

Mount Saint Vincent University  
Department of Family Studies and Gerontology

**The Mental Health and Well-Being of Older Immigrant Punjabi Women Living in  
Nova Scotia**

by  
Sandeep Dhillon

A Thesis

Submitted in partial fulfillment of the requirements for the degree of  
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### **Dedication**

Being born and raised in Canada, I felt as if I was born with a silver spoon in my mouth. My parents came to Canada with a small suitcase in the early 1980s, with a few Canadian dollars, limited English skills, and in my dad's case, no education. My parents worked very hard to provide my brother and me a very comfortable life. From paying for our undergraduate degrees to buying our first cars, my parents did everything they could to make sure my brother and I did not have any limitations to becoming "successful". When I turned nine, my parents had bought a larger home and when we were leaving on the last day, my dad took a picture of the small home and hung it up in his room. I believe that this picture of our past home is an artistic form of expression, holding many memories for my dad. The picture was an expression of who he once was. Even today, when my dad looks at that picture, he becomes isolated from the world and senses his accomplishments.

For my dad, leaving his homeland and coming to Canada was a big change. My dad was a man of colour, did not know the English language, and had no educational background. I watched him work day and night as a laborer to make sure he could afford this small home for our family. As an immigrant man, I believe my dad felt liberated to be able to buy a larger home in an upscale neighborhood, where many upper-class, white families lived. At the time my dad took the picture of the home, nine-year-old me asked him why he had this picture, and he responded, 'One day you will understand why'. This statement ruptured me because as I am growing older, I know how hard it is to buy a home, for even though I am educated, I do not experience any language barriers in Canada and I do not need to financially support my family. These were all challenges my

dad experienced when he came to Canada. Now that I am older, that photograph ruptured me, but it also liberated me. I should never let the mere fact that I am a woman of colour slow me down to pursue my dreams, because that did not stop my dad from achieving his dreams.



Sandeep Dhillon (2016)

Thank you Mom & Dad.

### **Abstract**

With the increase of immigrants in the Maritime region, the mental health and well-being of older immigrant Punjabi women living in Nova Scotia needs to be understood. Given the increase of immigration in Nova Scotia, research needs to focus on how the experience of immigration may cause health issues for older immigrants. Because of the cultural stigmas and taboos associated with mental health in the Punjabi culture, there is a larger need than ever to focus on how older women from this cultural group deal with their mental health and well-being after immigrating to Canada.

Guided by the social determinants of health and intersectionality feminist frameworks, this qualitative study interviewed five women about their life now in Nova Scotia, how they defined mental health and well-being, their migration experience, and how they experienced cultural issues. The following themes were identified: (a) having freedom yet not being free, (b) defining mental health as having a happy family, and (c) wanting to connect with other older Punjabi women in Nova Scotia. These findings demonstrate a need for understanding this cultural group and how they define mental health and well-being, and the need to develop culturally competent health care services in Nova Scotia.

### **Acknowledgements**

I would like to first thank everyone in Nova Scotia for making this province feel like home for me and making my masters experience that much more enjoyable. Also to Mount Saint Vincent University. I'm proud to say I'm a graduate from the Mount, which is a university that believes in women's education and excellence.

I wish to express my sincerest appreciation and gratitude to my thesis supervisor, Dr. Áine Humble, for her support and helping me grow as a student throughout this process. I truly appreciate all your help Dr. Humble. Also, I'd like to thank my committee members, Dr. Katie Aubrecht and Dr. Sailaja Krishnamurti, for their insight on this research project and making my thesis that much stronger.

A special thank you to the Nova Scotia Health Research Foundation, for their generous Scotia Scholars Award that helped me focus on my thesis. Thank you for giving my research a platform in Nova Scotia and allowing the voices of older immigrant Punjabi women be heard. I also want to sincerely thank my participants for taking their time to speak to me about a topic that is heavily stigmatized in the Punjabi culture. Without these women's contributions, this project would have never have been accomplished.

Foremost, I want to acknowledge the importance of my family, especially my grandmother who always told me to never stop learning and motivated me to break cultural stigmas and taboos held in the Punjabi culture.

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## Chapter 1: Introduction

Canada's population has been steadily aging over the past 40 years (Statistics Canada, 2016c), and by 2036, 25% of its population will be 65 years of age or older. This aging population is expected to have a major impact on the economy, society, and health care system over the next 25 to 30 years (Statistics Canada, 2016c). Moreover, because Canada is recognized as a country that welcomes thousands of immigrants, the proportion of immigrants who are aged 65 years and older has also increased over the past decades. Canada's aging immigrant population comprises 30% of all Canadians who are over the age of 65 (Gierveld, Van der Pas, & Keating, 2015; Peng & Cassie, 2015). This aging immigrant population is becoming increasingly ethnically and culturally diverse (Peng & Cassie, 2015), and many of them are resettling in provinces like Ontario, British Columbia, Quebec (Peng & Cassie, 2015), and Nova Scotia (Statistics Canada, 2017). Of the overall older immigrants in Canada, the majority are from South Asia (Statistics Canada, 2016a).

Although Canadians are among the healthiest people in the world, some groups of Canadians are not as healthy as others (Ball et al., 2004). Health disparities still exist throughout Canada, with people's health affected by social factors such as gender, educational attainment, income, and immigration, which result in disadvantages or inequalities of opportunity (Ball et al., 2004; Raphael, 2016a). As the aging population and immigrant seniors living in Canada continue to increase, health disparities need to be reduced while addressing where and how people live, allowing all individuals to have equal access to health care services. However, limited information on immigrant health, and the health of older immigrant women exists (Peng & Cassie, 2015).

Immigration is a critical social determinant of health (Raphael, 2016b).

Immigrating to a different country and adjusting to the new way of life can affect individuals of all ages and backgrounds. Resettling in a new country requires one to adapt to a new culture, which includes the challenges of maintaining lifelong beliefs and practices while learning how to live a harmonious life (Creatore et al., 2012). Older immigrants can also face great difficulty resettling in North America, affecting their mental health and well-being (Creatore et al., 2012).

On July 4, 2016, the Council of Atlantic Premiers and Federal Atlantic Ministers announced the launch of an Atlantic Growth Strategy to help ensure that the provinces throughout Canada maintain a unique linguistic balance (Government of Canada, 2018), and in January 2018, the Atlantic Immigration Pilot Project was initiated, the goal of which was to welcome approximately 2000 immigrants to Atlantic Canada every year for the next three years (Government of Canada, 2018). Older individuals will also be a proportion of those who immigrate to Nova Scotia, and given this, a greater understanding of their experiences and concerns is needed in order to attract newcomers and retain them (Ayers, 2018; Government of Canada, 2018). Furthermore, because the Canadian immigration laws recognize the importance of keeping families close together, Nova Scotia is helping people seek immigration to Canada. This specific program allows the immigration process to be faster while providing opportunities for newcomers to be united with their families after arriving to Nova Scotia.

Marginalized populations such as older Punjabi women need to be studied. Many older women from this cultural group are often disregarded and are invisible in the South Asian culture, giving them minimal recognition in their families and communities, which

may be compounded when they immigrate to Canada. They are also known not to express their emotional and physical pain, and tend to ignore their mental health problems (Choudhry, 2001) because of the social stigma associated with mental health. The World Health Organization (WHO) defines mental health as a “state of well-being in which the individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community” (WHO, 2014, p. 1). Living with good mental health is a critical to overall good health and quality of life (Canadian Mental Health Association, 2017; Gilkinson & Robert, 2012).

Another reason to study older Punjabi women is because many of them may not realize that they are now in a society that can help them cope with their mental health and well-being, and one in which there are options for treatment. They have lived most of their lives in India, within a patriarchal culture, causing them to rely on their social status through their families. As a result, many of them experience discrimination and poor health. Using a framework of social determinants of health and feminist theory, this qualitative study of five older immigrant Punjabi women explored how they define mental health and well-being and describe their experiences of living in Nova Scotia. By focusing on social determinants of immigration, social isolation, gender, education, and culture, the mental health and well-being of older Punjabi women can improve.

## Chapter 2: Theoretical Framework

This study was grounded in the social determinants of health (Raphael, 2016a) and the intersectionality feminist framework (Calasanti & Giles, 2017; Koehn et al., 2013). It is vital to recognize the context within which older Punjabi women live in order to understand their mental health and well-being (Bunjun & Morris, 2007). Because a majority of women in Punjab grew up in a patriarchal society, their social status may not be equivalent to a man's. Having low social status in a society hinders women's possibilities of achieving better health (Raphael, 2016a).

The Canadian Medical Association (2013) has suggested that only 15% of population health is determined by biology and genetics. They note how much of a person's health is determined by factors outside their bodies: 10% by physical environments, 25% by the health care system, and 50% by one's social and economic environment. To improve the health of Canadians, attention must be drawn to factors affecting health inequities such as social determinants of health and how they impact Canadians throughout their lives (Canadian Medical Association).

Social determinants of health are recognized as the conditions into which people are born, live, work, and age. These circumstances are all heavily related to the distribution of money, power, and resources at global, national, and local levels, resulting in health inequity (WHO, 2018). According to the WHO (2018), many factors affect the health of individuals and communities. Regardless of whether people are healthy or not, their circumstances and environment play a fundamental role in their ability to achieve good health (Raphael, 2006; WHO, 2018). Factors such as where someone lives, the environment, genetics, income, education level, and the relationships one has with their

friends and family all play a vital role in their physical and mental health. Despite Canada's health care system providing universal access to some health care services, Canadians face many different health outcomes due to social factors (Dunn & Dyck, 2000; Raphael, 2006; Statistics Canada, 2016d). Older immigrant women in Canada encounter more health disadvantages because of their ethnicity, sex, and age when compared to the general population (Peng & Cassie, 2015). These disadvantages relate to depression and other mental health problems (Peng & Cassie, 2015).

The Government of Canada (2011) recognizes 12 social determinants of health: (a) income and social status, (b) social support networks, (c) education and literacy, (d) employment and working conditions, (e) social environments, (f) physical environments, (g) personal health practices and coping skills, (h) healthy child development, (i) biology and genetic endowment, (j) health services, (k) gender, and (l) culture. However, Raphael (2016a) suggests four additional social determinants of health: (a) immigration status, (b) race, (c) social exclusion, and (d) unemployment and employment security. All of these 16 social determinants of health have a strong effect on the mental health and overall well-being of Canadians and are vital in addressing health equity (Raphael, 2016a). Yet, although past research has shown that the presented social determinants of health affect population health, social and economic outcomes, the public still has limited understanding and knowledge of these determinants (Lavis, 2002; Raphael, 2006, 2016a), and Canadians still predominantly believe their health is based solely on individual choices such as smoking, diet, and physical activity (Raphael, 2006, 2016a). Influences such as social support and education are not as well understood and recognized as strong societal factors on health (Raphael, 2016a). In using the social determinants of health

provided by Raphael (2016a) as the theoretical framework for this study, I hope to bring awareness of how these determinants of health influence older immigrant Punjabi women's perceptions of their mental health and well-being. For instance, educational attainment is widely acknowledged as a critical social determinant of health. Because higher levels of education can influence an individual's employment opportunities and their ability to make better decisions regarding their health and wellbeing, it can also equip people with knowledge and skills to support a sense control over their lives (Government of Canada, 2011; Shankar et al., 2013). Higher levels of education are strongly linked to improved health status (Government of Canada, 2011; Shankar et al., 2013). Canadians who have lower literacy skills were more likely to be suffering from unemployed, have poor health, and have lower life expectancy (Government of Canada, 2011).

