reach out for help from their parents.

> *Participant #F001: my dad's side of the family did have a family history or whatever of mental illness. I know that my mom was like I think in Grade 9 or 10 she was telling me this story about back home…and it was like oh he sounds like he would have a mental*

illness and she was like oh but don't go telling people that because then they will think that you will be like that. And I was like so strange because well first I have no control it's just and whatever. It's just that I felt like she was a little embarrassed by it. And I had never heard that story from anyone else in the family, so I knew everyone else was obviously hiding something. So that was what made me think that they wouldn't understand.

Participant #F011: …if I talk to my mom she would worry even more, and like I can't talk to her about feeling depressed or like self-harm or anything like that right…Well when I get distressed, even like slightly, my mom gets very upset and she doesn't know how to handle it per se. And so my dad's dad committed suicide so her first thought is, you know, am I going to do something like that and I don't want her to stress out even more because I feel like I can sort of- I feel like it's better for me to handle things on my own then to you know, worry her even more.

Intergenerational gap.

Participants felt that the parents could not relate to the youth's experiences, and/or did not understand their unique struggles such as the implications of growing up in poverty, experiences of stress, help seeking for mental health, and mental health in general. One participant expressed that parents wanted to "live through" their children by having them accomplish what they didn't have an opportunity to do i.e. achieve post-secondary education/career. Participants also stated that parents made comparisons between their personal experiences/opportunities in Sri Lanka to those of their children's in Canada resulting in perceptions that their children should be happy and not worried, as they had come to Canada for the children's future and success. This

perception was often communicated to youth through a "you have nothing to be upset about" attitude towards expressions of mental health challenges. This attitude made it difficult for participants to communicate and be open about their experiences with their parents, and also increased the pressure they felt to achieve, and make their parents proud.

Female participants insightfully talked about the differences in the culture that their parents were raised in versus the culture they had been raised in. They attributed parents' lack of understanding of their children experiences, especially as it relates to stress, to their inability to relate to them by citing the difference in the lifestyle in which their parents were raised in their country of origin, compared to the more fast paced and more indoor based lifestyle of Canada. They also recognized that their parents had a lot of questions as they had not been raised talking about mental health. They recognized that their parents had come from a social culture where they had not experienced seeking help from doctors/specialists unless it was for a life or death situation, whereas in Canadian culture, individuals tended to seek help or medical attention for everything to get better faster in order to get back to work sooner.

Family conflict.

Overall, six participants (46%) stated that their own or their parents' mental health was impacted by family conflict, and/or that this conflict had an impact on the relationships they had with extended family. Three participants talked about how family conflict affected their mental health. As mentioned earlier, two participants (15%) stated that as a result of family conflict, they saw their extended family only up to four times a year. Family conflict contributed to anxiety attacks, and participants dreading going home or were at times not able to go home because of the issues in the home.

Participant #F003: 003: I was constantly fighting with my mom growing up… I guess I was always like I was never happy to go home from school because …there was like seven of us living together, at one point there was ten. There was so many people…People fight a lot at my house, so there used to be so much fighting so I always hated when 3:30 came along because I was like oh, I have to go home and deal with everyone or hear people fighting or arguing or whatever. And like it's not like, cause I used to read a lot and I feel like I just stayed in my room a lot cause I don't talk to my mom, my dad was always working, my sister was a kid and stuff. My sister was never close with me until recent years and stuff, so I guess my mental health wasn't all that. But back in the day, it was just like this was the norm. I didn't label it as oh, I am unwell, like my mental health is unwell, I was just like oh, this is my norm, this is how life is, right.

One participant stated that he'd had multiple issues related to family conflict, as well as a long-standing conflict between himself and a sibling which affected their mother's mental health. Another participant stated that the pressures of child rearing a troubled older sibling with a lack of support and being perceived as a bad mother by the father and others affected her mothers' mental health. As a result of this, the participant felt pressured to live in a way so as not to add any additional stress on her mother and prove to others that she was a good mother.

Participant #F011: I feel like it's better for me to handle things on my own than to you know, worry her even more. She dealt with a lot with my older brother and I've been like the child that was sort of cleaning up after his mess, so I didn't want her to like go down that road, like she's been a bit more calm nowadays… He was born in Sri Lanka; he came here when he was 10. He was just really troubled in high school, he did some drugs, he got into a lot of like, he was arrested quite a few times, he's just really aggressive and violent

and stuff and yes, it's because of that my dad wasn't very understanding. He wanted him to be like -if you- he didn't want to bail him out or anything like that and my mom was stuck in between and my dad was like you know, it's your fault because you didn't raise him properly cause he's at work most of the time right, so my mom didn't really have anyone to turn to. Her siblings… in terms of our family…if a kid turns out bad it's the mom's fault, right, so I felt like I had a lot of pressure to relieve a lot of that stress and like, so that she could tell people that she's not really, she's not a bad mom, right.

Troubled and/or a lack of relationships with immediate family members was another theme that arose during this study where seven participants (54%) specifically verbalized troubled/difficult relationships, or lack of relationships with family members, specifically parents. As mentioned earlier, one participant found it difficult to find time to spend with family due to odd work and school schedules. Two female participants had troubled or a lack of a relationship with their fathers as they either found it difficult to connect with them or felt that they couldn't communicate certain concerns with them, especially as it relates to how certain actions of their father affected the family unit. Both participants found that this contributed to a negative impact on their mental health.

Four participants described difficult relationships with their mothers. One female participant described a strained relationship with her mother owing partly to the fact that her mother had left Sri Lanka at a very early age and had also become a mother at a very young age. She felt that when her mother's sisters came to Canada, her mother was very close to them, which caused strain on the relationship between her and her mother in various ways. Two of the participants' mothers had mental health diagnoses, and both participants (one male, one female) found that this affected the relationship they had with them i.e. feeling like they weren't there to

fill the conventional mother role. One of these participants also had a strained relationship with their sister, which impacted the health of their mother as well. The female participant found that she was also able to connect to her mother more when she herself started experiencing mental health issues. Lastly, a male participant described his experiences of growing up with a single mother. Although he also had a sister and grandparents, he expressed feeling a lack of attention/affection from his family.

> *Participant #F002: …cause my mom suffers with bipolar disorder and depression and stuff but because of that, that freaks out my dad cause she's not really not supportive but it was always hard on us because of it and I've never really understood her until I started going through my depression myself, and I'm like oh! like this is what a panic attack feels like, and this is what you do when you're depressed, like I get her more. It just sucks because that's your mom and you expect them to be there for you, but she can't because she can't even help herself, so that was kind of rough…*

> *Participant #M010: …the way I was raised, was that it's a single mother, but I had no one to look up to because I didn't know my dad then and my mom she was going through issues of her own, so the only… maybe like, I was only getting supervised by her parents, but even they went to work, so to me, it was only like school and then however I felt, I'd be home, I just be there. So, like with that situation, for that to happen, I was brought up differently… my older sister and I, we went to school together but my sister and I, we weren't as like- we never really shared a lot of stuff together. It was just like, I'd be in my room and my sister would be out like, in the living room so we never really explained a lot. We never really talked a lot…so if I were to talk to my mom and stuff, I didn't really get like, I didn't really*

get the normal mother and son, like the nice, like the good, like the fun family, like you know, they all bond - No, it was more like 'hi mom' and stuff and if I would try to like, it's like I get yelled at, so like, by everyone too. When I was little I just felt, it's not like attention, but was just like, when I wanted to do something it was more like no, it's like you get pushed off right.

Participant #M009: She just…she says some…she would say things like, it's cause of my behaviour too…like if I say something that would really piss her off. I do stuff that really gets under her skin, regarding my sister and me not talking – that's her daughter right. I would say stuff or comments that would trigger her. And she would be like you're not my son, or this that. When she lost her father, she was going crazy. I don't know. Like I said, she was just falling down, right, not taking her (medication)…"

Parents and academic expectations.

Parents and their high academic expectations were talked about by five participants (38%), and two participants (15%) stated that their parents pressured them to do well, consistently told them to study, and that they felt like they had no time for fun/play. One participant even mentioned this as being the weakness of Tamil youth in relation to mental health due to the stress caused by their high academic and career expectations. As children wanted to make their parents proud and not disappoint them, it left them at a crossroad between what they wanted and what their parents wanted in terms of academic and career success. Interestingly, this participant also heavily focused her responses about her experiences related to health/mental health on academic choices, achievements and her parent's perception and acceptance of these.

The same five participants (38%) also talked about Tamil parents having stereotypical expectations for their children, such as a preference in their children obtaining a university degree, instead of a college diploma, and making academic decisions that would allow them to pursue specific careers stereotypically perceived to be highly desirable and representing success. These careers were listed by the participants as doctors, lawyers, and engineers. This perception held by parents made it more difficult for participants to make their own choices, according to their own interests or preferences, when it came to academic and career decisions.

> *Participant #F003: Well I guess, cause I'm the oldest as well, so there's a lot of pressure. I feel like my parents kind of live through me because they couldn't go to post-secondary, or achieve any…a career for themselves I guess. So, um there's a lot of pressure to be the best, you know before, "it's like be a doctor or lawyer," or whatever. And if you don't want to be that, you have to convince them that there are other jobs and that um, or like just growing up, I feel like it was always like study! Study! Study! There was no such thing as play or have fun or whatever. And then school or work becomes your only thing.*

> *Participant #F008: So, I think there was a lot of like times in high school when I was like what am I going to do with my life. I know my parents would want me to become a doctor, like a lawyer or an engineer, which is all great because like I'm sure, in my mind I was like I'm sure there's something that would work out for me like I would like one thing that they would also like me to kind of be part of. So, like my kind of mind was set on not just pleasing them, but I just didn't want them to be disappointed with my choices and stuff like that…*

Participants had experiences of their parents pressuring them to do well by comparing their academic achievements and decisions to others including siblings, which they did not like, as expressed by three participants (23%). In one case, a participant described that her parents did not approve of her choice of program and compared her to her siblings who they perceived were going to be successful based on their choices in programs. They questioned her about what she was going to do, and what they were going to tell others about her choices (refer to reputation section), which led to the participant feeling low, angry, and lying to her parents to get out of the house as she dreaded being at home.

> *Participant #F007: … I did a degree in sociology and my dad was like always putting me down and saying like- what can what can you get with that degree and like what kind of degree is that, what are you going to do afterwards. And like my sister's….doing her life science degree, and my brother was in business …they knew what they were going to do and I was always the "lost one" and they always put me down saying what are you going to do, two of your siblings are successful, what are you going to do, what are we going to say about you? And they would always put me down, and I felt really low. I didn't really have anyone to talk to, I would lie to them a lot. Just to even get out of the house cause I just hated being home…*

Parents' impact on help seeking and experiences.

Family was viewed by nine participants (69%), with parents being specifically identified by seven participants (54%), as the *most significant barrier* to Tamil youth accessing mental health services. Parents were also identified as a *key challenge* in accessing mental health services by six participants (46%). Participants felt that their parents being strict, lacking mental health knowledge, fearing the unknown, and not teaching them how to care for their mental

health functioned as barriers to accessing services. They further stated that their parents being “in denial”, and not knowing how to handle and engage in conversations about mental health when needed, and not being accepting, supportive, or nurturing when it came to mental health related concerns functioned as barriers.

The inability to communicate openly with parents, and lack of healthy relationships with parents resulted in a negative impact to participants. One participant stated that the lack of a healthy relationship with their father prevented them from being able to communicate their feelings and experiences with them. Another participant described the sense of being trapped if/when they were not able to share their feelings with or seek mental health support from their parents/families. Two participants expressed that when they did try to talk to their parent about their mental health challenges, they did not accept what they were being told, and remained “in denial”. One of the participants was asked what was wrong with them and told to go to sleep to feel better in the morning, while the other was told that that everyone goes through depression.

> *Participant #F006: Yea. And for a while they were kind of like in denial, they would kind of like ignore -not ignore, but like act like that wasn't what was it-- was going on or like just kind of be like I thought you were over that like something came up they didn’t understand how it's kind of like a spectrum and so it's never like- your mental health is like always, it could be like up and down so they were kind of like oh it’s been so long we thought you were like over this stuff and thought everything was good now, and so they like -I would have to respond to questions like that and not really know how to like explain myself. But yeah, it was definitely a challenge*

Participant #F007: I've told my parents out of anger that I tried to commit suicide off of Tylenol… They never bring it up but they are in denial, and were like I can't believe you did that, no, you're just joking, like how can you do that and stuff and then, I knew in my heart that my mom knew what happened but they would always talk about it during nighttime, like I can hear their conversations, like, they would be saying oh I can't believe she did it, what if she does it again, what if it actually happens, what if she actually does, like what do we do…So after that point, it's just, they were in denial so I knew I couldn't talk to them about it .. They were just kind of hiding it under the rug, that's how I feel.

Even when participants attempted to receive, or were offered supports/services, they did not feel comfortable sharing this information with their parents. This resulted in them actively attempting to hide seeking services or not accessing them at all, which is reflected by the four (31%) participants who were delayed in receiving or did not receive the help they needed out of fear of their parents finding out. One participant stated that they had been waitlisted for mental health services through Ontario Health Insurance Plan (OHIP) but did not want to seek help from private options through her father's insurance as she did not want to disclose information about whether she was seeing a therapist or taking medications to him. One male participant stated that he stopped going to anger management classes that his school had recommended for him to attend, out of fear that his parents might find out, while another male also stopped attending classes recommended by his family physician for the same reason. Another participant expressed that they held back information from health care practitioners in the presence of family members.

Participant #F005: I think (the most significant barrier for Tamil youth accessing mental health) would be family, because you wouldn't want family to know and if they do- there's like a negative stigma around it so yeah, I guess you don't want your family to

find out so you just don't do it…I feel like I'm more like held back when my family is there rather than when I'm alone, and it's probably because like certain things, you don't want your family to know or you know that they'll have a negative mindset around that.

Moreover, seven participants (54%) expressed concerns about their parents or others finding out as a result of breaches in confidentiality by health care/service providers, specifically when they were of a similar cultural background; thus, they were less willing to disclose mental health concerns to these individuals. In some cases, this fear stemmed from the participants having shared family doctors with their parents. One participant stated that a friend of theirs got into trouble with her parents for disclosing something that led to the police and Children's Aid Services becoming involved. Two male participants stated that as a result of not being able to talk to parents, or wanting to hide their mental health concerns, youth might also face other barriers to accessing the services such as a lack of transportation to these services. In addition, they may not be able to access services unless they skipped school, as their parents would want to know where they are going outside of school hours.

Some participants mentioned positive experiences with their parents in relation to health and mental health. One male participant stated that he had a good relationship with his parents, and although he has never had to, he would feel comfortable seeking support from them for mental health related challenges, and another male participant expressed how caring his parents were, specifically his father. A female participant was pleased that her parents were starting to ask more questions and gain some understanding about mental health as a result of a rise in the number of aunts and uncles facing mental health challenges. Additionally, three participants (23%) (all females) acknowledged that they had previously held negative presumptions about their parents' ability to understand and support their experiences and decisions i.e. wanting to

switch school programs/schools but were surprised to discover during identified scenarios that their parents were in fact understanding and supportive. In fact, one female participant's mother noticed symptoms of distress and encouraged this participant to seek mental health help/services from their family doctor. This support led to the participant being able to better manage her mental health. Another female participant described not wanting to cause her mother stress by telling her about her mental health challenges during a difficult family situation; however, she felt that it strengthened their bond once she was able to talk to her once the situation was over. Yet another female participant described that it took a lot of time, research, and information provided by doctors for her parents to eventually understand her diagnosis and how her prescription medication would help her mental health, but they are now her greatest support, and the first people she would go to if she were having issues with her mental health.

> *Participant #F001: it's just that we don't... we haven't had that discussion with our parents. We haven't had that discussion with our parents. We haven't given them the platform to say like hey yeah, we know we understand. I think it's just that… I think it's a matter of … just somehow getting the parents involved in it and having that discussion between like parent and child.*

> *Participant #F006: they didn't have any experience with this, and they were really used to like -if it was a physical health problem, they would like put that number one and they didn't understand like that the huge complexity of mental health. They didn't know what mental health was and so it took them awhile, but like I can honestly say like 4-5 years later my parents are like always -they can see the signs and symptoms in some people and they're always ready to support anyone or who's like going through something.*

4.7.8 Self-identity.

Participants gave a range of answers when asked how they would identify themselves.

Participant #M004: I guess it's just a question of who you are, like to start exploring and like looking for yourself you realize that there is a lot of history behind Tamils and it doesn't seem that information is accessible or ever brought to you but once you start delving into it for yourself you start to question I guess who you actually are. I feel like we don't have a lot of resources to access or even utilize to help build that sense of identity and so it's not to say we're lost but it feels like there's an aspect of who we are that hasn't been as addressed as it should have I guess, as a first-generation Canadian."

"Canadian" and "Tamil" were included in ten (77%) of participants' identities respectively. Despite their origin, only three participants (23%) included "Sri Lankan" in their identity. One participant specifically stated that Tamil youth face more challenges and questions about their identity than most other Canadians. Interestingly, during recruitment, one community member even questioned the name of this study including "Sri Lankan" in it. When it was explained to them it was for the purposes of specifying the population's origin, the suggestion was made to re-name the identifier as "Tamils of Sri Lankan origin" versus Sri Lankan Tamils. Interestingly, four participants (31%) used "back home" to refer to Sri Lanka, their country of origin.

The diagram below illustrates the answers given by participants with each axis identifying one distinct part of their identity. Circles were placed in areas dependent on the descriptors that participants identified with, and darker shades were used to represent a larger number of participants who identified with it. For example, the darkest circle being black was placed on the "Tamil" and "Canadian" axes with it being slightly higher on the Tamil axes as the

participants identified as “Tamil-Canadian”. The dotted arrows indicate the fluidity of these descriptors and exemplifies that although certain descriptors were used in specific orders, it cannot be assumed which identity is stronger than the other in certain settings and certain times. One participant identified themselves in two ways; therefore, both answers were included in the diagram.

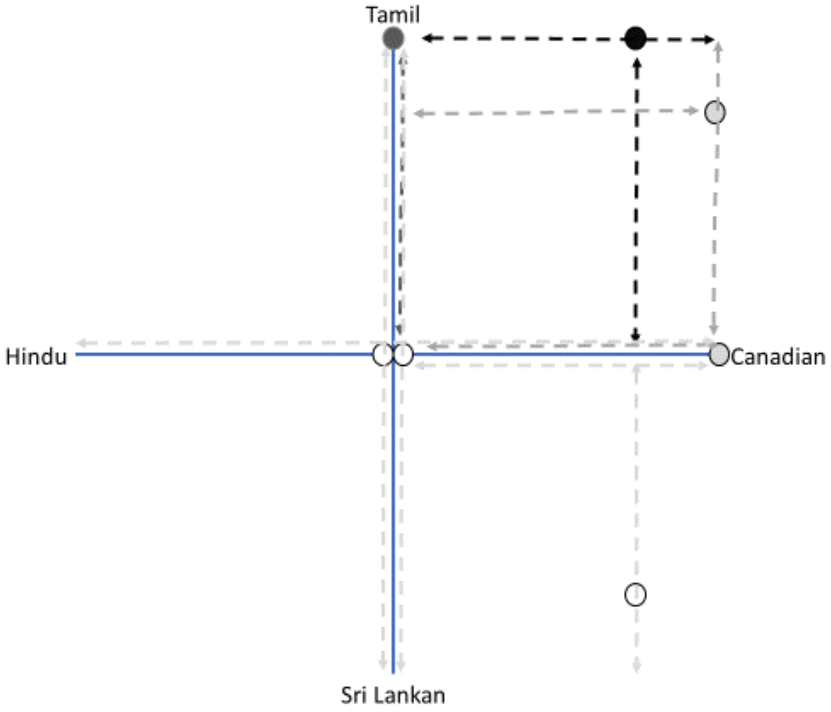

Figure 9*: Identity as expressed by participants*

Importantly, although the diagram is two dimensional, it is meant to represent a cross sectional, simplified version of self-identity based on participants’ answers to this question, and it is acknowledged that identities are intersectional and fluid.

4.7.9 Current Self-Esteem Instrument.

Participants completed the Current Self-Esteem Instrument, which measures their feelings about themselves over the course of the past week, with a score of one meaning they

didn’t feel good about themselves and ten meaning they felt great about themselves (Khanlou, 2004). The results can be found in Table 1: First/Second Generation Tamil Youth Living in Toronto Canada’s Current Self-Esteem Scores. Classification of the current self-esteem levels is defined as low, between one and four; medium, between five and six; and high, between seven and ten (Khanlou, 2004). Self-esteem amongst the participants was medium overall with an average score of 6. The average self-esteem was high among females with the average being 6.75. There was one outlier of a score of 3, while the remaining participants reported higher scores between 7 and 8. The average self-esteem was medium for males with the average being 4.8. Males in their teen years had low self-esteem, while those in their twenties had higher self-esteem.

> *Participant #M010: I've always had depression, so it's just like…growing up with that, it’s actually pretty bad. It’s really bad cause it really brings yourself down, it brings your self-esteem down. Even a small thing, the smallest thing can impact you in a way that you would feel so bad, you just isolate yourself.*
>
> *Participant #F005: Internal motivation, yeah, but I think a lot of the internal motivation comes… like initially starts with other people and how they give you feedback as to what you're doing and just what you get from other people I guess and that build your internal motivation I guess.*
>
> *Participant #F007: Yeah, I got this app called Daylio, and I use it to track my moods and stuff, so that kind of gives me motivation, so I know that going to the gym helps me like feel more happy, feel more better about myself. I have low confidence, so for sure that that helps me a lot.*

Participant #M009: Not a lot of people get to me but as a result of my poor confidence, it's really hard for me to get back up, get back out there, it's um…cause I'd, I don't really have an answer for that, but from my side, it's really hard.

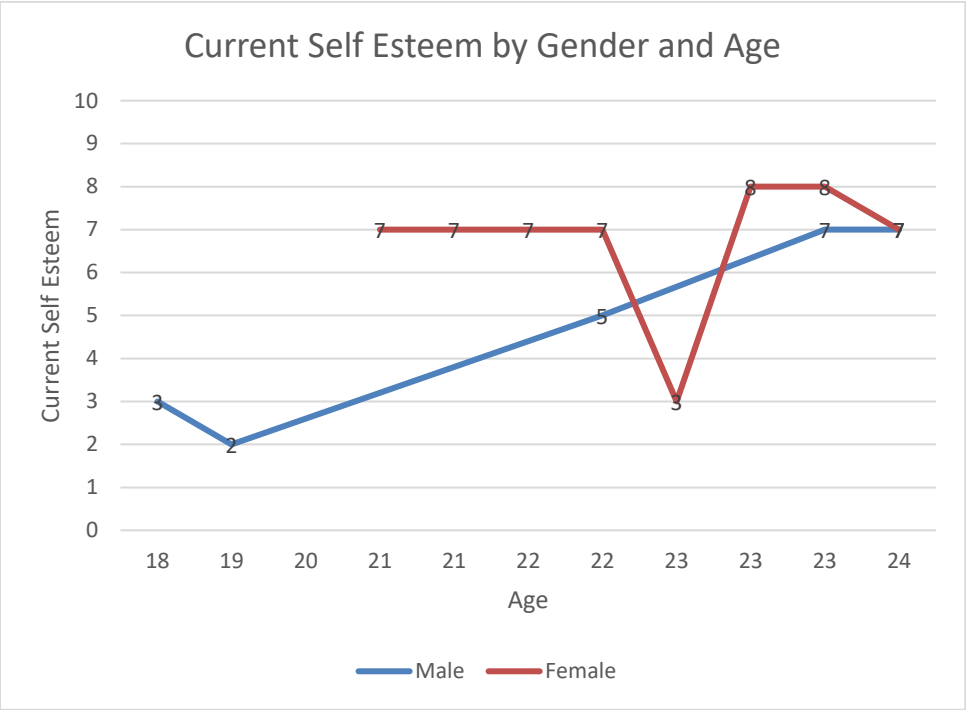

Figure 10*: Current Self-Esteem Scores of Participants by Gender*

4.8 Participant Recommendations

4.8.1 At the individual level.

When asked for recommendations at the individual level, eight participants (62%) listed individual practice/lifestyle/self-initiatives including increasing self-motivation for care, self-evaluation/self-reflection and changing of practices, setting healthy boundaries, work/life balance, taking the time to relax, having a hobby/passion, cutting down on social media use, improving coping skills, eating healthier, meditating, remaining physically active and not engaging in self-depreciative or harmful activities. Being aware of who you are, where you come

from and being happy with that, and showing, recognizing and embracing love i.e. a parent's love may not look like what you see on TV, were also mentioned. Eight participants (62%) stated taking the initiative to research and seek help/support, talking about it/confiding in friends, family, or others, being there for others to listen and check up on them, and reaching out to a professional when needed. They recommended not feeling restricted due to the culture of stigma and living for oneself instead of others. Two participants also recommended specifically increasing parents understanding of youth's experiences by communicating with them and educating them about mental health. Three participants highlighted the importance of increasing education/awareness about mental health such as not viewing mental health/illness negatively, recognition of the signs and symptoms, and where to seek help. In addition, two participants recommended religion/spirituality/philosophy and one participant recommended having friends from different backgrounds other than Tamils to have different perspectives.

4.8.2 At the family level.

Increasing parents' mental health literacy.

Most participants highly recommended increasing mental health literacy amongst Tamil parents to make mental health conversations with youth easier; help them recognize signs and symptoms of mental health concerns in themselves, their children and others; and to help them appropriately respond to, understand, and support those experiencing mental health concerns. One participant highlighted the importance of creating safe spaces to do this so that parents could ask questions without being judged. Two participants stated that tailored resources that are culturally sensitive and available in Tamil would be helpful in achieving this, while another participant suggested creating awareness, and providing education/outreach in places that Tamil people frequent such as the Temple, doctors' offices, and community events like Tamil Fest.

Another participant suggested educating families and improving family dynamics through workshops or presentations using art mediums that parents enjoyed, such as a drama, movie or theatrical productions. Furthermore, three participants emphasized that parents need to be involved in youth accessing mental health resources, and that service providers need to support and educate parents when their children face mental health challenges.

> *Participant #F002: I feel like people don't know what it is, I feel like it's something they should be more informed about, be more educated about it. They shouldn't have to fear it. I feel like if they have a kid and they see these signs, they should know what to do with it, and they should create that warm and welcoming environment, so their kid doesn't feel like they have to go through it alone. I feel like that would solve a lot of problems, I feel like a lot of kids wouldn't commit suicide, or they wouldn't be going through depression, or whatever they're going through alone. And they wouldn't be lashing out and resorting to drugs and alcohol to numb the pain.*

> *Participant #F002: A lot of parents don't get it. I think they find out about it when it's too late. I feel like when their kid has committed… suicide or they've attempted it, or they're just in a really bad state, like … they're either abusing alcohol, or just acting out because they don't know what to do with like all those emotions and what they're feeling. I think that's when they like …get it, it's like there's a problem here, they need to fix this. But I feel like it shouldn't be like that. I feel like there should be that open window of communication. I feel like your kid should be able to come to you and talk to you about it. Even in the early stages. I feel like it's not something someone should have to go through alone. It's scary. Especially if you're like 14 or 13, it's hard because kids are mean. And*

it's hard to find people that understand you, so I think your parents should be more informed of it. I think that's something the Tamil community definitely lacks.

Closing the gap.

The recommendation of closing the intergenerational gap between youth and parents through more open and honest communication with each other in order to meet at "the crossroads" were made by five participants (38%). This included having open conversations around the differences and experiences of the two cultures that parents and youth were raised in, and the impact that this has on parents' and youths' mental health. Participants wanted parents to understand their struggles and mental health experiences including the stress they endured to make their parents proud. Two participants suggested achieving this goal through family counselling. As mentioned above, one recommended option was by improving family dynamics through workshops or presentations using art mediums that parents enjoyed, such as a drama, movie or theatrical productions.

Participant #F002: …no one should feel unable to talk to their parents, there shouldn't be a barrier with parents, should be able to be open with problems…

Participant #F011: I feel like if we were able to bridge the gap between our parents and like we're better able to communicate with them, and parents are more educated about mental health, and some of the things that youth experience, and like some of the stress they may experience to make their parents proud, and give back to them, was more like understood, then we would be able to achieve better mental health.

In addition, two participants (15%) voiced their thoughts around the need for parents to be more open-minded about certain issues including the caste system, LGBTQ community, and inter-religious/racial marriage as opposed to always considering what others will think.

> *Participant #F003: we should try and like I feel like it would help them and it's a part of coming to Canada like being open-minded and viewing things from a different perspective and stuff and not just thinking the same way they thought when they were living in the village or something…*

> *Participant #M013: I would say like…parents have to be more open-minded, because they have the third world mind state of not accepting anything at all. They don't understand our first world issues I guess, even though it won't be as serious to them. But they never really were a part of certain issues here, right. So, I guess if parents were more accepting and understanding, more Tamil youth would be more open to their parents than do stuff to themselves.*

4.8.3 At the community level.

Recommendations made by the participants at a community level included education, outreach, and increasing awareness within the Tamil community, especially in places where Tamil people frequent, such as the temple, doctors' offices, community services, and major Tamil events/festivals. Participants wanted the stigma around mental health to be broken so that the community was more accepting of mental health, and open to talking about it. One participant identified that men in the community should especially be more sensitive towards mental health issues and seek help when necessary instead of "being manly". Increased services, such as counselling, or family counselling, targeted at the Tamil community focusing on their

different experiences as immigrants and first-generation youth was also mentioned. Suggestions included improving family dynamics through workshops/presentations, using art drama/movie/theatrical production with a message to raise awareness, education/outreach on how to support someone with mental health issues. One participant also stated stopping the violence between Tamils. Participants also recommended that the community engages in good mental health practices such as taking time to relax instead of working and worrying about money and reputation all the time, spending more time with family, having positive friends, living for yourself instead of others, and not engaging in self-depreciative or harmful activities.

> *Participant #M013: "And then I guess for youth to be more open to each other, like their group of circles about what's their problems in their lives. It's kind of off topic, but still health I guess, like Tamils need to stop doing dumb shit to each other like violence."*

4.8.4 At the structural level

Proposed solutions by most participants at the structural level included increasing culturally competent care by increasing access through funding to hire service providers of the same ethnicity, or of color who are relatable, and having more Tamils branching into mental health careers. One participant stated more research needs to be done to identify and address the problems that this population has. Another suggestion was that since parents did not grow up talking about mental health, services should be inclusive of parents and their involvement such as mediating or facilitating conversations between parents and children and having providers that can increase mental health literacy using Tamil so that they understand. They also expressed a need for spaces/opportunities to increase belonging/togetherness within the community and increasing community involvement/outreach activities to promote health/well-being.

Recommendations based on the educational system included changing curriculums to be inclusive of all populations, not specific ones, having other mental health professionals besides guidance counsellors to go to for mental health i.e. nurses/someone in the medical profession, and having resources, support groups, and safe spaces for students to safely talk about mental health. They also mentioned having an unfragmented mental health system and a place where they could go to a central location for help versus having referrals and going from one place to another and bridging the link between the educational system and the health care system to ease transition or collaboration. Others mentioned increasing accessibility to services, by increasing the number of services/resources, specifically public/free services and culturally sensitive services in different parts of the city, increasing research on this community, and increasing ease of system navigation.

> *Participant #M011: Ensuring that there's more research done in our community and making the changes to ensure that the appropriate research is done so that whatever strategies that we do implement, are more reflective of our community and the needs of our community. And ensuring that we have like youth groups like the CANTYD youth group, and other youth groups that specifically serve our community and other minority populations.*

4.9 Summary

This chapter provided answers to the first two research questions. Parents, the Tamil community and Tamil culture emerged as major themes reflecting the important roles they play in Tamil youth's meanings, beliefs, practices, and experiences of mental health. Within these contexts, gender, culture, trauma, resilience, and identity were found to be major influencers. The next chapter will further contextualize these findings into meta-inferences.

5.0 Chapter Five: Interpretive Results

Chapter four presented the descriptive results of the study. This current chapter proceeds to describe the interpretive results through meta-inferences while using Wesp et al.'s (2018) emancipatory approach to cultural competency. It also uses Thorne's (2008) interpretive descriptive research approach to acknowledge diversity, question and analyze processes of power and address the question of "so what" in determining how these meta-inferences apply to practice in the health and nursing fields. Specific recommendations on how this information can be used to increase quality of care and services provided to this population will be made at the end of this chapter. This study explored a large amount of rich data resulting in numerous themes from which many inferences and meta-inferences can be made. For the purposes of this thesis, I focus on four main meta-inferences. These four meta-inferences emerged based on critical analysis of the qualitative and quantitative results of the study and comparisons of these results to other relevant literature. In addition to the study itself, I had kept a "pulse" on the topic of mental health within the Tamil community which allowed for in depth insights and a plethora of experiences. I will discuss relevant insights and experiences as they apply to each meta-inference, and address reflexivity in chapter six.

Here are the four meta-inferences gleaned from this study:

1. Individual and collective trauma may have impacted families and the community and led to intergenerational trauma and resilience.
2. Culture and migration may have significantly impacted gender roles in the post migration context, contributing to higher mental health needs and stigma experienced by the male population, and gender inequity resulting in gender-based violence and family conflict.