Gender affects both men and women differently and is crucial to their health and well-being (Government of Canada, 2011). The term gender is used to define particular characteristics of men and women that are socially constructed, whereas sex is determined biologically (Phillips, 2005). People (cisgender) are born male or female but learn to be boys or girls who later grow into men and women. Through this learned behaviour, gender identify and gender roles are developed (Phillips, 2005). The social and cultural construction of gender impacts women when delivering rights and equality for females (Phillips, 2005; Piantato & Pinantato, 2014). The biological differences, gender roles, and norms have an influence on how male and females access health services. Gender inequalities can lead to a better understanding of how social differences between men and women affect both genders and the differences of health-seeking

behaviour affect men and women from different ages, cultural groups, and social groups (Denton, Prus, & Walters, 2004). Gender hierarchies are enforced through institutions such as the family (for example, as seen in the unequal division of labour between heterosexual couples), and tend to be accepted because they are socially determined relations (Piantato & Pinantato, 2014). Furthermore, gender inequalities assumed through such roles can lead to women experiencing oppression, affecting their overall health and well-being (Piantato & Piantato, 2014). Although women live longer than men in Canada, they are more likely to suffer from depression, stress overload, chronic conditions, injuries, and death due to family violence (Government of Canada, 2011).

Social support and networks is a determinant that focuses on the ability to have support from families, friends, and communities, which is directly associated with achieving better health (Government of Canada, 2011). A sense of belonging and increased self-worth both provide a sense of satisfaction and well-being, which can be a protective barrier against health problems. Low levels of social support can lead to social isolation, affecting one's mental health (Stewart et al., 2009). Without caring and supportive social relationships, people may develop health behaviours that are detrimental to their well-being; they may be at risk for smoking, obesity, and high blood pressure, for example (Government of Canada, 2011; Stewart et al., 2009). By examining social support networks, a better understanding can be developed regarding how this affects men and women and those from various cultural groups.

Lastly, every individual is influenced by human behaviour that includes language, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups (Knibb-Lamouche, 2013). The social determinant of culture influences affects the

conditions in which people are born, grow, work, live, and age, and as a greater set of force, it shapes their health and their ability to receive care (Knibb-Lamouche, 2013). In order to improve Canada's health status and reduce health inequalities, it is vital to explore cultural factors that are held within ethnic groups. For instance, culture greatly shapes the understanding of topics such as mental health in that there are philosophies that imply that openly displaying emotion is a result of weakness (Kramer, Kwong, Lee, & Chung, 2002). Admitting to mental health problems is taboo and could threaten the *izzat* (reputation) of one's family. South Asian societies tend to be communal, resulting in repressing any stigmatizing characteristics, and are typically hidden from the public view (Chaudhry, 2016; Choudhry, 2001; Hossen, 2012; Jhangiani, 2011). The fear of losing respect or becoming an outcast in the South Asian community has been shown to be a valid concern in addressing any mental health problems (Chaudhry, 2016). Similarly, holding an honourable reputation is very important in these respective communities because the person can become the subject of gossip or the recipient of pity.

With the increasing immigration population residing in Canada, there are now various cultural interpretations of health by different ethnic groups (Knibb-Lamouche, 2013). However, immigration is not included in the Government of Canada's list of social determinants of health. Rather, it is classified as a component of culture and explored as an example of what culture is (Government of Canada, 2011). Raphael (2016), in contrast, separates out immigration as a social determinant of health, on its own.

To understand older Punjabi women's mental health, it is vital to recognize the context within which they live. Most women from the Punjabi culture experience patriarchy, and as such, their social status may not be viewed to be equivalent to men's.

Low social status of women in their respective societies hinders their possibility to achieve better health (Raphael, 2016a). The social determinants of health that most affect older Punjabi women who have immigrated to Canada are culture, education, gender, social support, and immigration. For instance, immigrants are limited to behavioral choices which are linked to their social positioning. One's race/ethnicity, gender, and socioeconomic status all affect their ability to access health services. Culture focuses on how different cultural or ethnic groups practice health related practices and behavioral characteristics. Thus, after immigrating to Canada, it is important to explore how the social determinants of culture, education, gender, social support, and immigration impact how these women and how they view their mental health and communicate it to others.

Perceptions of mental health and well-being are determined by cultures and social practices (Armstrong & Pederson, 2015; Raphael, 2016b; WHO, 2014). Despite Canada being recognized as a leader in developing and promoting health promotion and population concepts, there is still a lack of public policies that support the health of Canadians (Raphael, Curry-Stevens, & Bryant, 2008). In Canada, marginalized groups such as Aboriginal peoples, immigrants and refugees, racialized groups, people with disabilities, single parents, children and youth in disadvantaged circumstances, women, elderly and unpaid caregivers, and LGBTQ (lesbian, gay, bisexual, transgender, and queer) communities tend to encounter higher power inequalities that impact their meanings of mental health (Raphael, 2016a; Raphael et al., 2008). The social determinants of health framework allows a deeper analysis of how Eurocentric assumptions in the Canadian health care system have created inequalities across gender and different cultural groups (Armstrong & Pederson, 2015; Raphael, 2016a).

Additionally, this framework challenges the Canadian health care system due to institutionalized racism in the health care system, which is seen in language barriers, lack of cultural sensitivity, absence of cultural competencies, barriers to access health service utilization, and inadequate funding for community health services (Peng & Cassie, 2015; Raphael, 2016a). All of these factors impact the health status of immigrant and racialized groups living in Canada (Peng & Cassie, 2015; Raphael, 2016a).

An intersectionality lens analyzes the experiences of those who are marginalized in society, which varies from the different forms of social stratification such as class, race, sexual orientation, age, religion, disability, cultural groups, and gender (Carastathis, 2014; Deckha, 2004). An intersectionality feminist framework focuses on understanding how the various forms of social stratification are interwoven together and results in systems of oppression (Carastathis, 2014). Women from particular cultural groups are socialized to carry out their gendered roles throughout their lives (Carastathis, 2014; Deckha, 2004). However, women's intersecting identities or social positions also result in potentially unique experiences for them. For instance, culture, gender, and age intersect with each other. The experience of a young immigrant woman from Punjab may be quite different from the experience of an older immigrant woman from Sweden. Religious backgrounds may further contribute to differences among women.

Through this lens a deeper understanding can be formed when analyzing how factors such as race, culture, and class shape women's lived experiences and how they interact with gender for marginalized women (Carastathis, 2014; Deckha, 2004). These experiences affect different groups of women in society in various forms at micro, meso, and macro levels (Bastia, 2014; Calasanti & Giles, 2018; Koehn et al., 2013). By

including the intersectionality framework, the social determinants can attempt to identify how each determinant impact those who are marginalized in society (Koehn et al.) while challenging principles of social justice, anti-racism, and anti-oppression.

The intersectionality framework draws attention to social inequality based on intersecting social relations such as gender, race, culture, and class that are manifested on an individual and population level, and a greater understanding can be achieved by studying how those relationships act as social determinants of health disparities (Bauer, 2014). Furthermore, through exploring patriarchal values held in the Punjabi culture, an exploration of inequalities can be further understood and how other social determinants cause health inequalities for older Punjabi women.

In summary, focusing on the social determinants of culture, education, gender, social support, and immigration and an intersectionality feminist framework allows for a deeper understanding of how older immigrant Punjabi women view their mental health and well-being and communicate it to others. With these frameworks, a greater understanding can be gained to help support and educate policy-makers, reduce health inequities in the health care system, as well as decrease institutionalized racism many marginalized populations experience. Both frameworks could help researchers, practitioners, and others working to advance the mental health and well-being of aging immigrant Punjabi women in Nova Scotia.

### **Chapter 3: Literature Review**

In this chapter, I first discuss immigration trends in Canada and then the mental health of immigrants. The third section reviews existing literature on South Asian women and the perceived barriers older women endure while living in India and after they have immigrated to Canada. The final section provides a critical overview of the limited research on older immigrant Punjabi women living in Canada and their mental health and well-being.

#### **Immigration to Canada**

Every year, people from various countries around the world immigrate to Canada. Canada has been and continues to be recognized as a land of immigration since Confederation in 1867, making it home to over 17 million immigrants (Statistics Canada, 2016a). Since the early 1990s, Canada has permitted permanent resident status to an average of more than 250, 000 immigrants each year (Creatore et al., 2012). With the diverse population in Canada growing, it is projected that by 2031, the total number of immigrants living in Canada will rise to 25-29%, compared to 19.8% in 2006 (Creatore et al., 2012; Statistics Canada, 2016b).

Historically, the majority of the immigrants came from Europe, but in more recent years, the largest group of newcomers to Canada are from Asia (Peng & Cassie, 2015; Statistics Canada, 2016a), representing 60% of the total immigrant population. The three largest visible minority groups in Canada are South Asians, Chinese, and Blacks (Statistics Canada, 2016b). The National Household Survey (2011) indicated that between 1996-2001, the number of individuals who identified as South Asian rose by 33%, whereas the overall population only grew by 4% (Raphael, 2016a).

Patterns of immigration to Canada have dramatically changed over time because of the changes that occurred to the federal immigration policy in 1967, which introduced the Points System (Creatore et al., 2012; Statistics Canada, 2016a). The point system analyzes an individual's educational credentials and entrepreneurial abilities, rather than viewing the country of origin (Creatore et al, 2012). Such credentials determine eligibility for immigration and whether someone is an attractive candidate. As a result, Canada's racial and ethnic minority population increased considerably from 1981 until 2001.

According to Creatore et al. (2012), three in ten Canadians will be from an ethnic minority group by 2031, with even higher proportion in metropolitan cities. Furthermore, the largest visible minority group among immigrant women is South Asian women, comprising 28% of the population (Statistics Canada, 2017).

Although South Asians are the largest visible minority group in Canada, the South Asian community is one of the most diverse visible minority groups, consisting of a diverse range of ethnic, religious, and linguistic groups (Allard, Kaddatz, & Tran, 2005). A South Asian (at times referred to as East Indian in Canada and Asian Indian in the United States) is any person who reports an ethnicity associated with the Southern part of Asia or who self-identifies as part of the South Asian visible minority group (Allard et al., 2005). This definition comprises people from many ethnic cultures and backgrounds, including individuals with Bangladeshi, Bengali, Goan, Gujarati, Hindu, Ismaili, Kashmiri, Nepali, Pakistani, Punjabi, Sinhalese, Sri Lankan, and Tamil ancestry (Allard et al., 2005). However, until today, South Asian immigrants are one of the most unified cultural groups who preserve their values, family interaction, the maintenance of social

networks within their cultural groups and ethnic customs, traditions, and heritage languages (Allard et al., 2005).

In the early 1990s, approximately 90% of immigrants lived in Canada's three largest cities (Toronto, Vancouver, and Montreal) (Peng & Cassie, 2015); however, eastern provinces like Nova Scotia are increasingly becoming the top choice for new immigrants to settle (Creatore et al., 2012; Statistics Canada, 2017). Nova Scotia has welcomed over 14, 845 immigrants to Canada that were 65 years and older, with the majority resettling in Halifax (Statistics Canada, 2017). The immigrant population in Halifax has dramatically increased over the past 15 years, nearly at the same pace as the Canadian-born population (Statistics Canada, 2017). Furthermore, in Nova Scotia there are over 58, 000 visible minorities and over 7900 have a South Asian background (Statistics Canada, 2017). Of those 7900 South Asians, 710 are 65 years and older, recognized as the second largest aging minority group in Nova Scotia (Statistics Canada, 2017). Given this increase in Nova Scotia, research needs to focus on how the experience of immigration may affect health issues for Nova Scotian older individuals.

### **Immigration and Mental Health**

Upon arrival, immigrants are typically in better health than the native-born population, a phenomenon recognized as the *healthy immigrant effect* (Delara, 2016; Flenon, Gagnon, Vang, & Sigouin, 2015; Ng, 2011). This effect is associated with factors related to the immigration selection criteria such as in-depth health screening, and generally, the immigration process indicates that healthier people tend to move more than those with a poor health status (Delara; Flenon et al.; Ng). Nevertheless, this effect appears to diminish over time. The longer immigrants live in the country they immigrated

to, the worse their health status becomes (Delara; Flenon et al.; Ng). The mental and physical health of new immigrants declines over time due to factors including socioeconomic status, financial and employment restraints, resettlement challenges, discriminatory treatment, and difficulty accessing services due to language barriers. Immigrants and ethnic minorities are less likely to access mental health services and seek preventative care, instead they seek alternative or traditional forms of health care (Delara, 2016; Flenon et al., 2015; Ng, 2011). Barriers such as the Canadian health care system not being culturally sensitive and a health care system difficult to navigate for such immigrant and minority populations may contribute to the result of the decline in their health (Peng & Cassie, 2015). Additional barriers include experiences of discrimination, distrust of the biomedical system, fear of deportation in some circumstances, as well as cost and language barriers (Creatore et al, 2012). As a result, immigration is a key social determinant of health that affects the health and well-being of immigrants throughout their life course.

Immigrating to Canada in later life often results in a higher risk of psychological stress and social isolation, due to language barriers, small social networks, and cultural differences (Choudhry, 2001; Hossen, 2012; Meadows, Thurston, & Melton, 2001; Peng & Cassie, 2015). In particular, the social networks of those who migrate late in their lives tend to be restricted due to an unfamiliar social environment (Hossen, 2012; Meadows et al., 2001; Peng & Cassie, 2015). Poverty, poor health, and communication problems are all examples of why many older immigrants are not able to participate effectively in their new surroundings. With such difficulties after migration, they become alienated and isolated from mainstream society (Choudhry, 2001; Hossen, 2012; Peng & Cassie, 2015).

For instance, difficulties in understanding media and news reports, reading newspapers or magazines, and being able to use public transportation to visit friends or attend doctor appointments reinforces a sense of feeling lonely and isolated, and affects an aging immigrant's well-being and mental health (Hossen, 2012).

Chronic depression and anxiety disorders impact women at a greater rate when compared to men (Gilkinson & Robert, 2012). On average, women experience poorer mental health outcomes than men, and women of color and those with lower socioeconomic status suffer even more so (Berkman & Kawachi, 2001; Gilkinson & Robert, 2012). Immigrant women are particularly vulnerable to poor mental health when compared to Aboriginal women, homeless women, and women in poverty: they are at an increased risk of depression, schizophrenia, post-migration disorders, and more commonly, anxiety disorders (Canadian Mental Health Association, 2017; Peng & Cassie, 2015).

Programs and service delivery related to mental health have undergone some changes, but are still found to be culturally insensitive (Kanth, Maddalena, & Weerasinghe, 2008). For example, current changes focus more on how to better deliver Western conceptions of mental health. With high percentages of South Asian immigrants in Canada, there needs to be a focus on significant cultural factors and problems experienced by such marginalized groups (Choudhry, 2001; Delara, 2016; Jhangiani, 2011; Kanth et al., 2008). For example, South Asian immigrants tend to be hesitant to seek help for their mental health problems because of the perceived belief of physicians prescribing pharmaceutical drugs (Jhangiani, 2011). Many South Asian believe in non-pharmaceutical treatments and more specifically, in holistic and traditional folk medicine.

Traditional healers providing treatment for South Asians must be from the same culture, must be members of the community, and have an understanding of the cultural norms and rules, which will allow patients to feel more comfortable in seeking help regarding mental health problems (Agarwal-Narale, 2005; Jhangiani, 2011; Kakar, 1991; Kanth et al., 2008).

According to Choudhry (1998), Western health promotion programs are not beneficial for individuals with non-Western values. Although the Canadian health care system has changed in the field of mental health, including the hiring of multilingual staff, providing interpreters for mental health workers, and producing multilingual health pamphlets and educational workshops that focus on how to communicate with non-English speaking patients, increased resources and training staff in the health care field on communicating with culturally diverse clients are still needed (Kanth et al., 2008).

A Western psychoanalyst Kakar (1991) found that the patients he visited in India had a different understanding of the mind and body than in the West. Mental health problems were described in somatic or physical terms by South Asians, but in contrast, mental health problems in Western countries were described in and strongly influenced by the Diagnostic and Statistical Manual of Mental Disorders. The description of symptoms communicated by South Asians is not found in this manual, and at times is considered as an ineffective description of emotions (Agarwal-Narale, 2005; Kakar, 1991). Similarly, culture does not only influence how South Asians view mental health, but it also affects the way they express their symptoms. Without culturally sensitive health care providers, misdiagnosis may occur because of the lack of understanding within the context of health problems one may be experiencing (Agarwal-Narale, 2005).

Delivering culturally sensitive care is vital in Canada because of the high immigration of South Asians resettling in provinces and territories across Canada. More commonly, immigrant South Asians face great challenges in accessing help from the Canadian health care system due to the perceived lack of time and interest of physicians (Choudhry, 1998; Dadey, 2007; Delara, 2016; Jhangiani, 2011). Many immigrant South Asians felt that their physician was dismissive and did not take enough time to understand their problems, and felt that prescription medication was not beneficial to the type of health problems they were experiencing (Jhangiani, 2011). Furthermore, language was recognized as a major obstacle for many South Asian immigrant women when seeking help for mental health. The ability to express their needs and concerns may be limited due to language. Miscommunication may result in a missed or inaccurate diagnosis. Matching patients and practitioners with similar cultural backgrounds may result in positive health outcomes. In provinces such as Nova Scotia, there is a need for culturally-appropriate practitioners, due to the rise of new Canadians, and more specifically, the increase in South Asian immigrants living in this province.

Immigrating to a new country brings opportunities and some risk, and the Canadian Mental Health Association (2017) has emphasized the importance of culture due to the increasing immigration trends. Culture is vital to research when understanding immigrant populations because it often guides the perceptions that are held regarding mental health and help-seeking behavior associated with particular immigrant groups (Raphael, 2016a). Furthermore, gender is greatly shaped by cultural expectations and understandings, affecting more immigrant women when compared to immigrant men (Abrahamowicz, Lynch, Quesnel-Vallee, Setia, & Tousignant, 2011).

Although immigrants experience fewer chronic conditions and better health compared to the average Canadian-born population, the mental health of older immigrants deteriorates greatly over time (Abrahamowicz et al., 2011; Choudhry, 2001; Delara, 2016). For instance, older immigrant South Asians often experience isolation when settling in Canada, affecting more women than men (Abrahamowicz, et al., 2011; Choudhry, 2001). Social isolation involves a lack of social contacts or viewed as an expression of dissatisfaction with the number of social contacts one may have (Hossen, 2012). Being separated from one's culture and social environment is considered as social isolation, and this often occurs in old age. Retirement and the loss of daily contacts related to work, death of family members or friends, or the relocation of one's social environment may result in a decline in health (Choudhry, 2001; Hossen, 2012). With weakened social support networks, older immigrants may experience loneliness. Thus, immigrating to a new social environment, may result in aging individuals becoming emotionally isolated, resulting in one experiencing loneliness and affecting their mental health (Hossen, 2012).

The experiences of immigration and health are significantly shaped by gender, especially women from the South Asian culture. Immigrant women suffer from poor mental health when compared to the general population in Canada (Jhangiani, 2011; Meadows et al., 2001; Peng & Cassie, 2015). Studies that have compared immigrant women to Canadian-born women reveal that immigrant women who had lived in Canada for more than 10 years were likely to experience poor health when compared to Canadian-born women (Jhangiani, 2011; Meadows et al., 2001). However, there was no difference found in the health status between immigrant and Canadian-born males who

resided in Canada for more than ten years (Jhangiani, 2011; Meadows et al., 2001). Furthermore, immigrant women endure higher rates of depression and anxiety when compared to immigrant men (Jhangiani, 2011; Peng & Cassie, 2015). As a result, many immigrant women's mental health becomes negatively affected by factors that are within and outside of their control (Flenon et al., 2015; Jhangiani, 2011). Failure to receive the care they need and the difficulties of accessing mental health services are only some of the experiences immigrant women face (Choudhry, 1998, 2001; Delara, 2016; Jhangiani, 2011; Meadows et al., 2001; Peng & Cassie, 2015). Many South Asian women are particularly high risk for acculturative stress, due to the experience of immigrating and resettling into a new environment (Ahmad, Barata, & Riaz, 2004). By analyzing the life course of South Asian women, their perceived mental health can be better understood.