3. Collective coping through shared goals as a coping mechanism may have contributed to resilience and integration of the community and being female may be a protective factor.
4. Migration and racialization/othering of Tamil youth within a multicultural context as a result of their history may have contributed to difficulties in negotiations of cultural identity, belonging, constructions of meaning and socioeconomic equity for this population.

Throughout this chapter, I will examine how social, historical, cultural contexts influence varying social determinants of health at a systems level. The interpretation of the findings will be guided by critical race theory, post-colonial feminism and intersectionality, as identified in Wesp et al.'s (2018) emancipatory approach to cultural competency.

5.1 Trauma

Pre-migration experiences of refugees and some immigrants include exposure to war, trauma, torture, forced labour, political/chronic conflict, displacement, targeted persecution, violence, and/or death of family/friends during the pre-migration stage (Beiser, Simich, & Pandalangat, 2003; Wilson, Murtaza, & Shakya, 2010; Khanlou N. , 2008). Such factors have been shown to result in low tolerance for stress, distrust in other, symptoms of anxiety and depression, and gender inequity (Fenta, Hyman, & Noh, 2004; Guruge, Khanlou, & Gastaldo, 2010) and can also impact mental health needs in the post-migration stage (Khanlou N. , 2008). Immigrant populations cannot be treated as a homogenous group because differences exist between these groups (Khanlou, 2010). When examining pre-migration factors, the literature emphasizes the importance of distinguishing refugee youth from immigrant youth as refugee youth have additional and differing realities and unique experiences related to pre-

migration (Khanlou N. , 2008; Khanlou & Guruge, 2008). The Tamil population is however unique in that some members have arrived to Canada as refugees with exposure to pre-migration trauma related to war (Pandalangat, Rummens, Williams, & Seeman, 2013), but others have also experienced similar stresses of pre- and post-migration and arrived as immigrants. This variable situation is because a common occurrence involves one member of the family entering Canada as a refugee, then obtaining the means to sponsor their remaining family members, who then enter Canada as immigrants under the family reunification program (Beiser & Hou, 2016). This migration history was a common occurrence among Tamils of Sri Lankan origin. As described in section 2.3.1, Tamils of Sri Lankan origin experienced various forms of pre-migration trauma. The classification of the family members as immigrants does not negate the traumatic experiences they may have had before, during and after migration, similar to refugees (Beiser & Hou, 2016). These experiences of trauma can have an impact at an individual and collective level and can also be passed on intergenerationally in various forms of continuous trauma and/or as resilience at an individual and collective level as well.

The following sections will discuss the meta-inference that individual and collective trauma may have impacted families and the community and led to intergenerational trauma and resilience. Similarities will be drawn to other populations with similar experiences. Collective resilience will be discussed in section 5.2.2.

5.1.1 Individual and collective trauma

Sociologist Kai Erikson (1976) first conceptualized collective trauma when describing the effects of a flooding disaster on the communities of Buffalo Creek in the United States where 125 died. He noted that although individuals might experience either collective or individual

forms of trauma, experiencing both is common as they are interrelated. He differentiated individual and collective trauma in this way:

> *By individual trauma I mean a blow to the psyche that breaks through one's defenses so suddenly and with such brutal force that one cannot react to it effectively. This is what clinicians normally mean when they use the term. [Individuals suffered] deep shock as a result of their exposure to death and devastation, and, as so often happens in catastrophes of this magnitude, they withdrew into themselves, feeling numbed, afraid, vulnerable, and very alone. …by collective trauma, on the other hand, I mean a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality.* (Erikson, 1976, pp. 153-154)

Somasundaram (2007) conducted phenomenological studies on Tamils living in Northern Sri Lanka, which is where most Tamils living in Toronto come from, and found evidence of individual traumatization and psychosocial consequences resulting from the chronic traumatic stress. Somasundaram's (2007; 2010) studies also described the occurrence of collective trauma within this population, which he described it as having a long lasting, multi-level impact on "social processes, networks, relationships, institutions, functions, dynamics, practices, capital and resources" resulting in a collective transformation of a negative nature (Somasundaram, 2014). This research on trauma and its effects on Tamils in Sri Lanka at an individual, family, and community level can broaden our insight into similar experiences happening at these levels within the Tamil community who migrated to Canada from Sri Lankan. It provides information on possible pre-migration factors that the first-generation participants of this study and/or their parents may have experienced, and how these experiences might have directly and indirectly impacted the health and well-being of Tamil youth

An abundance of research highlights the significance of the sociocultural and political environment for the ways in which communities and individuals experience trauma (Womersley & Arikut-Treece, 2019). This research argues that the Western focused diagnosis of PTSD limits its perception to the individual and fails to consider the social or political context (Womersley & Arikut-Treece, 2019). One example is the failure to recognize the health impacts caused by racism towards Black people. The long-term and multidimensional impacts of the nearly 400 year institution of American slavery, and the continued oppression and marginalization of Black people results in their current day experiences of racism and discrimination resulting in racial trauma (Jernigan & Daniel, 2011). The psychological consequences of racial and ethnic discrimination impacting this population (Jernigan & Daniel, 2011) is a form of historical trauma. In fact, a longitudinal study of Black and Latino adults with anxiety disorders found that their experiences with discrimination played a significant role in the development of PTSD among these populations (Sibrava, et al., 2019). Racial trauma also impacts other populations with similar histories of colonization including Indigenous populations and the Tamil population. Skewes and Blume (2019) identified stress caused by racism as a theme that contributed to substance use and acted as a barrier to recovery among an Indigenous population in America. Participants of this study indicated that race-based stress stemming from historical trauma contributed to behavioral health issues (Skewes & Blume, 2019). Unfortunately, the history of Black and Indigenous people in USA and Canada has mostly been ignored preventing us from understanding these experiences of trauma within a sociocultural and political context. This form of trauma also fails to be captured within the Western focused diagnoses of PTSD.

As seen in the literature review, PTSD among the adult Tamil population is prevalent and a third of the respondents in the CID study reported past traumatic events (Beiser, Simich,

Pandalangat, Nowakowski, & Tian, 2011; Beiser, Simich, & Pandalangat, 2003). Although there are studies identifying elevated PTSD rates within the Tamil community, many studies have limited their views to a Western medicalized conceptualization of trauma, focusing on the individual and neglecting the social, cultural, historical or political contexts (Somasundaram, 2007; 2010). In collectivist cultures such as the Tamil culture, the individual is entrenched among their nuclear and extended family and their community in such a way that the boundaries between the self and these groups are blurred and these groups become part of the self, their identity and consciousness (Somasundaram, 2007; 2010). Welfare of the family and community are of great importance and events that are traumatic are experienced at the level of the individual but also through the family, community and the broader society (Somasundaram, 2007; 2014). Participants of this study also voiced their experiences of discrimination. The failure to recognize the collectivist aspects of this culture beyond the individual, and the impacts of racial trauma/discrimination can limit the potential for healthcare providers to accurately assess and support Tamil people.

According to Somasundaram (2014), the collective trauma included the collapse of traditional structures, institutions and familiar ways of life, and the breakdown of social norms and ethics. In rural areas of Sri Lanka (where most Tamil Canadians come from), the village or "uur" was traditionally the secure, protective and familiar environment where families and extended families lived near each other and provided a way of social support, functioning (Somasundaram, 2007), and identity (Somasundaram, 2014). Some communities such as the farming and fishing communities depended on their way of life and land for survival. Due to war, the tsunami and displacement/immigration, these protective systems which were part of the collective social fabric were broken and/or ceased to exist (Somasundaram, 2007). Loss of their

familiar way of life and environment often resulted in loss of traditional social support systems, leadership, rituals, belief systems and practices (Somasundaram, 2007). Similar occurrences of trauma have been described to result in "broken cultures" (Erikson & Vecsey, 1980) among Indigenous populations in North America. The Tamil culture could have been further "broken"/ lost during experiences of war/genocide such as the burning of the Jaffna public library (refer to section 2.2.5), and experiences of migration resulting in a grief reaction or cultural bereavement. Similar to the experience of Tamils displaced in Sri Lanka, families that migrated to Canada may have also experienced a negative impact to their socioeconomic status as a result of decreased social supports, loss of parts of their culture, and the loss of economic stability due to the loss of their land and way of life. This may have had an intergenerational impact on Tamil youth as discussed in section 5.1.2, and on their identity as discussed in section 5.3.1.

In Sri Lanka, the effects of "brain drain" and the war further contributed to a loss of social values negatively impacting sexual and social behaviours including unwanted pregnancies, teenage abortions, child sexual abuse and alcoholism (Somasundaram, 2007). Thefts, abduction and sexual assault of females, harassment, abuse, and violence against women became widespread (Somasundaram, 2007). There was also dramatic increase in child abuse cases (Somasundaram, 2007). Sexual abuse attributed to displacement occurred due to the inability for parents to closely watch their children as they were occupied with attending to survival needs, and due to loss of social support and protection from their family, extended family and friends (Somasundaram, 2007). The loss of social values could have impacted the sexual and social behaviours within the Tamil community in Toronto in the same way. Childhood abuse/sexual abuse was mentioned by participants of this study. Currently, there are organizations within the community such as ANBU that are addressing this issue within the community. These aspects

could also be a reason that gender-based violence is one of the main challenges in the adult Tamil community in Canada.

Somasundaram (2014) noted that Tamil families had strong bonds within their immediate and extended families. The functioning of Tamil family systems in northern Sri Lanka were majorly impacted by the war in terms of family dynamic and functions due to loss or separation of family members, displacement and/or traumatization of a member of the family and impact on skills in parenting (Somasundaram, 2007; 2014). Somasundaram (2007) also found depressive symptoms and inter and intra family conflict within those displaced from their villages. These experiences had an adverse affect on families, particularly on the children, in terms of cohesiveness, lack of trust, changes in significant relationships and changes in practices of child rearing (Somasundaram, 2007; 2014). The impact of disruptions to social and family relationships may have had a similar impact of on Tamil families who immigrated to Canada as indicated by the findings of this study including inter and intra family conflict, intergenerational conflict, and mental health experiences of youth such as anxiety. It may help explain the findings related to family conflict and dynamics in this study (refer to section 4.7.7).

Many of the Tamil diaspora had family in Sri Lanka during and after the war. As instability and disturbing incidents continue to take place in Sri Lanka, these stressors continue to contribute to collective trauma for Tamil families in Canada. The diaspora maintains close contact with the help of technology with those who remained in their country of origin and remain closely informed of current news through media (Somasundaram, 2014). Events in their country of origin and those impacting their families had an immense impact on families who migrated elsewhere, so they continued to experience trauma even after arriving to their host countries (Somasundaram, 2014). The diaspora can also suffer from feelings of responsibility

and guilt for having left behind extended families (Somasundaram, 2014). Based on the emphasis placed by the participants of this study on community, parents and family, this population seems to maintain a strong collective bond and identity. As such, we can determine that trauma experienced by this community as it relates to war/genocide and displacement effects them at an individual level, but also at a collective level in the form of collective trauma.

Collective trauma can result in a sense of betrayal by others including the governments and global systems they trusted. There is a devaluation and humiliation that comes with this betrayal and loss of trust. A significant event that may have contributed to collective trauma within the Tamil community is the inaction by the global community at the end of the war in 2009 as discussed in section 2.2.9, and the negative responses to the Tamil protests. Many recognized these protests as a political response, but the trauma behind it, and resulting from it, may have been less understood. Furthermore, the lack of official recognition of the Tamil Genocide by the international community, and the continued denial of this occurrence by the state of Sri Lanka may be further contributing to this collective trauma. This analysis also raises the question of whether the mental health needs of this population may have been better addressed with the recognition of this genocide. As per Erikson, denying responsibility, and lack of expression of regret or apology is often a component of collective trauma. In Sri Lanka, a lack of consequences to perpetrators and in some cases their promotion and transfer feeds into the worldview where faith is lost (Somasundaram, 2007). Denial of genocide can continue to affect subsequent generations as seen in the Armenian population due to the continued denial of the Armenian genocide by the Turkish government (Mangassarian, 2016). The experiences of trauma/genocide by Tamils of Sri Lankan origin, the nature of the global response to it, and the

lack of recognition of the genocide may be impacting the mental health of families and their subsequent generations.

Collective trauma has been referred to in research of communities with similar experiences as the Tamil community. These include communities with experiences of war such as the six Guinean communities attacked by forces (Abramowitz, 2005), communities with experiences of oppression and attempts at genocide such as those displaced due to their religion like the Yezidism in Northern Iraq (Womersley & Arikut-Treece, 2019), and communities with experiences of terrorism such as communities in the USA following 9/11 (Holman & Silver, 2011). Collective trauma has also been researched in communities that have experiences of genocide such as the Rwandan genocide (Jansen, et al., 2015), including the Rwandan youth diaspora in Toronto (Ainsworth & Innocent, 2018), and Armenian genocide (Karenian, et al., 2011), and communities with experiences of colonization such as the Australian Indigenous communities (Krieg, 2009) and Aotearoa/New Zealand Indigenous Māori community (Wirihana & Smith, 2019).

Such studies indicate that individuals without direct exposure to trauma can also suffer mentally and physically. These populations have been found to have high rates of depression and PTSD (Womersley & Arikut-Treece, 2019; Abramowitz, 2005); high rates of fear, physical distress and sadness (Abramowitz, 2005); increased rates of physical ailments which predicted greater health care utilization (Holman & Silver, 2011). Collective trauma increased risk of developing mental health problems, impacted family integration and support (Rieder & Elbert, 2013). Migrant youth can also suffer from the effects of racialization in their host countries (Ainsworth & Innocent, 2018). As seen among these communities with experiences of collective trauma through war, genocide and oppression, it is possible that Tamils of Sri Lankan origin

living in Toronto may also be affected in these same ways considering their shared experiences with these communities.

5.1.2 Intergenerational/historical trauma

A scoping review of immigrant and refugee youth mental health in Canada by Khan et al. (Khan, Khanlou, Stol, & Tran, 2018) identified post migration challenges including parent-child relationship difficulties as a determinant of mental health. Communication difficulties, intergenerational linguistic and cultural factors, and high academic expectations contributed to these difficulties (Khan, Khanlou, Stol, & Tran, 2018). The participants of this study placed a large focus on their parental and familial interactions and parent-child relationships including problems with communication and how it impacted their emotional and behavioural health.

Trauma can be transmitted intergenerationally through conscious and unconscious mechanisms (Eagle, 2014) . Intergenerational trauma occurs when the experiences of trauma in one generation impacts the health and well-being of descendants of subsequent generations (Sangalang & Vang, 2017). There is ample research identifying intergenerational effects among subsequent generations of survivors of abuse, armed conflict, and genocide (Sangalang & Vang, 2017). A recent systematic review on intergenerational trauma within refugee families by Sangalang and Vang (2017) identified that most studies found evidence of negative effects to the mental health and well being of subsequent generations while a few studies did not. Their definition of "refugees" as anyone forced to flee their country due to political violence, persecution and instability fits the descriptive experiences of most Tamils living in Toronto. Most studies suggested that the subsequent generation of refugee families experienced an increased risk for negative psychological outcomes and vulnerability to psychosocial stress (Sangalang & Vang, 2017). These included greater "PTSD, mood, and anxiety disorder

symptoms, psychological pain or burden in relation to parental trauma, and greater risk of abuse and neglect" (Sangalang & Vang, 2017, p. 753). Epigenetics research also indicates that trauma can be inherited in the DNA of children of genocide survivors (Yehuda, et al., 2015).

Both the Tamil community and Indigenous populations are collectivist communities that have experienced historical trauma as a result of genocide and colonization. Walker, Fredericks, Mills, and Anderson (2013) described indigenous well-being as both a collective and individual intergenerational continuum and that interferences with this continuum weakened their approaches of upholding health and well being. Maria Yellow Horse Brave Heart (2003) first defined historical trauma experiences of indigenous populations as follows:

> *Historical trauma (HT) is cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences. The historical trauma response (HTR) is the constellation of features in reaction to this trauma. The HTR may include substance use, as a vehicle for attempting to numb the pain associated with trauma. The HTR often includes other self-destructive behavior, suicidal thoughts and gestures, depression, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions. Associated with HTR is historical unresolved grief that accompanies the trauma; this grief may be considered impaired, delayed, fixated, and/or disenfranchised.* (p. 7)

Findings of depression, suicidal/self-harm behavior, anxiety, anger, drug and alcohol abuse, low self-esteem, difficulty with communication and domestic violence have been identified within the Tamil community both within this study and existing literature which may indicate the occurrence of the HTR. Other mental health concerns including violence, abuse, perceptions of lack of child rearing skills and substance use which are identified as part

of the HTR (Heart, 2003) were also identified in this study of Tamil youth indicating that historical and intergenerational trauma may be occurring within this population as well. Intergenerational trauma may also explain a relationship between the number parents and family members living with a mental illness and the high number of participants in this study who have had a history of suicidal ideations, attempts, and self harm.

Sangalang and Vang (2017) noted that the literature specified parental and familial interactions, specifically parent-child relationships, played significant roles in the ways in which parental trauma was processed. In addition, they potentially mediated the traumatic experiences of the parents and the emotional and behavioural health of their children (Sangalang & Vang, 2017). Poorer psychological outcomes and increased psychiatric symptoms were associated with communication problems within families, history of child maltreatment, and the perception of the burden of trauma (Sangalang & Vang, 2017). Similar effects could be occurring among Tamil youth as a result of intergenerational trauma stemming from their or their parents' experiences of armed conflict and war/genocide.

Research shows that policies that enabled removal of Indigenous children from their families contributed to continuous interferences with the equilibrium of social and kinship relationships and further intensified their trauma (Walls & Whitbeck, 2012). Legal interventions furthered the loss of Māori language and culture and wounded the relationships within their families and communities. Such chronic and complex trauma impacted the well being of subsequent generations of Māori people and damaged the environments of child rearing. The ensuing collective trauma resulted in a lack of parental and cultural role models putting them in a position to reconstruct fragmented strategies while navigating two cultures and during their own parenthood later on (Shepard, O'Neill, & Guenette, 2006). A similar effect may have taken place

amongst the Tamils of Sri Lankan origin. As previously discussed in the literature review, enforced disappearances, arbitrary detention, torture, harassment and illegal detention of Tamil youth (Leary, 1983; Office of the High Commissioner for Human Rights, 2015) by the Sri Lankan government were common. The LTTE also enforced a "one man per household" strategy for recruitment of civilians. Some family members fled the country for a better life. This could explain the study's results of youth describing a lack of parenting skills and role modelling by their parents, their challenges with navigating their identity, and challenges with healthy relationships with their families and communities. These aspects could be contributing to high rates of mental health problems, substance use issues, physical and sexual violence, child abuse, family conflict among Tamils in Sri Lanka (Somasundaram, 2007) and in Canada.

> *Participant #F003: …and my dad left because of the war and I think when he left, they were asking one man from every family and his dad died so he was the only man in his family and he needed to support his sisters and his mom who was like who's actually mentally ill and his fiancée, which is my mom, so he left because he needed to get away from the war and not be like trapped and leave everyone stranded he had that responsibility and stuff so it's kind of frustrating when people talk about the war and it would be really nice if there was someone may be like people my mom's age my dad's age could have used someone to go and talk to someone about leaving their home and their families. I don't blame my mom for not being there for me cause I'm like oh like maybe she cause she left when she was young, and she didn't get that chance with her family to bond with them I guess.*

Family and societal influences in the form of stories, collective identification, involvement, parenting, empathy and acculturation were the main mechanisms for the

transmission of trauma to subsequent generations of those who survived the Armenian Genocide (Karenian, et al., 2011). Somasundaram (2014) noted that Tamil families collectively experienced, understood, responded to, coped with, and gave meaning to experiences of trauma. This may include passing on their stories, contributing to the transmission of trauma. The Tamil community also engages in events such as protests, activities and events, online campaigns, etc. related to acknowledging and recognizing the atrocities and genocide committed by the Sri Lankan state which can also function as another way that trauma may be transmitted. Mangassarian's (2016) review on intergenerational trauma in the Armenian community in the United states found that Armenian Genocide survivors and their subsequent generations struggled with areas of identity development including safety, trust, esteem, intimacy and control, with the self-development areas of cognitive schemas, psychological needs and self-capacities being the most affected. Given the Armenian community's similar experiences to the Tamil community, these are areas that Tamil youth may also be struggling with as well. Cultural identity will be further discussed in section 5.3.1.

Children became significant symbols of hope for a better future after the Armenian genocide which assigned a major sense of responsibility on children from an early age contributing to intense emotions and internal sadness that their roles in life had partially been defined by the genocide of their people (Dagirmanjian, 2005). Survivors and children of the Bosnia-Herzegovina genocide similarly expressed feeling pressure to be academically and professionally successful as a result of their past and the suffering experienced by their parents, so that there could be change and peace (Genevieve, 2016). According to Tamil parents in Norway, it was important for Tamil survivors to integrate themselves within their host country and community and to maintain their Tamil identity so as to work with others

that were part of the Tamil community and improve the conditions for the Tamils remaining in their country of origin (Guribye, Sandal, & Oppedal, 2011). This included placing a high emphasis on youth doing well academically and professionally. Findings from this current study and the literature review also indicate there is an increased academic and professional pressure/expectations on placed on Tamil youth by their parents. Academic success can substantially influence youth's sense of self-worth (Khanlou & Guruge, 2008) and the inability to meet parental expectations may negatively impact youth mental health. This increased pressure and the expectations to do well academically and professionally and contribute to and help the people in their country of origin as a result of intergenerational trauma could be impacting the Tamil youth resulting in poorer psychological outcomes.

Parents' could also be indirectly transmitting their experiences of trauma through their responses to their children, and influence their help seeking, based on their interpretation of and coping with their own trauma. Somasundaram (2007) found that Tamils became so accustomed to the scenes of war and trauma that even though their situations/experiences contributed to reactions which would normally be considered pathological, they became the norm given their not-so-normal situation (Somasundaram, 2007). For example, startle reactions, which are a characteristic symptom of PTSD were not considered abnormal as they were a common presentation (Somasundaram, 2007). Other reactions included being tense, extremely vigilant, irritability, nightmares, somatic issues, and sleep disturbances. The possible normalization of such issues due to their prevalence may contribute to individuals not seeking Western psychiatric help or recognizing and/or accepting Western psychiatric disorder diagnoses; however, some were seeking help through traditional means or through facilities for somatic complaints (Somasundaram, 2007). This would explain why youth

feared sharing mental health experiences with their parents, identified them as having low mental health literacy levels, and identified them as a barrier to help seeking. This may have also been a barrier for parents identifying mental health concerns within their family members or themselves and seeking help as appropriate which could be contributing to family conflict and further intergenerational trauma. In this study, both first- and second-generation participants talked about the Tamil protests and genocide. It is possible that even those that did not speak about these experiences or have direct experiences may still be experiencing the indirect results of trauma through the community or their families as a result of historical and intergenerational trauma.

5.1.3 Intergenerational resilience

Although the effects of war, genocide and migration can result in trauma to individuals and communities, it can also result in coping and resilience. Research on transgenerational trauma and resilience indicates that just like trauma can be passed on from parents to children, so can resilience including strategies for coping, overcoming traumatic stress and practices of sustaining their culture in the face of oppression (Goodman, 2013; Duran, Firehammer, & Gonzalez, 2008). Resilience was identified by Somasundaram (2007) amongst Tamils in Northern Sri Lanka, with them coping even better than those in the South after the Tsunami. He found that Tamils displayed a form of resilience in the way that they were able to carry on and attend to their survival needs even within the heart of so much war related trauma, and that they naturally sought and employed traditional practices to effectively cope with stress. Traditional coping strategies of faith and praying identified as mental health strengths and practices by participants may have been influenced by their family. In this study, participants positively reflected on their parents' experiences with insightful understanding of the difficulties they

experienced and overcame, and their parent's resilience may also be influencing that of the youth.

> *Participant #M010: Yeah like I wanted to take my life away basically, but the thing that did stop me was like my mom …literally like I would have like this much like time to really think whether I should or not, you know. But I always think about my mom, so I know that's like the only thing that kept me away…*

Many of them had a desire to make their parents proud and maintain their Tamil identity. Although participants wished that there had been more support available for their parents following their arrival to Canada, the next generation of Tamil Canadians overall seem to be excelling in academics and the workforce. All these factors may be contributing to the resiliency of the participants and their parents in managing the challenges that come with migration, navigating two cultures, and the impact of war related trauma. The following section will speak more specifically about the role of culture as it relates to migration, trauma and the impact of these factors on the mental health and well-being of Tamil youth, their family and their community.

5.2 Culture

Jahoda (2012) critically examined the historical and current attempts to define "culture" and found that many of the definitions were logically and substantively incompatible and summed up culture as a social construct which ambiguously refers to an extensively complex set of phenomena from which one can select and build their own definition. The author agreed with Alfred Lang's (1997, p. 389) conclusion ''that attempts at defining culture in a definite way are futile'' and recommended using the term without seeking to define it unless it's required for a theoretical or empirical reason. For the purposes of this thesis, the definition of culture is that it

includes the learned and shared beliefs, knowledge, values, life ways, customs, art and behavioural patterns transmitted socially and intergenerationally which influence one's thinking, decisions and actions and guides their worldview (Leininger, 1993; 1985; Purnell & Paulanka, 2003). As societies by their nature are always changing, culture is dynamic and continues to adapt to its environment (Lenburg, et al., 1995) within evolving global, local, and political contexts. Significant changes in how people make a living, historical events such as war and genocide, and mixing with other cultures such as through migration can considerably affect culture (Triandis, 1995). Experiences of trauma and migration can also affect the culture of the community as youth and families try to navigate two different cultures, changing gender roles and expectations.

The following sections will discuss the meta-inference of how the intersections of trauma, culture, and migration may have resulted in ineffective stress coping, gender inequity, and mental health issues, and contributed to IPV and family conflict. Guided by post-colonial feminism, it will also examine the processes of power and oppression at these intersections and the different ways they effect the practices and experiences of males and females.

5.2.1 Hypermasculinity

A part of the complexities associated with developmental stage and pre/ post-migration factors are the role that sex and gender play in the mental health of immigrant youth. In a study involving South Asian students in the United States, more males were found to have negative attitudes towards professional psychological help seeking (Arora, Metz, & Carlson, 2016). Guerra and Vasiliadis (2016) discovered similar findings in their Quebec study with females aged 25 and younger being more likely than males to have accessed healthcare services in the year prior to suicide. Findings of this study indicate that Tamil males had

lower mental health literacy levels and were less likely to seek help for mental health than their female counterparts. Help seeking behaviours, mental health literacy, levels of stigma and self-esteem can differ based on gender due to influences of culture.

The Tamil culture and traditional family is highly patriarchal where males are more respected than females (Tyyskä, 2015; Hyndman & De Alwis, 2003; Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). Similar to other patriarchal cultures, the "hyper-masculine" culture of Tamils (De Mel, 2007), based on a "warrior-hero" ideal denotes them to be physically and psychologically stronger than females, courageous, self-reliant, with sexual and leadership competence (Thirangagama, 2011; Hellmann-Rajanayagam, 2005). A unique aspect about Tamil masculinity is the importance given to the character trait of self-sacrifice for others such as their family, community or the nation, and the greater the sacrifice he is willing to make, the greater a man he is considered to be (Gross, 2008). These aspects are in fact acutely embedded in the Tamil culture through characters exemplifying these traits in Tamil legends, myths, Hindu deities, religious practices, poems and film and television (Clothey, Ramanujan, & Fred, 1978; Murty, 2009). Personal sacrifice has also been a cultural-political notion of Tamil culture related to the LTTE who pioneered suicide belts/suicide bombers (Guribye, 2011). Soldiers, both males and females, were trained to commit suicide by cyanide in the risk of capture, and "Black Tigers" were an elite group who were suicide bombers (Guribye, 2011). These soldiers are often honoured as they are seen as heroes and martyrs for their self-sacrifice on behalf of the well-being of the collective (Guribye, 2011).

Gender roles in the Tamil culture are strictly defined and internalized by both genders, where the men are the primary breadwinners even if women also contribute financially

(Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). In general, men are more active in the social realm and women's functions are mainly in the household including family care (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018; Tyyskä, 2015). Women remain accountable to male members of the family through traditional practices of arranged marriages, chastity and obedience (Kendall, 1989; Sivarajah R. , 1998). This culture of patriarchy results in male children being given more opportunities and men holding more authority within families and filling more positions of power (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018; De Mel, Peiris, & Gomez, 2013). In Toronto, though there is heterogeneity within the Tamil community, these cultural norms and values related to gender roles and marriage are commonly shared among most (Pandian, 1987).

Mental health issues specifically amongst the males of this population can be particularly devastating to families and communities, and the individuals themselves (Affleck, Thamotharampillai, Jeykumar, & Whitley, 2018). Such issues can lead to increased anger and rage, drug and alcohol abuse, financial mismanagement and domestic violence (James, 2010). Intimate male partner violence (IMPV) has been identified as a challenge among adults within this community as discussed in section 2.3.3. The contributing factors included experiences of war and trauma in the premigration context (resulting in low tolerance of stress, distrust in others, and symptoms of anxiety and depression), sources of stress and conflict in the postmigration context **(**changes in socioeconomic status, power and privilege, decreased social supports), patriarchal cultural norms that dictated gendered behavior (gender inequity in the marital institution), and individual male attributes and behaviors (Hyman, et al., 2011; Guruge, Khanlou, & Gastaldo, 2010). Findings of this study indicate there may be an increased stigma related to Tamil males speaking about mental health or seeking help as they

may fear themselves being perceived as being weak. These beliefs may be stemming from cultural stigmas, beliefs and cultural gender roles rooted in Tamil culture. This stigma may also be leading them to resort to other forms of ineffective coping as the male participants in this study also spoke about drug use as a coping mechanism.

Furthermore, males in the previous generation such as the parents of these participants failing to recognize, or seek help related to mental health may have an impact on youth, their families and the community at large. Somasundaram (2007) found that in Sri Lanka, male youth took on responsibilities of protecting others and were sometimes blamed when they were unable to save someone, and this guilt often complicated grief reactions as many of them faced loss of family members and other additional forms of trauma (Somasundaram, 2007). The lack of initiatives to address issues of trauma, guilt and grief among Tamil male youth and lack of employment and opportunities for advancement resulted in Tamil male youth drifting to anti-social groups and activities, joining militant groups, violent groups or criminal gangs, or abusing alcohol (Somasundaram, 2007). Rivalry and violence between groups developed to an unprecedented level in Jaffna (Somasundaram, 2007). Youth held anger and resentment towards the military viewing them as an occupying force responsible for the brutalities and violence (Somasundaram, 2007). They held their emotions and hostility and aggression just below the surface (Somasundaram, 2007). Youth overall may have missed out on a natural and "normal" developmental stages of childhood and/or youth and their experiences could also eventually be impacting their parenting. Male youth with anger eventually growing into parents with anger may have contributed to intergenerational trauma and explain the anger management theme identified amongst male participants of this study. The male participants in this study used drugs as a coping mechanism and were identified to

have challenges with anger management. Living in a household with others with mental health issues that are not well managed or witnessing violence could be contributing to these behaviors, either as coping mechanisms to deal with their emotions/stress or as learned behaviors, among males within this population.

Based on the findings of this study and those that were discussed in the literature review, we can determine that the culture of hypermasculinity may be contributing to male youth being less likely to seek mental health help; pre-migration trauma's effects on mental health and post migration changes to culture may be contributing to gender inequity, IPV, and family conflict, and a need for healthy role modelling for youth.

5.2.2 Resilience and collective coping

Collective forms of coping have been a topic of research in various scientific disciplines. Collective coping differs from social support in that more than providing support in interpersonal relationships, group members collaborate to find a solution to a problem that they perceive as shared (Wong, 1993; Guribye, Sandal, & Oppedal, 2011). For example, the general tendency for Asians is to put emphasis on their collectivistic identity and seek support from their social networks instead of mental health professionals (Guribye, Sandal, & Oppedal, 2011). Tamils in Toronto also employed limited use of professional help seeking (Beiser, Simich, & Pandalangat, 2003). One way that they collectively coped, as explained in section 2.1, was by approaching researchers with the awareness of widespread mental health concerns within the community and actively engaging in research (CID study) to gain a better understanding of what was happening. Tamil individuals place importance on engaging in collective coping within their family and community as they perceive themselves as basic

entities of a broader traumatized society rather than as individuals who suffered trauma (Somasundaram, 2010; Guribye, Sandal, & Oppedal, 2011; Guribye, 2011).

Collective coping within this community occurred through two shared goals as expressed by Tamil parents in the UK (Guribye, Sandal, & Oppedal, 2011; Guribye, 2011). The first was the importance of their family integration into their host country/community. In this sense, they strived to overcome post migration challenges of acculturation, prejudice, gaining opportunities for employment, and maintenance of social support systems (Guribye, Sandal, & Oppedal, 2011). To this effect, social support and community organization membership were deemed particularly important resources (Guribye E. , 2011b; Dharmaindra, 2016). These efforts were also related to the second shared goal which was to maintain their Tamil identity, especially among young and future generations so that all Tamils worked with other members of the Tamil community to address and improve the social conditions for the Tamils remaining in their country of origin (Guribye, 2011). The personal challenges that Tamils had experienced pre-migration and post resettlement played a large role in amplifying these wishes for both their host country and country of origin (Guribye, 2011). For example, parents placed a high emphasis on their children obtaining higher levels of education and doing well academically as these factors allowed access to more resources which in turn could benefit the Tamil community in their host country as well as their country of origin (Guribye E. , 2011; Guribye, Sandal, & Oppedal, 2011; Dharmaindra, 2016). Their previous experiences in Sri Lanka related to barriers to education through policies described in section 2.2 may have fed into these aspirations.