### **Immigrant South Asian Women**

Women from the South Asian culture have traditionally been taught to be subservient to their fathers, husbands, and in old age, their sons; they have generally been taught to be good wives, daughter-in-laws, and mothers (Choudhry, 2011). From a young age, females are taught their stereotypical gender role. As they grow up, they are more likely to be exposed to gender norms that dictate appropriate feminine behavior and they are less likely to pursue education (Rao, Sriramya, & Vidya, 2015). In 1947, only 12% of the population in India was literate, but with the implementation of a nation-wide education from kindergarten to grade 12, the literacy rate rose to 63% in 2011 (Census of India, 2011). India has made considerable progress in raising their literacy rates, however there is still a large literacy gap between men and women: in the 2011 census, the literacy rate for men was 82% whereas for women it was 65%. Many older women are either

illiterate or poorly educated (Census of India, 2011; Prakash, 1999). For instance, Prakash (1991) found that only 8% of older women were literate and due to high illiteracy rates, older women rated their mental health less than satisfactory. Women are less likely to be educated than men because their primary responsibilities reside in the domestic domain. Tasks such as cooking, cleaning, and taking orders from their brothers and fathers are taught at a young age and, young women continue these tasks once they enter their married life and, then, later in life (Rao et al., 2015).

The traditional view of females has left many feeling they need protection because a woman's honor and sexual innocence is a cherished value in many communities throughout India. The burden of shame threatens the family status and reputation because honour is represented by females throughout their lives as daughters, wives, and mothers. Families in India gain and lose honour through money, power, and through the behavior of women (Palakonda & Vishwanath, 2011). Due to the patriarchal culture of many families, some women may be oppressed due to the rigid gender roles and the patriarchal structure of their families.

Marriage is viewed as forever and divorce is considered taboo. Once a South Asian woman is married, her primary role is to uphold traditions, preserve culture, and be the caretaker of the family (Choudhry, 2001). However, if a woman decides to divorce her husband, she will face countless difficulties, such as resentment from the South Asian society, financial constraints, and emotional problems of her children growing up without a father (Hassan & Niaz, 2006). Although it may appear that South Asian women do not hold much power within their perceptive households, some women are still respected and

valued. For example, customarily, many South Asian women are compared to goddesses who embody power and impose respect for women (Choudhry, 2001).

The social organization of family in the South Asian culture revolves around kinship and the continuity of culture and religion is typically enforced by women (Choudhry, 2001). In most South Asian families, elders live with their children, and more commonly with their sons in a joint household. Similarly, in the South Asian culture, it is traditionally expected that children, more specifically, daughter-in-laws will care for their aging parents. Many South Asians believe caring for their aging parents is not only an expectation, but also a moral duty. Adult children are morally obligated to provide elder care for their parents because their parents provided for them (Harrison, Hughes, Neufeld, Spritzer, & Stewart, 2002). In a traditional South Asian family, parents are to be honored and respected and elders are appreciated for their wisdom and their life experiences (Choudhry, 2001). This value system is learned from an early age: children are made aware of their responsibilities and duties for taking care of their parents in old age (Choudhry, 2001). These culture traditions have defined structural roles, beliefs, and expectations (Gupta, Levy, & Pillai, 2011).

Under the Canadian immigration policy of family reunification, many first generation immigrants sponsor their aging parents from India, paying for their travel and living expenses, due to custom and economic reasons (Choudhry, 2001; Peng & Cassie, 2015). Over 80% of older immigrants are sponsored by their son or daughters (Koehn, 1993; Peng & Cassie, 2015). Because of the cultural tradition of caring for aging parents, children who immigrate to Canada are pushed to practice the values and expectations they have been taught throughout their lives. When South Asian immigrants move to

Canada, many older women are forced to live with their children, as it recognized as a cultural practice (Choudhry, 2001; Peng & Cassie, 2015). Seniors' homes are viewed as a Western way of life and are heavily stigmatized in the South Asian culture (Koehn, 1993).

However, living in a joint household is customary in India, this arrangement in Canada can be problematic for many older South Asians, particularly for women. Traditionally, in India, daughter-in-laws are expected care for their in-laws but in Canada, the older family member can easily experience isolation and loneliness because many immigrant South Asians need a dual income in order to live a comfortable life (Choudhry, 2001). Because South Asian women in Canada are working outside of the home full time, the responsibilities of caring for older parents can become difficult. It is particularly challenging for South Asian adult children to maintain strong relationships and responsibilities when they have children of their own, resulting in older South Asians feeling socially isolated and lonely in Canada (Choudhry, 2001; Peng & Cassie, 2015). As the aging population increases among South Asian immigrants in Canada, daughter-in-laws may not able to provide the kind of attention and assistance to the aging, as they may have been able to provide in India (Choudhry, 2001).

Adult women are morally obligated to provide elder care for their parents because their parents provided care for them as a child (Harrison et al., 2002). In India, daughters-in-laws are expected to care for their aging in-laws as this upholds cultural hegemonic traditions (Harrison et al., 2002). With Canada's current economic structure and along with the South Asian cultural traditions, many women are forced to abide by traditions and customs, and are expected to work outside of the home while caring for their aging

loved ones, hindering the well-being of older individuals. Working South Asian women are unable to tend to their aging parents and find themselves leaving aging parents at home by themselves. As a result, the loss of independence in Canada and disconnectedness from living in a new country affects the mental health of older South Asian women (Choudhry, 2001).

However, studies conducted by Ahmad et al. (2004) discovered that the mental health of South Asian older women improved when they immigrated to Canada because the patriarchal beliefs they had to conform to in India had diminished after immigrating. These women were happier when resettling in a Westernized society because they no longer felt the need to abide by their cultural values (Ahmad et al., 2004; Choudhry, 2001). Thus, older South Asian women may experience an increase in mental health after immigrating to Canada (Harrison et al., 2002; Choudhry, 2001). These studies have researched older women who lived in large metropolitan cities largely populated with South Asians. Family commitments, transportation problems, and poor weather affected the development and maintenance of new and close relationships (Choudhry, 1998; Dutt & Webber, 2009; Jhangiani, 2011).

A telephone survey of individuals aged 55 and over found that older immigrant Indian women living in Canada had negative mental health outcomes (Lai & Surood, 2008). Marital status, language barriers, dependency on family members for transportation to doctor appointments, and restricted mobility due to childcare responsibilities are a few reasons why the mental health of many older South Asian women decreases once they have resettled in Canada (Choudhry, 2001). Typically, older South Asians are sponsored to Canada to be close to their kin but then expected to

provide help with childcare responsibilities. Immigrant older South Asian women provide care for their grandchildren and domestic responsibilities to help their children who work in the labor force and may work jobs with non-standard hours. Many immigrant South Asians come to Canada and are forced to shift work, jobs that are often filled by immigrants. These childcare responsibilities bring satisfaction to aging South Asian women but also difficulties, because they are confined and isolated in their homes and felt as if they were in a prison (McLaren, 2006). Older women also experience disappointment over the North American values instilled in their families and the disappearance of their traditional culture, causing sadness. These South Asian women were found to be unwilling to verbalize their problems, causing them to suffer from physical illness and emotional distress (Choudhry, 2001).

For example, speaking publicly about one's mental health is still viewed as a taboo in the South Asian culture (Choudhry, 2001; Faulkner, 2012; Hossen, 2012; Jhangiani, 2011; Uppal, Bonas, & Philpott, 2014). South Asian immigrants are lead to believe in a holistic view of health and a strong connection between the mind, body, and soul (Hilton et al., 2001, Leong & Lau, 2001). Additionally, they define mental health based on holistic factors involving physical, mental, and spiritual characteristics. These specific attitudes and beliefs result in beliefs of mental health problems being incurable, and are associated with large amounts of stigma (Leong & Lau, 2001; Choudhry, 2001). Moreover, seeking treatment for mental health problems in various South Asian communities is challenging because of the shame associated with South Asian women, living in Canada and in India (Choudhry, 2001; Gilbert, Gilbert, & Sanghera, 2004; Hilton et al., 2001). Rather South Asians believe in the strong importance of having faith

in God and prayers to help them cope with their mental health problems (Choudhry, 2001; Hilton et al., 2001; Jhangiani, 2011). However, it is vital to recognize that religion does not disregard mental suffering in any particular way, rather it is silent on the matter, whereas culture influences the stigma associated with mental health (Ruprai, 2016).

In Canada, there are three major religious groups from South Asia, identified as Sikhism, Hinduism, and Islam (Uba, 1992). Praying is viewed as a way to practice good mental well-being in the South Asian culture, as it provides a sense of peace and identity. Many South Asians turn to religious healers for help regarding their mental health rather than seeking Western medical services (Peng & Cassie, 2015; Ruprai, 2016; Uba, 1992). Additionally, attending regular prayer days is fundamental for many older South Asian women regardless of whether or not they are religious because it allows them to have greater social capital, connecting to their ethnic communities and building/maintaining social capital (Koenig, 2009; Ruprai, 2016). Consequently, religious organizations help provide many South Asians with support for their overall well-being.

Religious organizations in Canada play a critical role in creating community and provide social and economic resources for those in need (Akresh, 2011; Hirschman, 2004). Immigrating to Canada often leads to many people to turn to religious organizations, which are usually packed with familiar linguistic and cultural context (Akresh, 2011). Many non-religious immigrants will attend religious services because of the traditional foods and customs that are available (Akresh, 2011). Similarly, newcomers to Canada often have economic and social needs and religious organizations typically have a long history of providing community service, especially who are in need of resources and information (Akresh, 2011; Hirschman, 2004). At these ethnic churches,

temples, and synagogues in Canada, newcomers can access information without experiencing language barriers (Akresh, 2011; Hirschman, 2004). The ability to hear one's native language can help South Asian immigrants connect with a community, as many immigrants tend to gravitate to people who come from similar ethnic backgrounds (Hirschman, 2004).

Most people from the Punjabi culture practice Sikhism, which is recognized as the fifth largest organized religion in the world. Sikhism was established by Guru Nanak Dev Ji, who taught about equal rights irrespective of caste, creed, colour, race, sex, or religion (Jakobsh, 2006; Singh, 2016). The Sikh religion focuses on practices of humbleness, compassion, the act of *seva* (the act of selfless service to others), and social commitment to others (Singh). These principles can be seen through the practice of *langar*, which is a term used in Sikhism for the community kitchen in the *Gurdwara* (temple). Any person who enters a Sikh temple is served a free meal, regardless of their religion, caste, gender, socioeconomic status, or ethnicity (Singh). Food is prepared through the act of *seva* (selfless volunteer work) and is eaten by sitting on the ground as a community and equals. Through the practice of *langar*, the *Gurdwara* is recognized as a community establishment for any human being (Singh).