In Canada, Tamils organized, created, administered and took part in many organizations and initiatives catering to their community including those related to sports, academics, businesses, etc. Before 2009, there were many LTTE-linked community organizations and

associations including development organizations, media, and cultural organizations (Amarasingam, 2013) that provided social, cultural and economic supports to those in the diaspora. These community organizations and systems helped the community overcome challenges related to the war and migration, while furthering Tamil nationalism and increasing support for the liberation struggle. For Tamils, the second shared goal of improving social conditions for Tamils who remained in Sri Lanka increased the desire and effectiveness of the community to work together (Guribye, Sandal, & Oppedal, 2011; Dharmaindra, 2016). As previously discussed in section 2.2.9, this occurred through support of the LTTE, involvement in political and human rights activism, financial support/fundraising, organization of protests, and increasing awareness of what was happening in Sri Lanka. The Sri Lankan state's denial of the genocide and the absence of attention from the global community continues to contribute to Tamil diaspora continuing to seek justice and recognition for the Tamil genocide. The Tamil community's shared goals and purposes of successful integration into their host country, and improvement of the situation in Sri Lanka enacted through community membership may have reinforced their Tamil identity, strengthened their relationship to the community and offered a sense of belonging, meaning and purpose. The Tamil diaspora continues to strongly connect with their identity as Tamils as can be seen in the way that they identify themselves. The term "Norwegian Tamils" was preferred among Tamils in Norway (Guribye, Sandal, & Oppedal, 2011) similar to the way in which the majority of the participants in this study also placed an emphasis on their Tamil identity through identification with the "Tamil-Canadian" or "Canadian-Tamil" identity. The strong connection to the Tamil identity and community may have functioned as ways that Tamils collectively coped to overcome post-migration challenges. Although the end of the war and the defeat of the LTTE may have resulted in complexities

related to the Tamil community, its identity and purpose, there is no doubt that these initiatives played and continue to play a vital role in the processes and mechanisms of collective coping, resilience and unity within the community.

A similar occurrence has been seen in the case of Armenians where the genocide inspired unity among the diverse groups of Armenians that fled to various countries around the globe (Dagirmanjian, 2005). This unity and search for justice and recognition of the Armenian Genocide was further spurred by Turkey's failure to take accountability, the absence of attention from the global community, and the overall knowledge of the violence that took place (Mangassarian, 2016). To this day, Armenians worldwide raise awareness and engage in protests and marches (Mangassarian, 2016). This unity and these activities can be considered to be engagement in collective recovery as it recognizes harm, opens avenues of dialogue about this harm and can to some level steady the pain, sorrow, and grief of victims (Mangassarian, 2016; Staub, 2006). In a similar way, events organized by the Tamil community such as protests, activities and events related to acknowledging and recognizing the atrocities and genocide committed by the Sri Lankan state against Tamil people can also be seen as a form of collective recovery.

Research indicates that the Tamil family and/or community plays a major function in defining and interpreting trauma, while supporting each other and coping together through mechanisms such as collectivization of individual trauma, reconstruction of meaning, and employment of cultural/ritual practices (Somasundaram, 2010; Guribye, Sandal, & Oppedal, 2011; Guribye, 2011). The Tamil community in Canada collectively engages in traditional coping strategies such as rituals, ceremonies and recognition of anniversaries related to the war/genocide. Some examples include Black July recognized on 23 July as the beginning of

the Tamil Genocide, the commemoration of Maaveerar Naal or Great Heroes Day on November 27th of every year to recognize and remember all those who lost their lives during the struggle for freedom, and the month of May which marked the end of the war. Commemorations at these events include pictures of those who have died, flowers, candles, singing, dancing, and performing. Somasundaram (2007, 2014) found that among Tamils in Sri Lanka, such traditional coping strategies were effective in alleviating grief and guilt, creating meaning, and providing support and strength. In Canada, these collective cultural/rituals may play a role in socially locating individuals steadily within the community by rendering grieving a community process or by emphasizing social obligations that originate from the sacrifices of those who are deceased (Guribye, Sandal, & Oppedal, 2011; Guribye, 2011).

Overall, the Tamil community's shared goals of successful integration into their host community, desires to preserve their identity and improve conditions in their homeland through the support of the LTTE, along with their engagement in traditional coping strategies may have functioned as protective factors leading to unity and resulting in collective resilience. Despite their history intertwined with the LTTE, Tamils are often seen as a model minority community in Canada due to their successes and contributions to Canadian society. In fact, in 2016, the month of January was adopted unanimously by Parliament as Tamil Heritage Month to recognize the social, economic, political and cultural contributions that Tamil-Canadians have made to Canadian society, the richness of the language and culture, and the importance of educating and reflecting on Tamil heritage (Government of Canada, 2020; Parliament of Canada, 2016).

5.2.3 The resilience of females

There can often be notable differences when it comes to the experiences of females and males. Beiser & Hou (2016) found that among six ethnocultural groups with immigrant and/or refugee backgrounds, which included Sri Lankan Tamils, female youth experienced increased levels of internalized problems, but lower levels of aggressive behaviours than their male counterparts. Guruge & Butt's scoping review (2015) identified female immigrant and refugee youth experienced more mental health problems than males. In this study, being a female appeared to be a protective factor; females evaluated themselves to have higher self-esteem and as more resilient.

A study conducted by Khanlou and Crawford (2006) on newcomer female youth found that factors influencing female youth's self-esteem included those associated with self, school, relationships, achievements and lifestyle. Themes found to contribute to this population's self-concept included dynamic self (self-identification, comparisons with Canadian-born peers, and comparisons with male peers), silenced self (disassociating from others due to fear of negative consequences), cultural identity (which they negotiate between their new and original country/culture), female role models (and the kind of cultural values and codes they convey as females), and future goals (Khanlou & Crawford, 2006). Regardless of the challenges they faced, in general, newcomer female youth felt good about themselves, and held an optimistic view of their education, career and future (Khanlou & Crawford, 2006).

The findings of this study indicated that compared to males, females were more likely to seek social support and professional help, had higher levels of self-esteem, were more likely to engage in health promoting activities, had higher levels of mental health literacy, and

evaluated themselves to be more resilient than males. It may be of importance to note that females were older on average than the male participants, had higher levels of education and more of them were working compared to the males. Some of the challenges identified by females in this study were related to their gender as a result of cultural norms such as restrictions to their freedom and pressures related to timelines for marriage. This led to difficulties with stress, identity and belonging as they struggled to "fit in" and live up to expectations. Findings among female participants indicating high self-esteem and engagement of health promoting activities despite the limitations and challenges they experienced within Tamil culture (i.e. patriarchy, limitations to freedom, etc.) is indicative of their resilience. During my research dissemination activities, I noted that despite women in the Tamil community facing oppression and men still holding many positions of power due to the culture of patriarchy, women are continuing to reclaim their power and raise their voices. I also noted that it was mainly women who were taking the lead to address mental health in the community through grassroots organizations such as ANBU and Aadyha.

Although female participants expressed higher levels of current self-esteem than males in this study, they also expressed the need for positive role models. This could be related to the lack of healthy role modelling of mental health practices by family and friends. It could also be related to a lack of role modelling when it comes to their education and careers, as a majority of the parents, especially mothers, did not work in professional fields to be able to provide the support and guidance that females may need given their high levels of education and fields of practice. These supports are necessary to empower women in this community to overcome cultural and socioeconomic barriers. Tamil women's resilience when it comes to these issues has also been addressed by a professional networking group and non-profit

organization called Tamil Women Rising which aims to empower Tamil women and their allies to advance in their careers.

5.3 Migration and Multiculturalism

As globalization and immigration trends increase, multicultural communities and the concept of multiculturalism correspondingly continues to receive increased attention in the realms of health, education and public policy. The exploration of identities belonging to an ethnic group displaced from their home country of Sri Lanka due to political turmoil relating heavily to ethnic identities truly necessitates the contextualization of Canada, their host country's national identity and politics. Canada prides itself in multiculturalism being a vital component of its national identity and being the first country in the world to formally implement an official policy of multiculturalism in 1971 (Winter, 2015). This policy moved away from the nation's previous integration approach of the "melting pot" and was communicated as moving towards a pluralistic society of cultural freedom and national unity by means of increasing confidence in individual identity, valuing enriching contributions, and viewing all citizens as equal (Wayland S. V., 1997). Implementation of the 'multiculturalism within a bilingual framework' policy brought forward the apparent differences in needs between different ethnic groups, specifically between those of the more recent racial minorities compared to the longer standing, mainly white Europeans of Canada, who had been the ones to initially pressure the policy into its existence (Wayland S. V., 1997; Mann, 2012). This resulted in an interpretation of the policy as concurrently appropriating the diversity of ethnic minorities while excluding them politically and economically due to its limitations in addressing their social equity issues such as housing, education, employment and accessibility (Wayland S. V., 1997; Mann, 2012). In effect, a push to further develop multiculturalism's role became a contributing factor in the incorporation of

multiculturalism into the 1982 Charter of Rights and Freedoms, the 1986 Employment Equity Act, and the 1988 Canadian Multiculturalism Act (Wayland S. V., 1997). These collectively expanded the role of multiculturalism and balanced cultural diversity and equality through law enforcement, cultural/language preservation, anti-discrimination, cultural tolerance, cultural understanding and sensitivity (Wayland S. V., 1997).

Albeit incorporation of multiculturalism as a significant facet of Canadian culture, its concept, history, and role have remained a topic of controversy. Stratton and Ang (1994) state that although Canada recognized the existing mosaic and the state's responsibility to address consequent concerns like equity, ethnic minorities or immigrants were encouraged, and in a way forced, to preserve their heritage through government assisted supports and facilities. This resulted in the dependency on their officially recognized ethnic identities as legitimatization of their societal location (Stratton & Ang, 1994). Ng and Bloemraad (2015) however, dispute the claim of multiculturalism debilitating the socioeconomic mobility of ethnic minorities or immigrants by citing the lack of research related to specific contexts and environments where such policies are implemented i.e. government social services or educational systems. In the case of Tamils, I think that the need for, and the and significance of the recognition of Tamil Heritage Month at a federal level in Canada is a case in point as it relates to Stratton and Ang's (1994) statements about ethnic minorities' dependence on the government's officially recognized ethnic identities i.e. Tamil-Canadian as legitimatization of their societal location. I think the need for the recognition of this month was in part borne out of the ways in which multiculturalism may have negatively impacted the socioeconomic mobility of Tamils to begin with.

The role that multiculturalism may have played through the state and the nation in creating inequities for Tamils is worth examining, as it relates to belonging and identity and

institutional practices. Drawing from Australia's adoption of multiculturalism, Stratton and Ang (1994) identified dynamic differences in responsibilities as it related to the state, versus the nation. They defined the state as a government structure of administration involving bureaucratic aspects (Stratton & Ang, 1994), and the nation as the collective experience, or "imagined community" based on a socially constructed place of belonging (Anderson B. , 1991), that the people within the state identified with (Stratton & Ang, 1994). The responsibility of the nation was nationalism through identification with a multicultural ideology, to fulfill the responsibility of the state for national unity (Stratton & Ang, 1994). They argued that the state's interest in constructing national unity responded to, but also controlled the consensus of multiculturalism by managing disruptive or unpredictable cultural identities, possibly through use of force by the state to maintain power and repudiate cultural divisions, resulting in the restriction of the fluidity of identity, and suppression of existing differences within each of the cultures themselves (Stratton & Ang, 1994). In addition, as the country was a settler society, the inherent transference of the colonizer country's national culture to the state, represented primarily by individuals of the same origins, not only created a power imbalance through the ethnicization and consequent othering of cultures by the dominant group, but also masked this persisting hegemony (Stratton & Ang, 1994). A more recent article by Winter (2015) similarly critiques multiculturalism as process for what he refers to as "socioethnic leveraging" a boundary construction where the dominant group defines other groups as being outside the norm of "we" by comparing another group's level of social, cultural or moral deviance and the dominant group takes action to address (Winter, 2015). This action involves playing off minority groups by giving those who fit the norm privileges so as to increase chances of those in any "other" category to cooperate (Winter, 2015). This process can increase integration but can also increase marginalization of minorities;

thus, moving the discourse to being “about them” (Winter, 2015). One concern would be immigrants bringing the ongoing conflicts from their home countries to their new countries contributing to public discourses negatively assessing their citizenship and civic behaviour (Winter, 2015).

The complex history and identity of Tamils of Sri Lankan origin may have led to their marginalization in the context of multiculturalism. As discussed in section 2.3.2, based on this study, Tamils of Sri Lankan origin strongly identify with both their Canadian identity as well as their Tamil identity. It is interesting that identification with the “Sri Lankan” identity was not as strong, and this may have to do with the reluctance to identify with a state that carried out a genocide based on their culture/ethnicity. During one of my research dissemination events, I presented on the topic of mental health and Tamil Heritage to a group of young professionals. When asked the same question I asked the participants of this study regarding their identity, some of them included the identity of “Eelam”. Thus, the Tamil community maintained a strong connection to their “Tamil” identity, and identification with another "imagined community" whether it be “Tamil Eelam”, or belonging to the global “Tamil” diaspora community based on a socially constructed place of belonging or shared goals. As previously discussed, before 2009, Tamils in Canada were politically active in advocating for equal human rights for Tamils that remained in Sri Lanka and they supported the LTTE due to its vision to achieve this through a separate homeland called Tamil Eelam. Their identity and role/relationship regarding Tamil Eelam may not have been congruent with Canada’s multicultural ideology as it threatened national unity. Canada’s ideology did not include an identity or “imagined community” that extended beyond its borders. Tamils may have been perceived as immigrants bringing home conflicts from their country of origin. The effects of “the war on terror” when the LTTE was

internationally recognized as a terrorist organization could have further resulted in the othering of Canadian Tamils and the legitimacy of their identities (Sriskandarajah, 2010), marginalizing them as "terrorists". This marginalization could have occurred even among the Tamils that did not support the LTTE or simply because of "Tamil" being a part of the acronym of LTTE who were also otherwise known as the "Tamil Tigers". Identities such as the "Tamil" and "Eelam" identities may have been seen as a disruptive or unpredictable identity due to its association with the LTTE/Tamil Tigers despite their existence and relationship to Tamil identity before the war. Tamil people's engagement in human rights activism including awareness campaigns/events and protests, and support of the LTTE to achieve this through a separate state of Tamil Eelam reflected negatively on their citizenship and civic behavior. In this way, the Tamil identity may have been perceived as a threat or viewed as the "other" due to the group's cultural deviance from the dominant group. This othering may have negatively impacted their socioeconomic mobility leading to the need for the legitimatization of their identity, culture and history through recognition of Tamil Heritage Month in Canada. People within Canada identify with being "Canadian", and the nation's initiative in recognizing "Tamil-Canadians" fulfills its duty by identifying and legitimizing the Tamil community within the multicultural ideology of being Canadian and ensuring the state's national unity.

Ng and Bloemraad (2015) analyzed the strengths, weaknesses, opportunities and threats that multiculturalism presented by reviewing six recent articles focused on multiculturalism as implemented in various countries, including Canada. Strengths and opportunities identified by Ng and Bloemraad (2015) included the cultivation and promotion of national identity and cultural tolerance, a potential way to attract talents, a political strategy of discourse, and a source of national competitive edge. Findings of this study indicate a strong identification with the

"Tamil" and "Canadian" identity among Tamil youth. Multiculturalism may have played a part in the identification with the Canadian identity and may also be the reason that so many Tamils chose Canada as their home. In fact, my own parents chose to immigrate and settle specifically in Canada despite some of their relatives living in other countries because Canada was "multicultural" and thought to be more tolerant than other countries.

Weaknesses of multiculturalism included its influence on intergroup divisions on the basis of culture, religion, and race; the distancing and marginalization of ethnic minority groups by individuals of the host country due to ethnic minority groups restricting themselves within their own ethnic communities and decreasing their interaction and integration with the latter group (Ng & Bloemraad, 2015). Findings of this study indicating a strong identification with a "Tamil" identity also emphasize youth's strong connection to it. With such a large population of Tamils in Toronto and many Tamil organizations within the community, the community is also quite tight knit. In some youth, experiences of discrimination have been noted to increase sense of identity and resiliency through a sense of belonging to their ethnic community and by rekindling ethnic pride and drawing attention to their cultural identity ((Khan, Khanlou, Stol, & Tran, 2018). The experiences of othering may have led to the Tamil community becoming even more tight knit, restricting themselves within their own ethnic community and decreasing their interactions with groups and individuals of the host country. Othering/stereotyping and racialization can impact emotional and behavioural symptoms and have a significant impact on youth successes or difficulties (Khan, Khanlou, Stol, & Tran, 2018). The example below illustrates how it may impact self-esteem and function as barriers to opportunities.

B: Have you experienced racism?

#M012: No, but the thing is I feel as if they are a little bit superior than me. The thing is I was going to work at place where I had an interview with two white dudes, and I was- so overwhelmed. I don't know, I was like why it's just an interview, but at the same time, when I had an interview with other people, it wasn't that overwhelming for me, I don't know.

Although Ng and Bloemraad (2015) state that Canada's government policies has used multiculturalism as a means to devise and implement relevant policies and practices, it does not appear that these policies have truly engrained themselves in actionable ways as far as health, health systems, and mental health care is concerned. The political and historical context associated with the Tamil identity may have veiled the mental health and social impacts on this population in Canada and had dire consequences in the context of their health. The lack of official recognition of the Tamil genocide continues to contribute to this lack of support. Systemic processes of exclusion can also occur at the macro level. Racialization can contribute to inequities in institutional practices such as underrepresentation in political institutions (Ainsworth & Innocent, 2018), as well as educational institutions such as in the realm of research. As previously mentioned, this can be seen in the lack of representation of the voices of Tamils in academia related to their experiences.

Acknowledging the experiences of the Tamil community and critically examining the roles that power and privilege play on the complex identity of Tamil youth living in such a controversial multicultural context may reveal more defined and appropriate ways in addressing the mental health challenges they may experience. Formation of identity at multiple levels are factors that influence youth's psychosocial integration (Khanlou and Gonsalves, 2011), psychological well-being and sense of belonging. As discussed previously, the Tamil identity is a protective factor for this community, however the complexity of this identity within Canada's

multicultural ideology could create further complexities for Tamil youth as they navigate their identity, sense of belonging, inclusion and access to the Canadian and/or Tamil community, and socially construct meaning from the trauma the community has experienced. This will be further explored in the following section.

5.3.1 Identity, belonging and meaning

Culture and tradition provide values, goals and ideals that individuals depend on to give their lives meaning and direction, and to support them in creating a healthy identity at an individual and collective level (Aydin, 2017). Collective and historical trauma which can be transmitted intergenerationally, can rupture and disrupt the continuity of these identities (Aydin, 2017) and lead to a search for meaning as individuals and/or the collective try to make sense of the trauma as it relates to themselves, other people and the world (Aydin, 2017; Eagle, 2014). This ongoing process of constructing meaning is continuously negotiated within and between groups (Hirschberger, 2018). Constructing meaning can be a complicated process for Tamil youth as they navigate their identity and sense of belonging to both the Tamil and Canadian community within the context of a genocide, trauma, migration, competing cultures and changing historical events.

Tamil nationalism impacted the collective identity of Tamils in Canada. Many Tamils supported the LTTE, but this was not the case for all Tamils (Amarasingam, 2013). Some supported the LTTE reluctantly and/or out of fear as those who resisted or criticized the LTTE were known to face threats. Some parents chose to share the history and experiences of trauma, war and/or their support of the LTTE with their children and encourage their engagement in political and humanitarian activities while other parents opted not to with the intention of shielding them from harm. There were also those who viewed the LTTE as dominating the

discourse on how to relate to their homeland (Orjuela, 2011). In these ways, youth's belonging to the Tamil community and collective identity can vary based on their and their family's knowledge, experiences, involvement, and identification with Tamil history, community, identity and nationalism. The dominant beliefs, identity and shared goals among the majority Tamil community may have made it difficult for youth whose opinions, views, experiences or knowledge differed to find a sense of belonging to the Tamil community and their collective identity. The defeat of the LTTE by the Sri Lankan state in 2009 may have further disrupted the collective identity and unity of Tamils as it resulted in the fragmentation of organizations, leadership and the swindling of money originally raised for the LTTE.

Collective trauma has been found to burden subsequent generations with emotional memories, distrust, and a damaged sense of identity and reality (Cetrez, 2017; Eugene & Kalayjian, 2010). The lack of presence, support and assistance from trusted governments and global systems during the Tamil genocide and the continued lack of recognition of the genocide may be impacting youth's worldviews. Collective trauma can be so engrained in the foundation of a group identity that individuals start understanding their social environment through the lens of this trauma and victimization (Hirschberger, 2018). This worldview can foster rejection sensitivity (Hirschberger., Pyszczynski, & Ein-Dor, 2010), increased vigilance towards outgroups, irrational focus on threat and a sense that the ingroup must survive on its own (Hirschberger, 2017). Such worldviews can also impact sense of belonging and identity, which can ultimately impact the individual and collective health and well-being of this group.

Collective trauma's impact on meaning can be further complicated by what Primo Levi defined as the *gray zone* (Levi, as cited in Hirschberger) where victims and perpetrators are not always clearly represented (Hirschberger, 2018). The Tamil community's interpretation of the

Tamil Tigers as “freedom fighters” contrasted with Canada’s recognition of them “terrorists”, and the consequent othering of Tamils in Canada may have presented a crisis in identity and meaning. It may have raised questions about their continued affiliation with the “Tamil” identity and/or commitment to the community’s goals for a separate Tamil state of Tamil Eelam. The lack of information and documentation of what occurred during the war/genocide can further make it difficult for subsequent/younger members of the Tamil community to make sense of the trauma experienced by their community. It may have also raised questions about their willingness to identify with the state of Sri Lanka which carried out a genocide against the Tamil people and perhaps even the state of Canada for having carried out a genocide against Indigenous peoples and not intervening in the Tamil Genocide.

Despite these challenges, Tamil youth are navigating their identity and history through resistance and resilience. Rwandan youth diaspora living in Toronto also have similar coping strategies (Ainsworth & Innocent, 2018) to the Tamil youth diaspora in Toronto. These include joining youth groups (i.e. CANTYD), engaging in post-migration appropriation of cultural aspects such as dance (i.e. Bharatanatyam, Ghana) and establishing aid organizations to send help to those in Sri Lanka (i.e. Comdu.it). Rwandan Black men assimilated Hip Hop culture as a way to express and represent themselves in relation to their location, politics, memory and history and identified it as a search for identification (Ibrahim, 2004; Aisnworth and Innocent, 2018), and a way to create a place within the Canadian context of exclusion and invisibility (D’Amico, 2015). Similarly, Tamil youth increasingly use different forms of cultural art such as dance and fuse them with Western forms such as the fusion of Bharatanatyam and Ghana steps with hip hop. They also have strived to define themselves as being different from the umbrella South Asian community.

Intra-personal conflict related to uncertainty about their ethnic identities can impact migrant youth's mental health especially as they navigate their desire to maintain their ethnic culture within a Canadian culture that may be have different values and practices (Khan, Khanlou, Stol, & Tran, 2018). A strong sense of ethnic identity has been associated with higher levels of achievements and self esteem and lower levels of depression (Khan, Khanlou, Stol, & Tran, 2018). The loss of culture and traditions due to experiences of collective and historical trauma, the challenges of navigating the "culture clash" of two different cultures after migration, and the marginalization/othering of the Tamil identity in Canada may be presenting multiple complexities in creating a healthy identity at an individual and collective level for Tamil youth. This may be negatively impacting Tamil youth's psychosocial integration and sense of belonging to the Tamil and/or Canadian community. Navigating these complexities during their current life stage of being an emerging adult, such as in their professional lives or when seeking help, can present further complexities.

5.4 Recommendations

Multiple participant recommendations were outlined in section 4.8. The following section will make some further recommendations on how nurses and service providers within the contexts of practice, policy and research can ensure cultural safety with considerations to the emancipatory approach to cultural competency.

Practice recommendations for this community include taking a holistic (bio-psycho-socio-spiritual), trauma-informed and integrated/multilevel approach, and organizational and community capacity building. For this to occur, service providers need to be culturally aware and contextually informed of the Tamil culture and history, while acknowledging and respecting diversity of beliefs, values and experiences. Policy recommendations include demographic data

collection, acknowledgement of the Tamil genocide by Canada, and stronger international policies related to war/conflict and humanitarian crises. Research recommendations include the requirement of researchers to be culturally aware and contextually informed and ensure ethical standards, and the need for more research on male immigrant/refugee youth, intergenerational trauma, other communities with experiences of trauma and migration, and the health immigrant effect.

5.4.1 Practice

The Tamil community is resilient. Its strong identity, and cultural, social and spiritual practices will continue to contribute to its resilience; however, there are still ways in which service providers can increase the community's well-being. It is important for providers to gain an understanding of Tamil culture, and this population's experiences of pre and post migration to be able to work collaboratively with individuals and the community. This knowledge will maximize the cultural relevance/competence of the care provided to this population leading to improved consumer perception of inclusion in care decisions as well as overall health outcomes.

> *Participant #M004: But maybe culturally, we've gone through things that not a lot of other communities can say they have, and so there may be some blockades when it comes to the resources we have access to. For example, going through genocide, or like having your country being in a civil war, can really affect your mind-state once you start thinking about it and like those kinds of things may be harder to address when someone can't be as empathetic because they haven't been in that spot.*

The Tamil culture has many traditional practices that promote mental health. Awareness of these aspects can offer opportunities to incorporate traditional practices to healing that can empower the client, and opportunities to safely incorporate relevant Western treatment

modalities (i.e. trauma informed care, medications) in a culturally competent and informed way. Somasundaram (2007) states that "When methods are culturally familiar, they tap into past childhood, community and religious roots and thus release a rich source of associations that can be helpful in the healing process" (p. 20). Traditional options that can be offered are Ayurvedic treatments, yoga (asanas, pranayama and meditation), mindfulness, or religious practices such as rosary/prayer beads, Japa mala, thikir, and repetition of mantras or meaningful phrases (Somasundaram, 2014) . Spirituality (engaging in prayer, scripture reading, meditation, etc.) has been found to increase empowerment and in turn have a positive impact on mental health amongst those with childhood or adulthood experiences of violence or abuse (Hipolito, et al., 2014). It may have a similar effect on this population who has had varying experiences of trauma. As interest in these traditional methods is already prevalent among youth, service providers should offer and encourage their clients to explore these options and/or a combination of these with Western/medical approaches. For example, mental health treatment using drugs is not a preferred treatment by many within this population as the Tamil culture traditionally focused on herbal and spiritual interventions. In fact, the possibility of automatically being put on a drug can even be a deterrent to seeking help; therefore, acknowledging this possible reservation, sharing relevant information as it applies to their situation about traditional options, medication options and other psycho-social interventions will empower and educate the client to make informed decisions about their care. Educating parents or other family members can also help the client with decision making and committing to an intervention. A common Western approach to trauma therapy is to have individuals or groups open up and talk about the past in detail and revisit emotions and the impact it may have had. This type of intervention is not traditionally practiced in the Tamil culture. Although this type of therapy can be helpful in some

cases, it can be re-traumatizing in other cases, so providers must assess and collaborate with individuals to find the right intervention option. Cognitive behavioural therapy may also be a good option. Allowing individuals to work through options when possible can help them feel empowered and may make them more open to other alternatives. As such, it is important for providers to engage with clients to listen to their preferences and be knowledgeable about these options so that they can support the individual to make informed decisions about their care.

Another important cultural consideration is that this is a collectivist community which holds the family and community at high importance. Dagirmanjian (2005), speaking about Armenian families, stresses the importance of commending and making use of how close families are instead of avoiding or judging the relationships of an individual's family to be too entangled or dependent. This is because there is exists a difference in the Western view of it being unhealthy and the Armenian families view of them being strengths (Dagirmanjian, 2005). In the same way, within the Tamil community, the goal of therapy or services should be determined based on an individual assessment as individuation may not be the goal as it is with Western views of family psychology. However, there is a need to understand each individual within their family context as culture, roles and expectations can vary from family to family due to varying pre/post migration factors and levels of multiculturation. The healthcare system and educational system needs to consider these challenges when providing services and support to youth and implement strategies that promote the well-being of the family as a whole. This requires service providers to be inquisitive about an individual's family situation and whether involvement of parents would be helpful or not. Services and resources also need to be language appropriate and accessible. The ability to access services can also vary depending on the family's language barriers, literacy levels and the stigma they hold towards mental health. The

generational gap created by migration, trauma and/or genocide may be contributing to complex family dynamics. Closing this gap and promoting a healthy and functioning family unit is important for youth's mental health and well-being. Service providers can support families to improve their relationships, correct misunderstandings, and establish healthy roles and responsibilities. Interventions could include marital, family and group counselling/therapies, and employing or teaching conflict resolution, mediation and negotiation skills. Another option is to create bonding between generations through traditional methods of healing, like engaging in yoga together.

> *Participant #001: I think it's a matter of addressing it to the broader group so even just somehow getting the parents involved in it and having that discussion between like parent and child cause often times I think that as a Tamil person we take a lot of advice from our parents we do what our parents tell us to do.*

Due to experiences of war/genocide, building rapport to increase trust, using a trauma informed approach and creating safe spaces when caring for this population are necessary. Assessing for trauma, PTSD, toxic stress, self-harm, coping skills, substance use, and family dynamics should be considered. As defined earlier, the most recent *Diagnostic and Statistical Manual for Mental Disorders, 5th Edition*'s definition of trauma focuses on actual experiences at the individual level and fails to factor in long-term chronic and complex individual, collective and historical trauma (Wirihana & Smith, 2019). Therefore, it is important to factor in these chronic and complex experiences when assessing and/or addressing trauma. If interventions are to be effective, they need to include group interventions and take a multi-level approach beyond the individual (Somasundaram, 2007; Khanlou, Bender, Mill, Vasquez, & Rojas, 2018). Trauma informed interventions to consider are healing through art/creativity, mind-body interventions

such as yoga, strengths-based skill building i.e. resilience, and offering choice and collaboration whenever possible. Just as supporting individuals to engage in traditional coping strategies can be helpful, supporting this approach at a family and community-level along with cultural rituals and ceremonies, expressive methods, and creative arts (Somasundaram, 2014) can also be helpful in the process of healing from historical and collective trauma (Wirihana & Smith, 2019). It can help to review and come to terms with what has happened, revive hope, and increase solidarity, and support. In this study, participants expressed that hearing of others' lived experiences helped to decrease isolation and stigma, increase relatability and promote mental health. Community gatherings and support groups may increase these opportunities to share stories and establish connections and further develop resilience and promote well-being. Identity may also be an area that Tamil youth may struggle with, or they may be extremely proud of. Engaging with youth about their experiences, worldviews, meanings, and feelings related to their identity can be helpful to service providers in engaging in effective therapeutic practices. Knowledge about an individual's history and roots can contribute to identity development and have a positive impact on self-esteem (Khanlou, 2018). Since such opportunities for this may have been lost due to the genocide, opportunities to reconnect with and explore their history, heritage and roots would be helpful. These opportunities can further revive traditional healing rituals and practices, beliefs, values, skills and knowledge.

> *Participant #F002: it's nice when people, it's like people that you look up to, and you tend to idolize everyone, and then like when they open up and they tell you something so like, something that they're vulnerable about and like, it makes you realize, it's ok, they're human just like us. And it's ok to have a mental illness, because you can still be*

successful and have a mental illness. I think a lot of people think that those two don't go hand in hand and it doesn't work like that.

Organizational and community capacity building to obtain, strengthen and retain knowledge, skills and resources are also imperative (Somasundaram, 2014). Increasing mental health literacy among parents, youth and the community in general is important as health services and social systems are different to the ones that exist in Tamils' country of origin, and there exists cultural stigmas around seeking help. The community can be empowered to care for their health by raising awareness about the potential mental health impact of Tamil people's experiences of war and immigration (trauma, intergenerational impacts), as well as available services and how to access them. This awareness may facilitate the reduction of any existing stigma and allow members of the community to correctly recognize and seek appropriate services for mental health issues. Capacity building initiatives could include more training, education, resources and funding opportunities for organizations and services that are from this community and/or serve this population. These initiatives need to also be designed so that they address individual, familial and community level issues. Capacity building with community leaders and workers of Tamil background can build trust, hope, agency and resilience within the community (Somasundaram, 2014). The resilience of this community is already demonstrated through grassroots organizations like Aadhya and ANBU aiming to address mental health and sexual violence in the community. These organizations and others within the community have also carried out multiple workshops and panels which I have had the privilege of participating in throughout my thesis. However, the need for development of social infrastructure including training, more funding, and resources is evident and would be helpful in carrying out their mission and vision.

5.4.2 Policies

Demographic and race-based data collection of those accessing health and mental health services need to be collected and tracked if we are to address health equity within a systemic and widespread context. Currently, as this information is not being collected, it is difficult to tailor our resources to where and how it may be needed the most; therefore, policies must ensure the collection of these data.