Furthermore, the caste system held within the Punjabi culture is condemned in Sikhism and women are viewed as equal to men (Jakobsh, 2006). Gurus in the Sikh religion have voiced the importance of respecting women, stating "respect women for she gave life to all humans" (Singh, 2016, p. 15). Women also do not need to change their names after marriage as the tenth Guru in Sikhism introduced the middle names Kaur (for females) and Singh (for males) that can be used as surnames (Jakobsh, 2006; Singh,

2016). These surnames were intended to stop caste-based prejudice held within the Punjabi culture. Because individuals' last names are associated with a specific caste status, using Kaur and Singh allows Sikhs to reject the caste system.

Although the Punjabi identity is primarily linked to the linguistic and cultural aspect of the Punjabi language, the identity of a baptized Sikh relies on the "five K's", recognized as *Kesh* (uncut hair), *Kangha* (a wooden comb for the hair), *Kara* (an iron bracelet), *Kachera* (a cotton undergarment), and *Kirpan* (an iron dagger to defend oneself) (Singh, 2016). Although many Sikhs are not baptized and do not practice the five K's, they are encouraged to lead a life full of honesty and hard work, treating people equally, being generous to the less fortunate, and to serve others through volunteering (Singh, 2016).

South Asian immigrants in Canada predominantly come from traditional societies and strongly believe in the concept of *dharam*, known as duty, and *izzat*, known as honour. These ideologies impact and define their roles. For example, *dharam* for many South Asians involves the fulfillment of one's social duties, depending on their age and gender, whereas *izzat* reflect a family's honour, not only focusing on an individual, but also on the individual's family. Thus, an individual's personal actions reflect not only on themselves, but also on their family, potentially hindering the family's reputation in society. Furthermore, a woman's *izzat* is important in her family because she is often viewed as the one who preserves Indian culture and tradition. Speaking publicly about one's mental health issues could potentially hinder a family's reputation and status (Jhangiani, 2011). A strong relationship exists between South Asian immigrant women's

mental health and familial responsibility and health promotion practices, related to their upbringing (Choudhry, 2001; Faulkner, 2012; Jhangiani, 2011).

The perception of good mental health held by immigrant South Asian older women is having a happy and stable family. For instance, Jhangiani (2011) found that being mentally happy for many South Asian women was strongly related to having happy and stable families, children who spend time with them, children who are obedient, and freedom from family-related burdens. Due to this understanding of mental health, close knit familial social networks are linked to happiness. Thus, it becomes extremely difficult for South Asians to freely express their mental health problems to health care practitioners and to non-family members, leaving them feeling helpless and mentally depressed. Discussing family-related issues and problems is also interpreted as shameful behavior, resulting in many older South Asian women discussing their problems with family members rather than health care professionals (Chaundhry, 2016; Choudhry, 2001; Jhangiani, 2011; Peng & Cassie, 2015). South Asian women are a diverse population, however, and the next section presents a rationale for studying older Punjabi women.

### **Older Punjabi Women**

Throughout the history of India, customs and cultural practices have had and still have a strong influence on the social and political life of the population (Booth, Taylor, & Singh, 2007). The social caste system in India is still practiced today, and escaping traditional customs and standards is extremely difficult for women. From experiencing discrimination, the ability to reach better opportunities (whether economically, socially, or mentally), and empower themselves within not only their households, but also in a

village, or even in the community (Booth et al., 2007). Moreover, India is a large country with many states, which may differ from each other. The northern state Punjab is extremely patriarchal, making it difficult for females to feel their voices are important in society.

Punjab has an unequal population of females to males (Booth et al., 2007), with more males than females. This is linked to the patriarchal culture practiced in this northern state. Because Punjab is a patriarchal state, the son is viewed as a permanent member of the family, whereas daughters are viewed as a temporary family member until they are married to their husband (Booth et al., 2007). The understanding of daughters being a temporary family member influences the distribution of land and properties because it is traditionally inherited by the sons. The declining sex ratio of females to males becomes problematic greatly in Punjab because the main occupation is associated with the agriculture industry (Booth et al., 2007). As a result, women experience pressure from their husbands and their families to birth sons. Another unequal treatment women from Punjab experience is limited access to health care. Early marriages, limited education, and low status in their households are all just a few examples the hardships many Punjabi women experience throughout their life course (Booth et al., 2007). The cultural customs become deeply ingrained in these women, making it hard for them to speak openly about any distress they may be feeling, even after immigrating to a Western society where male and females are viewed more equally, and even though Sikhism practices equality among men and women.

Individuals from Punjab represent a large proportion of South Asian immigrants in Canada (Statistics Canada, 2016a). The first arrivals of Punjabi immigrants to Canada,

more specifically to British Columbia, were in 1904 due to the appeal for agricultural labourers. During that year, Canada admitted 2124 Punjabi immigrants (Koehn, 1993), and over time, the population of Punjabi immigrants steadily increased predominately throughout Port Moody, Vancouver, and Victoria (Koehn, 1993). Although Punjabis have lived in Canada for over a century, there is still limited knowledge about the aging experience of older Punjabi immigrants in Canada (Koehn, 1993), and more specifically women. With the rise of Punjabis in Canada, there is still limited research on what mental health is in the Punjabi culture and the way Punjabi people perceive their mental health (Jhangiani, 2011). For example, research has focused on the perceptions of aging in Canada of women who were primarily well-educated and Hindu women, living in the West coast (Koehn, 1993).

Education played a large role in the inequalities older women experience in Punjab, India (Jhangiani, 2011; Prakash, 1991). Educational attainment decreases age-specific rates of morbidity, disability, and mortality, but older Punjabi women have elementary level literacy rates or are illiterate (Jhangiani, 2011). Over 76% of aging immigrant Punjabi women who were living in British Columbia were found to have no formal education, compared to 44% of men from the same research study (Koehn, 1993). The low literacy rates for Punjabi women is a reflection of their role in society, which involves them serving the needs of a patriarchal culture, performing domestic chores, and fulfilling their social obligations (Jhangiani, 2011). These experiences are recognized as low social status, discriminatory practices, and poor attention to health, and are responsible for overall poor health of older women from the Punjabi culture. Without educational attainment, many females can be subjected to facing inequalities throughout

their lives (Bengston & Settersten, 2016). Prakash (1991) noted how many illiterate older women experienced poor mental health because of the heavy dependence they had on their families and the cultural stigma associated with speaking publicly about mental health. Although immigrants in Canada often have higher levels of education than the norm of their country of origin, this is not the case for older immigrants, more specifically for immigrant Punjabi women (Jhangiani, 2011; Prakash, 1999).

Poor education levels affect one's health and their ability to access and use particular health care services (WHO, 2018). Limited knowledge and education has a direct effect of how Punjabi women describe mental health problems. For instance, Jhangiani (2011) found that the Punjabi term *paagal* was referenced to describe poor mental health. The translation of this word is "crazy" and is viewed as a derogatory term. Individuals from the Punjabi culture tend to feel insulted if their mental health is questioned and is discussed with outsiders due to the cultural stigma associated with mental health problems (Jhangiani, 2011). As a result, Punjabi women are typically considered as the foundation of culture and honor and seeking help for their mental health problems or openly speaking about their mental health problems would not only impact how they are perceived by society, but also how their family would be perceived (Jhangiani, 2011).

Only a few studies have looked at aging Punjabi women living in Canada. Research from the 1990s indicated that they felt culturally isolated or were living like prisoners in their children's homes (Koehn, 1993). Many of them referenced that they wished to return back to Punjab to die (Koehn, 1993). *Izzat* was reinforced on older Punjabi women because speaking publicly to health care providers or outsiders of the

family may result in bringing shame and dishonor to the family name. Rather, they turned to religious agency and prayer as a coping strategy (Koehn, 1993). Old age in the Punjabi culture focuses more on the cultural and spiritual process rather than the biological process. For instance, old age is recognized to be a time of self-reflection and fulfillment, with a focus on spirituality. Some aging Punjabi women referenced that it was part of their *kismet*, or destiny to feel depressed because of their karma (Koehn, 1993). It is vital to recognize that many of these older Punjabi women did not understand that they were suffering from poor mental health and did not recognize what was happening to them as a medical health issue.

Additionally, older Punjabi women who immigrate to Canada many not be aware of available health services (Jhangiani, 2011; Koehn, 1993). For instance, sponsored seniors have shown to have a lower awareness of health services than those who immigrate independently. Thus, their mental health is jeopardized after immigrating to Canada because they are unable to communicate with the broader society and are socially isolated (Koehn, 1993). By joining their children in Canada, many older Punjabi women felt as if they lost their independence (Koehn, 1993). Adjusting to the Western lifestyle in Canada and limited English are a few examples how their perceived mental health can become heavily affected (Koehn, 1993).

Limited Canadian research exists on the mental health of older Punjabi women living in Canada, more specifically, living in provinces like Nova Scotia. Research on ethnic seniors living in Vancouver in the early 1990s highlighted the issues concerning older Punjabi women's mental health living in British Columbia (Koehn, 1993). A few Masters theses and PhD dissertations have studied immigrant Punjabi women living in

Canada but have not been published, however they are publicly accessible through institutions such as Simon Fraser University. These studies mainly focused on Punjabi, Sikh women from the ages 24-50 who were living in British Columbia, Montreal, or Ontario. Agarwal-Narale (2005) focused generally on South Asian immigrant women, ranging between the ages of 25-45, and living in Montreal. The majority of the studies conducted on Punjabi women researched younger women, domestic violence, and their experiences of living in metropolitan cities throughout Canada.

### **Conclusion**

This literature review examined immigration trends in Canada, the experiences of immigrant South Asian women, and the mental health and well-being of older Punjabi women who have immigrated to Canada from India. The current body of literature largely focuses on the mental health of Canadians and more specifically, Canadian women, but little research focuses on the mental health and well-being of aging Punjabi women, and nothing has looked at Nova Scotia. Given Nova Scotia's policy focus on increasing immigration, there is a need to support immigrants who are from Punjab, India. As a result, the research focuses on how older immigrant Punjabi women living in Nova Scotia define their mental health and well-being and their experiences.

## **Chapter 4: Methodology**

This chapter discusses the methodology. The design of the research study is described in the first section, followed by an overview of the sampling procedure. The third section describes the data analysis, and then I explain my positionality in the fourth section. Ethical considerations of the study conclude this chapter.

### **Design**

A qualitative design was used, as the goal of this study was to understand the participants in the study, the events, situations, and actions they were involved with, through their lived experiences (Maxwell, 2008). Although this type of design is often influenced by personal goals and experiences, it is important to study such topics for other people through practical and intellectual goals (Maxwell, 2008; Richards, 2014; Richards & Morse, 2012). Studying the lived experiences is often helpful when focusing on the practical goals of providing insight to a situation and the intellectual goals when trying to gain insight to understand a specific reasoning (Maxwell, 2008; Richards, 2014). Through this design, I was able to understand how the participants in this study made sense of their understandings of mental health and well-being and how it affected their experiences.