For the Tamil community to collectively and culturally heal, the Tamil Genocide must be acknowledged. Denial of genocide prevents healing of wounds caused by the genocide and can perpetuate continued suffering of victims and their children. Acknowledgement and reconciliation can help to heal collective trauma, prevent cycles of violence from being rekindled, and reduce the burden on subsequent generations from having to carry on this trauma and seek due justice as has happened with the Armenian community. Denial of genocide is dangerous as it legitimizes the offending state's previous actions and allows the same actions to be taken again in similar circumstances; therefore, to restore Tamil people's faith in world order and social justice, the Tamil Genocide must also be recognized by nations including Canada. Additionally, those responsible for the atrocities, and the violations of international human rights and humanitarian law must be held responsible and punished. At an international level, there is a need to ensure that the failure of the UN to intervene as in the case of Sri Lanka is never repeated by ensuring stronger policies and mechanisms to protect civilians and intervene during times of conflict and humanitarian crises.

5.4.3 Research

Researchers that engage in research with the Tamil community and other communities with similar experiences of genocide and trauma need to be contextually informed due to the

need for sensitivity around their experiences. It is also very important for researchers to know and take appropriate ethical precautions. During my study I was faced with some ethical scenarios that I navigated using CNO's ethical guidelines. As such I would recommend that registered professionals be appropriately engaged in such studies as they are accountable to a code of ethics.

Despite finding males to be a vulnerable population in this study, a scoping review by Affleck et al. (Affleck, Selvadurai, & Sikora, 2018) found that there exists a gender bias in addressing the experiences of boys and men in refugee and humanitarian research compared to women and girls, with 95% of past research in this area focusing on women's issues. This is particularly concerning as males play significant roles in families and communities, were found to be at more risk for mental health challenges than females in this study, and because intimate partner violence (IPV) has been identified as a challenge within the Tamil Canadian population. Therefore, further research involving males within this community is important. There is also a need for further research to examine the nature, processes and mechanisms of transmission, and consequences of intergenerational and collective trauma within this population. Protective factors and resilience should be considered in future research. Further research into other current refugee populations from non-western countries with experiences of trauma is also needed as most of the current literature focuses on Holocaust survivor families (Sangalang & Vang, 2017). Further research is also required to analyze mental health of Tamil youth from the perspectives of parents and health providers.

Guruge et al.'s scoping review (2015) identified the complex influence that pre-migration experiences of trauma had on the post-migration mental health of refugee youth based on conflicting evidence on the relationship between pre-migration collective trauma

and host country cultural adaptation. They noted that Somali refugee youth made associations of their personal trauma with depressive symptoms, and collective trauma with poorer social adaptations; however, Cambodian refugee youth associated collective trauma with positive social adaptation and fewer mental health symptoms. These findings bring to question the phenomenon of the "healthy immigrant effect" which recognizes a higher level of health in immigrants upon their arrival to the host country, which then declines after five years (Kennedy et al, 2006; Gee et al, 2004; Nebold, 2005). Although this effect has been observed within immigrant Canadian youth (Salehi, 2010; Kwak, 2016), there is a need for further understanding around how societal contexts impact different sub-groups of populations (Kwak, 2016). The intersection of differences within ethnic groups combined with their immigrant or refugee status could explain the mixed findings on the mental health differences between refugee, immigrant, and host country born groups. Therefore, further research is needed within other diverse refugee/immigrant populations. As the intensity of the impact of collective trauma, and its role as a protective or risk factor can differ for individuals and groups, Guruge and Butt (2015) recommend considering intensity, duration, and age at experience to help clarify its role in mental health and integration in future research.

5.5 The 'So What'

The current study applied Wesp et al.'s (2018) emancipatory approach to cultural competency which is informed by critical race, postcolonial feminist and intersectionality theories. This approach offers a way to acknowledge diversity, question and analyze processes of power, and explore interventions to combat implicit bias in the nursing and healthcare profession. Individuals' ability to have good mental health and/or develop resilience is influenced by varying social determinants of health that intersect within social contexts of power

at the micro, meso and macro levels. In order to ensure social justice and health equity for Tamil youth at these levels, nurses and service providers need to understand and disrupt the power dynamics and dominant ideologies that function to create the marginalization of these youth (Wesp, et al., 2018). As such, the emancipatory approach to cultural competency involves ensuring cultural safety. As per RNAO (Registered Nurses' Association of Ontario, 2007), cultural safety includes "cultural awareness, cultural sensitivity and cultural competence and involves the recognition of unequal power relations to address inequities in health care."

One of the many reasons Indigenous status is considered a social determinant of health in Canada is due to the ways in which their history of colonization is inextricably tied to the multitude of health inequities they experience (Mikkonen & Raphael, 2010). In a similar way, recognizing how Sri Lanka's history of colonization, and the Tamil people's experiences of genocide and migration, can socially determine their health and well-being would be helpful in decreasing their health inequities. As such, it is important for providers to be culturally aware of the Tamil culture and history but to also strike a balance between being culturally informed and stereotyping as the experiences of individuals in this community are not homogenous. This awareness can allow providers to better complete risk assessments and informed care interventions and take some of the burden off clients having to explain everything.

Providers must remain aware of how lack of acknowledgement/denial of the Tamil Genocide can lead to their marginalization. The denial contradicts the lived experiences of Tamils, fails to recognize and legitimize their trauma and can result in health inequities when it is not recognized or addressed by health care providers. This denial can propagate ambiguity and contradiction and effect different domains of society such as academia. There is a need for more opportunities for the experiences and discourses of Tamils of Sri Lankan origin to be shared and

acknowledged. Due to stereotyping, marginalization, and lack of recognition of the genocide, Tamils may not openly share their stories and experiences especially with providers that are not from the same background. Sometimes they may not share it if they are from the same background out of fear of confidentiality issues and/or judgment. Tamil healthcare providers need to especially be conscious of not reinforcing stigmas and maintaining confidentiality when working within such a tight knit community. Providers must also remain aware of the risk of experiencing vicarious trauma by seeking support and supervision when needed while providing trauma therapy and avoid psychological projecting by remaining aware and conscious of their own biases.

> *F#001: I think they're good. When I did the family therapy, I did notice there was difficulty in explaining to her culturally why I feel the way I feel cause I know when I'm trying to explain like our family dynamics it doesn't always translate. For example the counselor was a Black Canadian woman but she's not going to understand why I felt like I wasn't close to my father but I still felt obligated that if he were to become ill to take care of him and I could never even though at the moment we had no relationship I would never abandon him, even if I hated him. Just trying to explain that to her and the reason why cause she would ask me why do you feel that way and my thing is that (inaudible) like I would never - like I think we have a big respect thing yeah.*
>
> *B: In our culture?*
>
> *001: Yeah. They didn't understand that.*

At the societal level, there needs to be more representation of racialized populations among groups who maintain power so that issues that affect these populations at a systemic and widespread context can be challenged and addressed. This includes those that are in power

creating and enforcing laws, policies and programs, those that conduct and publish research and those that sit on ethics boards. Even in nursing, although a majority of those who work frontline are racialized, those who hold positions of power are from the non-racialized dominant group. If we are to create a culture where power relations can be fairly negotiated, representation is an important factor.

Nurses and service providers need to be self-aware of their own attitudes, and biases towards a culture as well as their power dynamics to ensure culture sensitivity (Wesp, et al., 2018). Culture sensitivity refers to "awareness, understanding, and attitude towards culture and places the focus on the self-awareness and insight" (Registered Nurses' Association of Ontario, 2007). For example, there is a power dynamic at play when we assume that Western approaches are superior to other cultural approaches. Providers must engage in critical reflection and remain self-aware of their understanding, knowledge, attitude towards a culture and self-reflect to gain insight of how they can be contributing to unequal power relations (Wesp, et al., 2018). They must also critically reflect on how individuals' social location may be marginalized due to the intersections of individual factors but also influenced how community, culture and history contributes to their marginalization (Wesp, et al., 2018). Through these approaches, nurses and other service providers can act as advocates within the healthcare system to challenge unequal power dynamics and dominant ideologies to improve the quality of care provided at multi-sectorial and multi-disciplinary levels, and break down structural barriers at the community, and societal levels for Tamil youth. It was noted that by the conclusion of this thesis, the Registered Nurses' Association of Ontario's (2007) Best Practice Guidelines regarding cultural competence was no longer available on their website indicating it may not be in effect. I hope the findings of this thesis can play a role in informing the a more updated guideline.

6.0 Chapter Six: Conclusion

This chapter will begin with my reflexivity as a researcher, outline limitations to the research, share the research dissemination activities I engaged in throughout the course of completing this thesis, and end with a conclusion.

6.1 Reflexivity

As the leading arm of this study was qualitative, my reflections as a researcher are important in that I cannot be separated from the research. The unique and privileged position I held as a researcher, registered nurse, emerging adult, and a member of the community of interest allowed for in depth insights and a plethora of experiences. It also presented challenges that I had to navigate as a researcher, self-regulated professional with ethical obligations, and a member of a tight-knit community that had experiences of war/genocide and trauma. I selected this specific topic due to the high number of youth suicides within my community.

On a personal level, the nature and focus of this research proved to be extremely difficult due to my positionality. As an emerging adult with many shared lived experiences as the participants, sharing space and empathy with the lived experiences of thirteen others was a challenge. As a researcher delving into the history of my country of origin, there were many moments where the research became heavy. Learning and navigating my cultural identity during the completion of this work, while being in the emerging adulthood period myself, was yet another immense challenge. As intergenerational trauma within this community was not something I had come across in the literature, to identify it within my study was quite a profound experience. The realization that intergenerational trauma may be a part of my family, my friends, my community and my experiences, and the further realization that it may be something that we and our future generations may experience and must heal from was not an easy one to come to

terms with. Research dissemination was also difficult at times when community members approached me with personal stories, questions and needs.

I navigated my way by learning and implementing healthy boundaries, maintaining healthy coping skills and utilizing my social safety network. It helped knowing that this work may help in starting the healing sooner than later. Engaging with the community, sharing what I had found and hearing feedback including how the work was helpful is what kept me going. I gained and continue to gain resilience from the Tamil community as I watch them remain strong despite the difficulties. I also had immense support from my supervisor, friends and colleagues. Ultimately, I acknowledge the experience as a blessing and privilege because it provided me a unique opportunity as a researcher, healthcare professional and someone with lived experiences to study and communicate these findings, and concurrently work on healing where needed for myself and within my circles. As a result of the challenges, this project took a longer time than anticipated; however, I hope that the depth and quality of the work makes a fair contribution to increasing the quality and access of mental health care for my community. I have learned that my community and I are connected to other communities, especially those that are Black, Indigenous and people of colour through similar experiences. I hope that our communities can stand in solidarity as we heal, learn, grow and evolve.

6.2 Limitations

A potential risk of participating in the study was the impact it may have had on participants discussing their perceptions of health, well-being, and mental health; however, as discussed earlier, efforts were made to minimize this risk by having myself, a Registered Nurse as an interviewer as I engaged in health teaching, assessed and responded to risk, safety and ethical concerns, and allowed opportunities to debrief after completion of interviews. Limitations

related to recruitment of participants through social media may have resulted in a sample that excludes individuals who do not use this type of social platform and includes individuals more likely to participate in studies related to mental health and well-being. There may also be limitations related the application of the convergent parallel mixed methods approach as this design can be complex to carry out for first time researchers, such as myself; and as was the case in my study there was a rich and extensive amount of qualitative data compared to the quantitative data. The extensive support and guidance provided by my thesis committee which was comprised of researchers with both quantitative and qualitative expertise helped to support strengthening the mixed methods approach used in this study. It should still be noted that the quantitative data cannot be generalized to the population considering the small sample size and lack of statistical significance testing after data transformation. However, the qualitative findings have the potential to be transferable in light of the amount of contextual and methodological information I have attempted to provide throughout my thesis. Another limitation may have been any biases related to my positionality as a registered nurse, emerging adult, and a member of the community of interest. Through overtly explicating my positionality I hope that that any such biases are evident to readers and were minimized through my self-reflective journal keeping as previously described.

6.3 Dissemination of Findings

The goals and objectives of the dissemination effort were to share and publicize the findings of the undertaken research. My thesis work drew extensive interest from the Tamil community and the academic world. This resulted in the opportunity to have my work published in a peer reviewed journal (International Journal of Mental Health and Addiction) in 2019, and to present my work at multiple conferences/workshops. These included:

- Oral presentation at University of Toronto's 45th Annual Harvey Stancer Research Day, the major research conference for the Department of Psychiatry at University of Toronto (approx. 50 in attendance);
- Panel/oral presentation at the Centre for Addiction and Mental Health (CAMH)
- for the Collaborative for South Asian Mental Health Conference (approx. 100 in
- attendance);
- Poster presentation at York University's 4th Lillian Meighen Wright Maternal-Child Learning Institute;
- Workshop presentation for the Office of Women's Health Research Chair in Mental Health at York University (approx. 30+ in attendance);
- Two community workshops through TESOC Multicultural Settlement Services (one for 75 teachers, and another for 100+ community members);
- Oral presentation for Canadian Tamil Professional Association's Tamil Heritage Day (approx. 50 in attendance);
- Guest presenter at a mental health event by Aadyha Empower Yourself (approx.10 in attendance);
- Three community panels on youth mental health by community organizations (approx. 50+ in attendance at each event).

The Tamil community has been taking an active role in addressing mental health issues in the recent past. As such, in adopting the "whole community approach" to promoting resilience by means of collaborative partnership and involvement (Khanlou & Wray, 2014), the findings of the research study were shared with the Tamil community at relevant community meetings/forums. Khanlou and Wray (2014) highlight the importance of the integration,

collaboration and engagement of family, school, environment, and the community as one way of fostering resilience and positive mental health, which in turn can contribute to closing the equity gap. Through this research dissemination, I hope to have increased resilience within the Tamil community, closed the gap in equity, and impacted the quality of mental health care provided to Tamil immigrant youth. As nurses and other healthcare professionals were a priority audience, manuscripts will continue to be submitted to peer-reviewed journals tailored to this audience.

6.4 Conclusion

The experiences of racialized youth are multilayered and are influenced by the complex and interlocking ways that the social determinants of health intersect to create power and privilege. This study aimed to contribute to knowledge in a subject area that up to present has received limited attention: -the mental health of the ethnocultural population of Tamil Canadian youth. I hope the findings of this study inform knowledge for healthcare providers in the provision of culturally competent and intersectionality informed mental health care to the Tamil immigrant youth population in Canada. As political and armed conflicts continue around the world and families are forced into similar situations as the Tamils, I further hope that this study helps to inform approaches to increasing health equity for these families and communities as well and advances research for other communities with similar experiences.

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Appendix A: Online Recruitment

YORK UNIVERSITÉ UNIVERSITY

PARTICIPANTS NEEDED FOR RESEARCH STUDY

Perceptions of Health, Wellbeing, and Mental Health Amongst Sri Lankan-Tamil Immigrant Youth in Toronto

The purpose of this study will be to explore, discover, and understand the meanings, beliefs, practices, and experiences of health, wellbeing, and mental health from the perspective of immigrant Sri Lankan Tamil youth living in Toronto.

- **Are you between the ages of 18 to 24 years old?**
- **Are you a first generation or second generation Sri Lankan Tamil immigrant?**

(First Generation: Persons born outside Canada. This includes people who are non-permanent residents. Second Generation: Persons born inside Canada with at least one parent born outside Canada.)

- **Are you willing and able to share information and knowledge related to your perceptions of health, well-being, and mental health?**

If you answered yes to all of the above questions, you may be eligible to participate in this study. Please complete the full questionnaire at https://goo.gl/i5Yzya .

For more information about this study, or to participate, please contact:

Babitha Shanmuganandapala

A $10 gift card will be provided to participants who complete the study.

Image 1: Social Media/Recruitment Poster

Image 2: Social Media/Recruitment Poster

Appendix B: Online Screening Questionnaire

1. a) Are you between the ages of 18 and 24?

   YES ☐ NO ☐

   b) If so, how old are you?

   18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐

2. What is the gender you identify with?

   MALE ☐ FEMALE ☐ OTHER ☐

3. Are you a first- or second-generation Sri Lankan Tamil immigrant?

   ☐ FIRST GENERATION: Persons born outside Canada. This includes people who are non-permanent residents.

   ☐ SECOND GENERATION: Persons born inside Canada with at least one parent born outside Canada.

4. Do you speak and understand English?

   YES ☐ NO ☐ A LITTLE ☐

5. Are you able and willing to be interviewed by the researcher for approximately one to one and a half hours in a private setting of your choice?

   YES ☐ NO ☐

6. Are you willing and able to share information and knowledge related to your perceptions/experiences of health, well-being and mental health? Please note that some questions may elicit strong emotions/ feelings and may cause some distress.

   YES ☐ NO ☐

Appendix C: Informed Consent Form

Study Name: Perceptions of Health, Well-being, and Mental Health Amongst Sri Lankan-Tamil Immigrant Youth in Toronto

Study Researchers: This study is led by Babitha Shanmuganandapala RN, MScN Candidate, York University, under the supervision of Dr. Nazilla Khanlou, Chair in Women's Health Research in Mental Health at the Faculty of Health, York University.