The analysis was informed by a social constructivism paradigm, which states that knowledge is socially constructed through the interaction between individuals and their social world, and through this paradigm I was able to understand the authenticity of the participants (Golafshani, 2003). Engaging in research that probes for deeper understanding allowed me to understand the realities that people experience throughout their lives (Golafshani, 2003; Richards, 2014).

Data was collected with semi-structured interviews, using an interview guide with specified questions, and probes, constructed in English (Appendix A) and Punjabi (Appendix B) (Allen & Goldberg, 2015; Golafshani, 2003). Because personal narratives are complex and contradictory, such experiences are often best captured through the exchange between interviewees and interviewers (Allen & Goldberg, 2015). Similarly, this method for data collection was appropriate for this study due to low levels of literacy found in India among the aging population, as they may not be able to complete surveys or questionnaires (Census India, 2011; Prakash, 1999). By completing qualitative interviews, participants were able to describe what they experience verbally in English or Punjabi without any language or literacy problems. Questions explored four topics: (a) migration experience, (b) life now in Nova Scotia, (c) cultural issues the participants have experienced, and (d) their perceived or self-reported mental well-being. Examples of specific questions are “After your arrival in Canada, how did your life change?”, “How do you feel about living in Nova Scotia?”, “How do you feel about life these days?”, and “How would you define mental health?”, which was further probed by asking “What is your understanding of good mental health?”.

Before the interviews took place, participants were given an Informed Consent Form (Appendix C) to review and sign. They were provided with a copy of the form in either English or Punjabi (Appendix D), and after reading, consent could be given either with a signature or a thumbprint (the latter for those unable to write in English or Punjabi). All of the women, however, gave written consent. Participants were also given an opportunity to ask any questions about the research study before the interview began, and my contact information was provided in case they had any additional questions.

Four interviews took place in the women's homes, as they insisted for me to come to their home and some were experiencing transportation issues. These four women had prepared *cha* (tea) and a meal for me, representing the hospitality in the South Asian culture. I brought a box of sweets with me to each woman's home, because in the South Asian culture arriving empty handed to a person's home is often viewed as disrespectful. Before the interviews began, the participants and I generally spoke about culturally relevant topics, which helped them feel comfortable before the interview questions were asked. All of the interviews were conducted in Punjabi and later translated to English by me. Two participants were able to speak in English but chose to be interviewed in Punjabi because they felt more comfortable with speaking in Punjabi. I also interviewed one participant over the phone because she lived very far away.

### **Sample**

Participants were Punjabi women aged 65 and over living in Nova Scotia. They had to be living in Canada for a minimum of one year and currently residing in Nova Scotia. The initial desired sample was between 6-12 women, a number identified necessary to reach saturation (Allen & Goldberg, 2015; Guest, Bunce, & Johnson, 2006; Sandelowski, 2001); however, I was only able to recruit five women who were willing to speak to me. Because of the small Punjabi population in Nova Scotia, it was difficult to recruit participants who matched the description of the study. Moreover, speaking publicly about one's mental health and well-being is relatively difficult for women from the Punjabi culture due to the patriarchal nature of the culture; some women may have found the study too personal and some women were not allowed to participate by their husbands.

A convenience sample was used. Participants were recruited from the local Sikh Temple and the Hindu Temple on scheduled prayer days in Halifax, Nova Scotia. These are the largest temples in Nova Scotia and they are associated with the Maritime Sikh Society and the Hindu Temple-Vedanta Ashram Society. I asked permission from the Maritime Sikh Society and the Vedanta Ashram Society if they were willing to accept me as a researcher into their community. I introduced myself to the community in the Sikh Temple and the Hindu Temple in order to help make participants feel comfortable about my study. A research poster was displayed on the community bulletin board at both places. This poster was written in both in English (Appendix E) and Punjabi (Appendix F).

Because I am a Punjabi woman, I thought that the women who would be recruited for my research study would feel comfortable participating. However, my positionality was also a limitation because some participants may have felt ashamed or embarrassed to voice the issues they were facing because I was from the same culture. Allen and Goldberg (2015) have noted that interviewing someone who is from the same culture as the researcher can result in implications for the interviewee-interviewer relationship. For instance, the older Punjabi women may have not revealed things to me because they worried that it could jeopardize their reputation held within the Nova Scotian Punjabi community. Anticipating this, I reminded them about the confidentiality that would be applied within the research process, and I assured them that their identity would be masked throughout the study. However, the interviews were short; on average they lasted approximately 25 minutes, and this may have reflected their discomfort with talking openly about the subject matter to a younger woman from their community.

If there was a need to follow up with participants, I was able to contact them again, however I chose not to because I felt that further contacting the women could have caused discomfort, especially because one of the women commented that the topic was very personal.

Because names in the Punjabi culture are unisex, they typically are more masculine, participants were given a traditional female middle name for gender differentiation. For pseudonyms, the women were given an alternative first name and then all given a middle name recognized as Kaur, meaning princess in Sikhism. Attaching the middle name Kaur for each participant highlighted respect for the older Punjabi women that participated in this study. Also, because two of the women were baptized Sikhs, I thought it was critical to reflect Sikh values of equality, strength, social justice, and empathy that are all held within the middle name Kaur. Providing the middle name Kaur provided an additional layer of cultural sensitivity.

### **Data Analysis**

Audio recorded interviews were imported into the MAXQDA qualitative data analysis software (version 2018) where they were transcribed, translated, and analyzed. I used a number of features in this program, primarily the coding functions, memo writing, log book entries, the retrieved segments functions, and set functions. First, I regularly updated MAXQDA's log book, which provided an audit trail. Second, I used the coding function to carry out open coding on the data. This process allowed me to identify categories found in the data and helped organize the codes. Memos were created for each interview, keeping track of basic characteristics of when the participants immigrated to Canada, how long they have been living in Nova Scotia, their educational attainments,

age, and marital status, and any key information about their interview, including field notes. Memos were also assigned to key codes to provide definitions of them. The “activation” function allowing me to view the data within the retrieved segments window, looking at all of the coded segments from one code at the same time. This allowed me to identify themes in the data and I was able to start making meaning of the data. As I identified themes in the data, I created “sets” in the code system window to keep track of the codes that applied to each theme. For each theme, a free standing memos was created to describe the theme. Finally, the code matrix browser was used to check the coding across the interviews (e.g., to check if a code occurred in all five interviews or just in one or two).

### **Researcher’s Positionality**

Given that I am from the same culture as my participants, I feel it is important to provide some information about my own positionality. I was born and raised in Canada from first generation parents, and as such I have been subjected to stigmas and stereotypes that are enforced in the South Asian culture. Speaking publicly against mental health problems and protecting the family reputation are just a few stigmas and stereotypes I was exposed to as I was growing up. My cultural awareness of immigrant experiences is based on my own experience of growing up in the Punjabi community. My skills in the Punjabi language provided useful background knowledge.

I recorded my personal thoughts and reflections throughout the research process in a reflexive journal, and a few of these reflections are included in Appendix G. As a feminist, this journal highlighted my thoughts, values, and assumptions, and it was critical for me because of my personal connection with the research (Ahern, 1999). For

instance, I believe that the Punjabi culture has a greater effect on the views on mental health rather than the Sikh religion. As a result, the reflexive journal helped articulate my personal experiences and how it may have shaped my ideas about mental health issues and how it is talked about in the Punjabi culture.

### **Ethical Considerations**

This study began after receiving approval from Mount Saint Vincent University's Research Ethics Board. Participants could have been at risk of anxiety and embarrassment due to the focus on the study. These risks were managed by providing them with information regarding the research study's purpose prior to their participation. The women signed an informed consent form before beginning the interview, which was written in English and in Punjabi. They were also informed that they would be able to withdraw from the study at any moment. Participants were told they did not need to answer any questions throughout the interview that could cause any discomfort. Participants were provided with potential contact information for resources that would be able to assist them with services that are available in Nova Scotia to help ease their transition in Canada. I hoped that by providing this information I would be able to help distribute knowledge of programs and services that are culturally component for aging immigrants.

Participants were assured of confidentiality by using pseudonyms in transcription and having all computer files of data stored on a password protected computer. The interviews were confidential as one's reputation in their community is heavily dependent on the woman (Jhangiani, 2011). The data was further protected by having the MAXQDA file password protected.

## **Chapter 5: Findings**

In this chapter, I first describe the sample and then present the data in three themes. The first theme explores the challenges experienced by the older Punjabi women after immigrating and the second theme discusses how this particular cultural group defines mental health. Lastly, the third theme examines the understandings of what can help improve older immigrant Punjabi women experience of living in Nova Scotia.

### **Sample Description**

Five women with ages ranging from 65 to 68 were interviewed. All of them were born and raised in Punjab, recognized as the northern state of India, in rural villages. Although only five women (identified here as Rani Kaur, Manu Kaur, Billo Kaur, Jassi Kaur, and Nimmi Kaur) participated, there was variation in education levels, reasons for immigrating to Canada, the age at which they immigrated to Canada and Nova Scotia, and their living arrangements. Three of them immigrated to Canada from Punjab, India through the Family Class Sponsorship Class, where they were sponsored by their children, whereas two of the women immigrated to Canada in early 1980s through the point system immigration program. Residence in Nova Scotia ranged from two years to 30 years and two women expressed that they had originally immigrated to another province in Canada, and then resettled in Nova Scotia due to employment opportunities. Three of the women lived with their married children and were financially dependent on them. Three of the women were still married (of these, two lived with only their husbands; their children had moved out of the province), and two had been widowed for more than a decade. The other two women were widowed and lived with their adult children. One woman was receiving pension and another woman was currently still

working full-time. The other women were not eligible to receive pension, but they were unable to obtain employment.

Two of the women were able to speak English, and one of them noted that she had attended English as a Second Language (ESL) school when she first immigrated to Canada. However, of these two women, only one of them spoke some English throughout the interview. She would at times state sentences in English and then would translate those sentences into Punjabi to help express herself. The other three women expressed that they had no English language skills and were unable attend their doctors' appointments without their children present. Also, all the participants appeared to be in good physical shape and were able to live independently with their families. None of them required any physical assistance with regards to their health and all of them wore traditional Punjabi clothes.

These women regularly attended the Maritime Sikh Temple in Nova Scotia and three of the women were good friends with each other. Although just two of the women were baptized Sikhs, all five women discussed how important Sikhism was to them as they regularly prayed and attended the prayer services at the Sikh temple in Nova Scotia.

### **Having Freedom Yet Not Being Free**

All of the women talked about having freedom in their daily lives, yet they described incidents where they did not feel independent while living in Nova Scotia. A variety of challenges were discussed regarding their lives and majority of the women did not feel fully independent because they were financially dependent on their family members. Even Billo Kaur and Nimmi Kaur, who both immigrated to Nova Scotia in the 1980s, still did not feel free in Nova Scotia.

Rani Kaur, Manu Kaur, and Jassi Kaur immigrated to be united with their families and were brought to Canada through the Family Class Sponsorship Visa. All three of these women expressed the importance of being close and united with their family.

My life there was great when my children all lived under one roof. I had my son, daughter-in-law and also my granddaughter with me. With all of them with me I felt *happiness*. But when they left to come to Nova Scotia to settle in before I would join them, it found it very difficult. I felt so alone and it was really hard. Without your family, there is no home. I can't even describe what I felt at that time. It was really hard but now that I'm finally with them again, I feel complete [laughter]. Even though I was working as a teacher in India and I kept myself busy, I still missed my family a lot. (Manu Kaur)

Manu Kaur expressed the importance of family and how being united with her family brought her great happiness. She explained that it became very difficult for her to live without her children and granddaughter because her happiness came from living in an intergenerational home. Although Manu Kaur, Rani Kaur, and Jassi Kaur gave up their careers and relationships in Punjab, immigrating to Nova Scotia was very important to them because being united with their families played a significant influence to live under one roof as a family unit. In contrast, Billo Kaur and Nimmi Kaur immigrated to Nova Scotia for economic and social reasons.

Ok, [in] Canada we were hearing about it in India that the life is *a lot* easier in Canada. I didn't know what was actually over there [referring to Canada] because in my student life my life was very easy, it was very comfortable but when I came to Canada, I had a lot of responsibility for my whole family. I have a big family—

my in-laws had a big family to sponsor so I had to do something because I was educated but I could not because me and my husband needed to sponsor his family and we needed money. The life is very hard here and I don't want to do work in the sewing factories but I had to. That is why I'm not so successful in this country.

(Nimmi Kaur)

Nimmi Kaur spoke about what her hopes and expectations in coming to Canada were going to be. She anticipated a better lifestyle and standard of living because she was immigrating to a developed country, and these views and assumptions of Canada were formed from what she had overheard from friends and family from her village. She acknowledged that her expectations after immigrating to Canada were tarnished as she expected to live a better life, the ability to find a job related to her education in India, and improved educational opportunities for her family. Rather, she experienced great hardships after immigrating to Nova Scotia because of the pressure to sponsor her extended family from Punjab. Although all of the women willingly immigrated to Canada for their families, they all also expressed concern regarding the hardships they had experienced in Nova Scotia.

All of the women talked about how they cooked and cleaned for their families and very much enjoyed taking care of their families by completing the daily chores in the home. They also spoke about how their daily routines which mainly involved staying within the home and doing household chores, giving them a sense of control over their daily schedules.

I also like to clean my house and take care of my children. When they were younger I used help get them ready and send them to school and then make sure they have

food for when they come home. For my husband as well, I needed to make sure that I had his lunch ready for when he went to work, for when he came home or when he would leave—that work all I had to do. (Billo Kaur)

Similarly, Manu Kaur stated, “When I’m here [Nova Scotia], I can see my children and talk with them and make food for them, which I enjoy doing for them”. However, although the women had freedom while living in Nova Scotia regarding what they want to do throughout their daily routines, they appeared constrained when they wanted to leave their homes. Three participants discussed their discomfort when wearing their traditional Punjabi clothes out in public in Nova Scotia.

I like it here but when other people stare at me I don’t feel comfortable. Like there is a saying “*thesa desh, vesa bas*” [the type of country you are living in, you have to adjust yourself and act like how everyone else is in that particular environment] and I don’t like that because I like wearing my Punjabi suit and I feel comfortable in it. Like for my children, for them to assimilate, it wasn’t that difficult for them but for me at the age I am, it’s very hard for me you know? Like I don’t like it when I go in public wearing my Punjabi suit and everyone is just looking at me. My husband wears a turban and I wear my suit and I sometimes feel like the people here don’t like that we wear these types of clothes. It makes me feel like these people here don’t like my culture. Because my children had to come here for work, it’s been hard for me to adjust at times. (Manu Kaur)

Manu Kaur discussed how she had been wearing the traditional Punjabi clothing from a young age and did not feel comfortable wearing Western fashion. Although Canada practices equality and provides the freedom for different cultural groups to wear

their preferred cultural clothing, these women still expressed limitations of them feeling comfortable walking around in public in Nova Scotia wearing Punjabi clothes. Three participants expressed that at times they did not feel like they were accepted in Nova Scotia due to their cultural heritage and clothing choices. Billo Kaur, Jassi Kaur, and Manu Kaur all reported discomfort of wearing their cultural clothing in Nova Scotia. One had thought about changing her attire to Western clothes entirely after immigrating but felt uncomfortable wearing Western fashion. Their personal freedom was limited because they did not feel comfortable leaving their respective homes when wearing their Punjabi clothing.

Moreover, they expressed discomfort in not seeing any visible representation of themselves in society. “That sure is one thing is that lacking, that there’s not enough of our people here—meaning people who can speak to in our language” (Rani Kaur). Having difficulty connecting with other people after immigrating due to the language barriers was also an issue. Rani Kaur, Jassi Kaur, Manu Kaur, and Billo Kaur all mentioned their hardships of speaking English, which they saw as not only limiting their freedom to go out but also resulting in feeling alone at times.

I don’t talk to anybody. I have no friends, only my husband, that’s who I’m closest to. I speak very openly with him but he doesn’t listen to me [laughter]. This is how our family is—I mean like my family, sorry the gents even like my son \_\_\_\_\_ or \_\_\_\_\_, I don’t know, all the husbands in my family and my brother, I think they don’t like to listen to the ladies’ complaints [laughter]. Because I actually complain a lot [laughter] but I want to explain to my husband but he doesn’t want to listen. Sometimes he’ll put his headphones in and he’ll go

on YouTube and sit there [laughter]. Even when he's working and he'll come home from work, I'm waiting for him and I want to ask him if he wants a cup of tea and that I was waiting for him but he's already on the YouTube and he'll put the earphones in his ears. (Nimmi Kaur)

Nimmi Kaur expressed how alone she felt in Nova Scotia and did not have many people in her life that she can socialize with. Similarly, after immigrating, Rani Kaur also spoke about how it was hard for her when she moved to Nova Scotia because she was not able to communicate to other Punjabi people and felt alone. Because of the low Punjabi population in Nova Scotia, some of the women discussed that it made them reminisce about their lives back in India.

In relation to the women having limited to no English language skills, most of them were dependent on their family members to attend their doctor's appointments. Because four of them were not able to drive, they were dependent on their family members to take them to appointments. Manjit Kaur expressed the hardships of attending her doctor's appointments because she had to ask when her children were available before she could book the appointment. In addition to the transportation issue, they also felt reliant on their family members to socialize and even attend their scheduled appointments because they needed someone to translate their symptoms to their doctor.

Sometimes it's been difficult because I'm not able to tell the doctor what pain/hardships I'm feeling. I had a sinus problem and when I came here it was in December and it was really cold outside, and especially since I came from a place that had warm weather—and coming here, the weather doesn't always fit well and I started having a sinus attack and when I went to the doctor, he wasn't able to

understand what I was trying to say. I was telling him “I’m having pain here. Over here it hurts” I don’t want to say that my condition was very bad but I wanted to know how would it stop here and he wasn’t able to totally understand what I was communicating. I felt like—I was telling my daughter and she was translating it to the doctor and I feel like I can’t ever go to the doctor by myself, if there’s someone here with me then my condition can be described, I can’t do it by myself. (Rani Kaur)

Rani Kaur also communicated how difficult it would be discussing her mental health with her doctor because she would not know if the Punjabi terminology would be translated into English. Even though Billo Kaur and Nimmi Kaur were able to speak English, they both still had a very hard time expressing their health to their Nova Scotian doctors. As a result, three of the women mentioned how they obtained medication from India, even though they had been living in Nova Scotia for at least a year.

Plus, I don’t understand what medication I will be taking if the doctor did give me a prescription. If I had an Indian doctor, I could explain my health and the history of what type of medication I used to take. That is the biggest thing lacking for me and I feel like the medications here aren’t as strong as they are in India. (Jassi Kaur)

Jassi Kaur was one of the women who voiced the independence she lost when immigrating to Nova Scotia. She mentioned later that she was going to travel to Montreal and was going to visit a Punjabi speaking doctor because she wanted to discuss and understanding the type of medications she was taking.

Overall, all of the women identified at least one negative experience of not feeling completely free after immigrating to Nova Scotia. For many, their dependence on others affected how they accessed services. Language issues were a barrier, even for the women who were able to speak English—they both expressed hardships in speaking English when expressing their health to their health care practitioners.

How women understand mental health and communicate about it is also an issue of concern. They were not free to discuss their mental health due to the taboo when speaking out about mental health. Instead, all of them stated that their understanding what good mental health was revolved around having a happy family, which the next section describes.

### **Defining Mental Health as Having a Happy Family**

Although mental health is a stigmatized and taboo topic to discuss to members outside of one's family, all of the women stated that their mental health was good. However, to them, good mental health related to how positive their interactions were with their family members. All of them responded by stating how one's relationship with their family unit could affect their mental health.

Mental health revolves around having good health and not having any tension about your family or worries like I have a little granddaughter who is three years old and I find happiness with her. Every day from morning till evening, I spend all my time with her. The biggest happiness—the main happiness I get is from my children. I wanted to tell you that I live very happily with my family and my mental health is good only because of my family. (Manu Kaur)

Moreover, they saw good mental health not only revolving around the family structure, but also including the ability for their children to financial care for themselves. Four of the women did not hesitate to state that their mental health was relatively good because their children were doing well in life.

Mental health means that the mind is very happy and that you don't have any worry. Like for me, my life has been a blessing and it's been very good. You know, that's what mental health is, if you have your children and they're able to stand on their own two feet and are able to support themselves. I don't have any *dukh* [hardships] about anything. All my children—all four of them, including my daughter, have children and they're all working after getting their education. I don't have any stress for them if they have enough money or not, it's great. I'm thankful for God, you know my daughter, that God has allowed me to see my children doing well and my grandchildren. I feel like I have a lot of *ash* [fun] in my life. I always tell my kids, let's eat good food and spend time with each other.

(Jassi Kaur)

Similar to Jassi Kaur, other women mentioned how their mental health was better since being united with their families in Nova Scotia. The connection between good mental health and family were very much associated with each other for these women. Some of them discussed that they lived happily with their children and also enjoyed cooking and cleaning for their children. However, these ideas about good mental health caused Rani Kaur confusion when she was experiencing health problems after immigration.