Purpose of the Research: The purpose of this exploratory, qualitative interpretive nursing research study will be to explore, discover, and understand the meanings, beliefs, practices, and experiences of health, well-being and mental health from the perspective of immigrant Sri Lankan Tamil youth living in Toronto.

What You Will Be Asked to Do in the Research: You will be asked to participate in a one to one and a half hour, audiotaped, face-to-face interview. During the interview questions related to your perceptions on health, well-being and mental health will be asked. The interview will be recorded, and notes will be taken during the interview by the study's interviewer.

Specifically, we will first ask you a short set of demographic questions. Then we will ask questions about (a) your perceptions and experiences of being a first/second generation Tamil Canadian immigrant youth; (b) your meanings and beliefs related to health, well-being and mental health; (c) types of health related practices you do or activities you participate in to maintain/promote your mental health and well-being; (d) your experiences if any. You will be invited back during the analysis phase of the research for 30min to provide your feedback and clarification on emerging themes and data.

Risks and Discomforts: We do not foresee any risks or discomfort from your participation in the research. However, in sharing personal experiences with the study interviewer, you may or may not find the experience stressful if recalling experiences related to your mental health and accessing resources. The interviewer, a registered nurse, will provide you with information on whom/where to contact for health/counseling if needed.

Benefits of the Research and Benefits to You: Culture/ethnicity influences many overall mental health-related beliefs, behaviors, help seeking, and treatment expectations. Therefore, understanding Tamil youth's perspectives, values, beliefs, and approaches to and experiences with health, well-being, and mental health is critical. This understanding can provide information about what this population values, needs and expects from health care professionals. By understanding this phenomenon, nurses can improve their approaches in health promotion, health education, practice/service delivery, and further research within this population. Benefits to you include participation in nursing research that contributes to these aims as well as a $10 gift card for agreeing to take part in the study. Participant who withdraw from the study, are still eligible to receive the gift card for agreeing to take part in the study.

Voluntary Participation: You have the right not to answer questions, and the right to withdraw at any time. Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence your current position at your place of employment or the nature of your relationship with York University either now, or in the future.

Withdrawal from the Study: You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, your employers, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality: All information you supply during the research will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. Data will be collected through handwritten notes, audio tapes and the demographic questionnaire you fill out.

Your data will be safely stored in a password protected computer hard drive, which will be kept in a locked filing cabinet and only research staff will have access to this information. The data will be stored for no more than five years and then it will be destroyed. Confidentiality will be provided to the fullest extent possible by law. However, where information has been provided that leads to a belief that a person may be at risk of harm to themselves or others, then the interviewer will report the pertinent information to authorities as she is legally obligated to.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact the researcher listed above, or the research supervisor for this study, Dr. Nazilla Khanlou.

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University.

Legal Rights and Signatures:

I_____, consent to participate in Mental Health and Well-being Amon Tamil Youth of Sri Lankan Origin Living in Toronto: A Mixed Methods Approach conducted by Babitha Shanmuganandapala. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Printed Name: _____
Participant

Signature _____ **Date** _____
Participant

Printed Name: _____
Principal Investigator

Signature _____ **Date** _____
Principal Investigator

Appendix D: Individual Questionnaire

Interview number: _____

Date and time of interview: _____

1. How old are you?

   - ☐ 18 years old
   - ☐ 19 years old
   - ☐ 20 years old
   - ☐ 21 years old
   - ☐ 22 years old
   - ☐ 23 years old
   - ☐ 24 years old

2. What gender do you identify with?

   - ☐ Male
   - ☐ Female
   - ☐ Other - Please specify:_____

3. a) Were you born in Canada?

   - ☐ Yes *(If born in Canada, please proceed to question 4.)*
   - ☐ No

If NOT born in Canada:

b) What is your country of birth? _____

c) What was the status upon your arrival to Canada?

   - ☐ Permanent Resident
   - ☐ Refugee
   - ☐ Immigrant
   - ☐ Other – Please specify: _____

d) What is the length of time you have been in Canada (in years)? _____years

4. How long have you lived in Toronto (in years)? _____

5. Which area of Toronto do you live? _____

6. a) What is your mother tongue? _____

   b) What is the primary language that you speak?

   _____

7. How many people live in your household? _____

8. What is your household's income bracket?

   - ☐ Less than $19 999
   - ☐ $20 000- $49 999
   - ☐ $50 000 – $79 999
   - ☐ more than $80 000
   - ☐ I don't know

9. What is your relationship status?

   - ☐ Single
   - ☐ In a relationship
   - ☐ Married
   - ☐ Common Law
   - ☐ Separated
   - ☐ Divorced
   - ☐ Widowed

10. a) Do you have any children?

    - ☐ Yes
    - ☐ No *(if you have no children, please proceed to question 11.)*

    b) If you have children, how many do you have? _____

11. What is the highest level of education that you have completed?

    - ☐ Elementary
    - ☐ Completed high school
    - ☐ Trade/technical/vocational training
    - ☐ Completed college diploma
    - ☐ Completed undergraduate degree
    - ☐ Completed Master's degree

☐ Completed doctoral degree

12. a) Do you have a paid job?

☐ Yes
☐ No *(If you answered no, please proceed to question 15.)*

b) If you have a paid job, what is your job title? _____

c) If you have a paid job, do you work full time, part time, or multiple part time jobs?

☐ full time
☐ part time
☐ multiple part time jobs

13. Are you in school/college/university?

☐ Yes, Full time
☐ Yes, Part time
☐ No *(If you answered no, please skip to question 14.)*

14. Are you in college?

☐ Yes - If yes, what program? _____
☐ No

15. Are you in university?

☐ Yes – If yes, what program? _____
☐ No

15. If you live with family, who are the members of your household?

_____

_____

Please list below the number and ages of your siblings.

_____

_____

17. The following questions are related to your mother.

a) What is your mother's immigrant status? _____

b) What is your mother's country of birth? _____

c) How many years has your mother been in Canada? _____

d) What was your mother's occupation prior to migration? _____

e) What is your mother's occupation post-migration? _____

18. The following questions are related to your father.

a) What is your father's immigrant status? _____

b) What is your father's country of birth? _____

c) How many years has your father been in Canada? _____

d) What was your father's occupation prior to migration? _____

e) What is your father's occupation post-migration? _____

Please put a checkmark in the boxes that apply by estimating the frequency with which you participate in these leisure activities.

Question	Never	1-3 times per	Once a month	2-3 times a	Once a week	2-3 times per	Once/more
19. Do you practice any personal health care tasks, such as planning and eating healthy food and drinks; following exercise program; other tasks for <u>your</u> health? *i.e. Purposefully planning time for healthy eating and exercise routines. Meeting with a nutrition consultant; organizing a gym membership; reading health magazines and books*							

20. Do you practice any physically active recreational pursuits that you do alone? *i.e. Walking; gym program; shopping for pleasure; gardening; swimming, jogging; cycling; walking dog; woodwork; cooking and preparing for a large social gathering*							
21. Do you practice any physically active recreational pursuits that you do with other people? *i.e. Tap dancing; playing squash; walking with someone else; gym sessions with personal trainer; playing team sports; camping; bush walking/hiking; golf; picnic at a park*							
22. Do you have any spiritual or rejuvenating personal time? *i.e. Praying; attending bible groups; being with similar others to pray/worship/reflect; meditating; contemplation and meaning making alone or with others; worship*							
23. Do you spend time/have social activities with people who are important and supportive towards you? *i.e. Going to another family's home, or entertaining another family; cultural events with family and friends; attending social functions organized by people and organizations important to the person; extended family gatherings*							
24. Do you take time out for yourself to spend as you wish? *i.e. Facials; shopping; doing nothing; resting; sleeping during the day; playing musical instrument/listening to musical instrument; artwork/crafts*							

25. Do you have quiet, physically inactive leisure pursuits that you do alone? *i.e. Reading; sewing; baking; computer use; listening to music; scrap booking; building models/table top constructions; artwork/crafts*							
26. Do you have quiet leisure pursuits that you do with others? *i.e. Watching a DVD; eating a meal; celebrating cultural occasions (Easter); outings; meeting a friend for coffee/lunch; playing cards/other games socially; social networking via computer*							

Health Promoting Activities Scale
Used with permission from: (Bourke-Taylor, Law, Howie, & Pallant, 2013).

27. a) What else do you do to maintain/promote your mental health and well-being? Please list below:

_____

_____

_____

_____

b) How many times do you do these things? _____

c) How many times do you like to do these things? _____

28. On the following scale, please **<u>circle</u>** the number that shows how you have felt about yourself over the course of the **past week.** The bigger the number, the more positive you have felt about yourself. **1** means **you didn't feel good about yourself**. **10** means **you felt great about yourself**.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Didn't feel good about myself									Felt great about myself

29. What things made you feel **GOOD** about yourself?

30. What things made you feel **NOT GOOD** about yourself?

31. What things can you **DO TO FEEL GOOD** about yourself?

The Current Self-Esteem Instrument
Used with permission from: (Khanlou, 2004).

Appendix E: Interview Guide

Open Ended Questions

1. Can you tell me about your experiences being a first/second generation Tamil immigrant youth?
2. Would you say your experiences are different or the same as other youth?

   Probe: same/different as Canadian youth, youth of different ethnicities
3. What does health mean to you?
4. How do you define mental health? How do you define mental illness?
5. What helps you to have good mental health and well-being? What helps you to maintain your mental health and well-being?

   Probe: family support/friend support/internal motivation
6. In your perspective:
   a) What are your strengths in relation to mental health?
   b) What promotes youth mental health within the Tamil population?
7. In your perspective:

   a) What challenges do you face in relation to mental health?

   b) What are the weaknesses of the Tamil youth population in relation to mental health?
8. What does resilience mean to you?
9. Do you consider yourself as resilient? Why?
10. In your perspective, what are the key challenges you experience in accessing mental health services?
11. Can you describe your experiences if any with the mental health system?

Semi-Structured Questions

12. How do you identify yourself? Canadian? Sri-Lankan? Tamil? Sri Lankan Tamil? Sri Lankan-Canadian? Tamil-Canadian?
13. Do you have an extended family in the GTA? If yes, how often do you see them? Do you think you can turn to your family for support?
14. Do you feel that you have friends you can turn to for support? If yes, how often do you see them?
15. If you were experiencing problems with your mental health, who would you go to for help?
16. Would you seek help for mental health related problems from a professional?
17. How/from where do you learn about mental health services?
18. What do you think are the advantages and disadvantages of accessing mental health services?
19. Do you think mental health services are easily accessible? If so, how? If not, why?
20. What type of mental health services do you utilize, if any?
21. Do you think mental health services are equally accessible to male and female immigrant Tamil youth? If so, how?
22. Do you feel organizations have the necessary resources to support Tamil immigrant youth?
23. In particular, what would be the most significant barriers for Tamil immigrant youth accessing mental health services?
24. What has been your experience with utilizing mental health services? Are immigrant Tamil youth able to utilize culturally/linguistically appropriate services?

25. As a Tamil immigrant youth, how do you feel you interact with health service providers? How do you feel they interact with you and your family?
26. Do you think individualized, gender-sensitive and culturally sensitive approaches are needed for easier access to mental health services for Tamil immigrant youth?
27. a) Do you think it is necessary to ensure equitable and appropriate access to services for Tamil immigrant youth in Toronto?

    b) What changes/practices would you recommend at an individual level?

    c) What changes/practices would you recommend within the Tamil community?

    d) What changes/practices would you recommend at a structural level?
28. What do you perceive would be a help in meeting *your* mental health needs as a Tamil immigrant youth?
29. Do you have any other comments you would like to share?

Appendix F: Mental Health Resources

Support Services

- **CENTRAL TORONTO YOUTH SERVICES (CTYS)** is a community-based, accredited Children's Mental Health Centre located in downtown Toronto. Since 1973, CTYS has been at the forefront of serving at-risk youth. **http://www.ctys.org/**

- **DELISLE YOUTH SERVICES** operates many programs: including counselling, a group home, a day treatment program, in school programs, a queer youth program, an art gallery, a youth centre and residential case management for teens with complex special needs. All of our programs provide opportunities for youth and families to tell us what they need and to help shape the work we do together.

- **EAST METRO YOUTH SERVICES**: Many young people and their families are referred to East Metro Youth Services (EMYS) because they are experiencing social, emotional or behavioural problems. These problems may exist in isolation or they may be complicated by physical, cognitive, or other difficulties. **http://www.emys.on.ca/**

- **GRIFFIN CENTRE** offers a range of professional services including; assessment, service coordination and planning, individual, family and group counselling, specialized day/residential services and respite services.

- **OOLAGEN** is an accredited mental health centre helping Toronto youth and their families. Highly-respected for the work it does, Oolagen serves as a University of Toronto teaching facility and is long-term partners with the Toronto District School Board, the Children's Aid Society, Catholic Children's Aid, Ministry of Children and Youth Services, as well as other children's mental health agencies and community groups.

- **TURNING POINT YOUTH SERVICES** is a multi-service accredited children's mental health centre. We are located in Toronto's downtown core and provide a range of mental health, counselling and support services to at-risk and vulnerable youth 12-24 and their families.

Phone Support

Distress Centres of Toronto
Provides 24-hour telephone support to those experiencing emotional distress or in need of crisis intervention and suicide prevention
416-408-HELP (4357)

Gerstein Centre
24-hour crisis services in Toronto and York
416-929-5200
Integrated Community Health Crisis Response Program
24-hour crisis services in Etobicoke and North York
416-498-0043
Kids Help Phone
24-hour, national telephone and online counselling, referral and information services for children, youth and young adults
1-800-668-6868
LGBT Youth Line
Peer support phone line for lesbian, gay, bisexual, transgender, transsexual, 2-spirited, queer and questioning youth
1-800-268-9688
Scarborough Mobile Crisis Centre
24-hour crisis services in East York and Scarborough
416-495-2891

Apps and online tools help students manage their mental health

More and more, youth are turning to online tools to help them cope with their mental health and substance use.
SayingWhen App – helps people reduce or quit drinking
Thought Spot – helps students find Mental Health Resources in the GTA
Be Safe – App developed for young people in London, Ontario, to help them navigate the mental health system.

Helpful Links

1. **http://mindyourmind.ca/** This is a place for youth and emerging adults to access info, resources and tools during tough times. Help yourself. Help each other. Share what you live and know.

2. **http://www.cmha.ca/highschool/studentsH.htm** The purpose of this site is to give teens who are having mental health problems some tools to help them get through high school and go on to work or further studies in college or university.

3. **http://www.gethelpearly.ca/home.htm** This website is an Early Psychosis Intervention (EPI) Youth and Family Education Initiative developed in partnership with the **Ontario Working Group on Early Intervention in Psychosis**. The site evolved from my family's wish for centralized access to best-practice, personal, and creative resources relating to psychotic disorders.

4. **http://www.torontoearlypsychosis.com/home.asp** Early detection of psychosis greatly increases the chance of successful recovery. This site provides information on psychosis and direction on where to get help in Toronto.

5. **http://www.psychosissucks.ca/epi/** This site promotes early detection, educates about psychosis and provides direction for seeking help.

6. **http://www.kidsmentalhealth.ca** Children's Mental Health Ontario (CMHO) represents and supports the providers of child and youth mental health treatment services throughout Ontario.

7. **http://www.ementalhealth.ca/** A family friendly guide to mental health resources.

8. **http://www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx** - The Mental Health Commission of Canada (MHCC) is a catalyst for improving the mental health system and changing the attitudes and behaviours of Canadians around mental health issues. Through its unique mandate from Health Canada, the MHCC brings together leaders and organizations from across the country to accelerate these changes.

9. **http://www.anxietybc.com/** AnxietyBC™ works with experts to increase awareness, promote education and improve access to current, evidence based resources on anxiety. They have many free of charge, self-help, downloadable resources to support management of anxiety for youth and young adults, adults, new mothers, and children.

10. **http://www.anxietybc.com/resources/mindshift-app** Struggling with anxiety? Tired of missing out? There are things you can do to stop anxiety and fear from controlling your life. MindShift is an app designed to help teens and young adults cope with anxiety. It can help you change how you think about anxiety. Rather than trying to avoid anxiety, you can make an important shift and face it.

11. **http://weconnectnow.wordpress.com/** The We Connect Now website was created to unite people interested in rights and issues affecting people with disabilities, with particular emphasis on college students and access to higher education and employment

issues. One of the goals of this site is to help college students with disabilities to succeed in their studies by getting the information and support they need, both through resources, **links**, **blogs** latest **news**, studying existing **laws and regulation** and through personal contacts. Through this website people can also share and read other people's **stories** as a source of support and comfort.

Source: http://toronto.cmha.ca/mental_health/youth-zone/#.WTGtMevyvIU