When I was in India I didn't have a blood pressure problem but when I came here my blood pressure went up and everyone started saying to me "you're having tension" and I told them that *I'm not understanding* [why] would I even have tension about because I'm here with my kids and I'm happy? But still I'm not sure what's affecting me and that's causing my blood pressure to increase. (Rani Kaur)

Rani Kaur was confused as to why she would experience high blood pressure because she was happily united with her family after immigrating to Nova Scotia and regularly tended to her children through cooking and cleaning tasks. She expressed that she had never had this health issue while living in India and noted that she was asked by other people in the community if her children were treating her well. She made it very clear that she was extremely happy to be united with her children and felt confused as to why she would experience high blood pressure. Similarly, Billo Kaur discussed how important it was to *ignore* negative thoughts in order to have good mental health. Seeking treatment or visiting a doctor regarding one's health problems were not even considered by either of them.

You need to go outside and go for a walk, then you need to push yourself from thinking bad things that you will have a problem or your health will be affected. You need to ignore those bad thoughts. You need to stay as happy as possible. (Billo Kaur)

Definitions of mental health and well-being in the Punjabi culture were captured throughout the interviews with the older immigrant Punjabi women. Mental health was associated with caring for others, specifically for their family members. All of the women referenced that they very much enjoyed completing domestic chores for their families.

Four of the women spoke about how they regularly tended to their families through various forms of household tasks, and that they enjoyed this.

Basically I like living with my children—being around my children brings me a lot of happiness. My children left and I was living alone and *jee nai langtha* [I felt alone]. When I'm here, I can see my children and talk with them and make food for them, which I enjoy doing for them. (Manu Kaur)

Manu Kaur and the majority of the other women described how they enjoyed taking care of their families, which ultimately brought them happiness. The enjoyment of cooking and cleaning may be due to the gender specific roles these women were exposed to when they were growing up in Punjab. Because they have been the primary caretakers of their families for many years, it was not surprising that they stated that they enjoy doing domestic chores for their families.

Nevertheless, although the women characterized good mental health with having a happy and stable family, Nimmi Kaur referenced how it was a difficult question for her to answer because she was unable to find the correct words to describe what she felt the definition of mental health was. Nimmi Kaur and Billo Kaur both mentioned in their interviews that mental health is stigmatized in the Punjabi culture and there needed to be a greater emphasis on speaking publicly about it.

[The] main thing is your children. If they don't listen to their parents, then it becomes difficult for people to speak to others and also your family. If someone's husband drinks too much that can cause so many problems for the wife because she won't be able to share that with the public. Also there is a problem if you don't have much money, you can't go and tell other people about and also people

aren't going to listen to this to help you, they're going to listen and tell other people. This becomes really difficult to share and then you're left with dealing with all these feelings within you and it's very hard. (Billo Kaur)

Billo Kaur and Nimmi Kaur further communicated the importance of developing trust with health care professionals and other people in the Punjabi community when discussing mental health. Billo Kaur emphasized how it is important to make people feel comfortable to share when particularly voicing mental health problems because it could affect their family's reputation held within society.

Even health care workers need to form some type of friendship with us older Punjabi women because that's the only way we will feel comfortable telling the truth of what is happening. We are scared because we want to keep these things like a secret and don't want it to leak out to other community members. (Billo Kaur)

Although the women were all asked how the Punjabi community views mental health, Billo Kaur was the only participant who highlighted the difficulties Punjabi women experienced.

They think mental health for women is about the fact she has problems in her home and that these women are making a bigger deal out of nothing. But for this, there needs to be a step taken to stop these misconceptions. We need to educate people on this and help them. (Billo Kaur)

Billo Kaur and Nimmi Kaur were the only participants that spoke about the hardships when speaking publicly about mental health in the Punjabi culture. Interestingly, they both had been living in Nova Scotia for over two decades and

communicated how they did not have anyone they could speak to about how they were doing. Instead, they relied on prayer as a form of hope for their mental health. All of the women prayed every day. Nimmi Kaur, however, was the only woman to state that when she felt extremely sad, she sometimes did not feel like praying. Generally speaking, the women used prayer as a way of coping when they were experiencing any difficulties.

Sandeep, you know the life is a struggle right? When we listen to Gurbani [hymns], even there in our prayers its written that every person has some kind of *dukh* [hardships]. Like this sentence in Gurbani states “*Nanak dukhah saab sanar, oh sukhah en nam uthar*”, anyone that prays and the support they may get, they may also feel *dukh*. Our Guru Nanak [one of the teachers in Sikhism] has said that everybody feels *dukh*, even people who are rich! Every person, my daughter. No one is *sokha* [easy], unless they pray because they understand that *dukh* are a part of life. The state of mind becomes very strong when you’re connected to God and start understanding *dukh* as not *dukh* but a part of life. That every life has challenges but only a few people are understanding this and are kind in this world.  
(Nimmi Kaur)

Nimmi Kaur expressed the importance of believing in God and that the hardships people experience is a part of one’s life journey. Praying brought calmness and peace to all of the women. However, even though all of them dealt with their hardships individually, they expressed a desire to connect with other Punjabi women who were similar to them in age. Furthermore, all of them stated that they would want to connect with other older Punjabi women outside of the Sikh Temple in order to build friendships and discuss such stigmatized topics, which is discussed in the final theme.

**Wanting to Connect with Other Older Punjabi Women in Nova Scotia**

The religious temples in Nova Scotia provided an important opportunity for the older immigrant Punjabi women to connect with other women in the community and preserve their culture. Four the women regularly attended the Sikh temple. Even though the location of the Sikh temple was quite far from where Jassi Kaur lives, she stated that her children made it a priority to drive her to the temple. Most of them attended the Sikh temple not only to connect with God but also to socialize with each other and talk about culturally relevant topics. Attending the religious ceremonies on Sundays provided peace and a chance for these women to pray as a group. Importantly, it was also the only location where these women could socialize with each other. “And like every Sunday we go to the Gurdwara [Sikh Temple] and I spend time talking with some of the older Punjabi women there too. I feel like it’s relaxation—therapy you know?” (Manu Kaur).

Like Manu Kaur, Nimmi Kaur also stated that a lot of the older women who attend the religious services only attended because they knew they could socialize with each other there. Connecting with other Punjabi women similar in age was very important to Billo Kaur as she expressed how she enjoyed spending time with the women at the Sikh temple.

I do actually do both. I also go to the temple [Gurdwara] and I do *sava* [volunteering] and that helps bring peace to my mind with the other older women too. We talk to each other and it brings my mind peace you know? (Billo Kaur)

Nimmi Kaur and Manu Kaur voiced the importance of connecting with other Punjabi women because it would remove any language barriers and they would be able to relate to one another regarding cultural understandings. Rani Kaur, Jassi Kaur, and Manu

Kaur all stated how important it was to remember the Punjabi culture and associate with one another after immigrating to Canada because at times they felt isolated.

To help me...well the few Indian families that do live here, it would feel good if we had a place where we could see each other outside of the *Gurdwara* [temple] to talk about our *dukh* [hardships] and *sukh* [happiness]. Since the white people here don't acknowledge us, we have to help each other here. They say "ok, thank you, bye" and they leave so we have to rely on each other as a community. (Manu Kaur)

Manu Kaur and the other women spoke to how they wanted to preserve their cultural identity and speak with other women in Punjabi.

Punjabi culture is what we are used to. Like people [other than Punjabi people] do whatever they want here but we stick to our cultural roots and the way we understand things. We want to keep our culture no matter what. (Jassi Kaur)

Because there was no community centre for these women, the Sikh temple was the only place where they could socialize. Although the temple was a great place for these women to connect with each other, this interaction was limited to the half hour after the weekly prayer to spend time with each other. Billo Kaur highlighted how any person would become depressed if they stayed home all day and that attending the temple would allow people to mingle with each other. She spoke about how if the older Punjabi women were able to connect with each other more often and for longer periods of time, they would be able to develop bonds that would allow them to express how they feel and ultimately, this might help them to become more open with each other regarding any hardships they may be experiencing.

I only wanted to say that we need to help each other and we need to come together like us Indian ladies because we find it really hard to open up to others and we need to become a support system for each other and show love to each other. That way us women can speak about what we are experiencing you know and open up with each other and what we are feeling inside you know, if there's family problems or dealing with financial insecurity or problems back in India, we need to think and talk about these things. (Billo Kaur)

Billo Kaur and Nimmi Kaur both described how connecting with other women in the Punjabi community could help stop the stigma of speaking publicly about mental health problems. They stated how this would allow the older Punjabi women to form friendships with each other and confide to one another.

Rani Kaur was one of the participants who discussed the importance of creating friendships with other older Punjabi women in Nova Scotia. Even though her children included her when hosting dinner parties, she still was not able to socialize with women her age and at times felt isolated.

They should create a place where we can get together and that would make us all feel good that we can see each other and see more of our own people. But when we go to a formal get-together with my children, there are all kinds of ages there and it's not always women my age. (Rani Kaur)

Like Rani Kaur, all of the other women voiced how they wanted to socialize with other older Punjabi women in a community centre environment. Nimmi Kaur noted how in larger cities, older Punjabi women have "Kitty Clubs" where they each pay \$100 monthly to cover the expenses of food and drinks. However, she expressed that she

would not be able to afford to attend such an expensive club and that something different needed to be done for the aging Punjabi community in Nova Scotia. She suggested that there needed to be programs in community centres targeted for older Punjabi women.

For instance, our *Gurdwara* [temple] here is planning on making it larger, maybe they could but I don't know how they would do this in the *Gurdwara* [temple] but there needs to be some form of a community centre. (Nimmi Kaur)

It is clear that attending the Sikh temple provided the women a sense of community because they were able to socialize with other immigrant Punjabi women. The Sikh temple thus became a place where these women could share culturally relevant experiences among each other. However, as indicated, the amount of time spent at the temple was limited and may not have met the socializing needs of these older women.

## Chapter 6: Discussion

In this study, aspects of immigration and the understanding of mental health and well-being were explored with older immigrant Punjabi women living in Nova Scotia. The findings highlight how mental health and well-being is understood by older immigrant Punjabi women, and reflects how gender intersects with other social determinants of health such as immigration status, which affects their experiences when living in Nova Scotia. Additionally, this study identifies some of the challenges faced by the older Punjabi women, such as some loss of independence after immigrating due to a heavy reliance on their family members. This chapter discusses the three themes of limited independence, definitions of mental health and well-being, and the desire to connect with women from the same culture and cohort.

In traditional South Asian culture, women are subjected to gendered roles and cultural values (Rao et al., 2015). The intersection of these two factors is seen in how they describe their enjoyment of taking care of their families, through activities such as cooking and cleaning. Older Punjabi women are nurturers and serve their family members through completing household tasks. Gender socialization is demonstrated when one of the women states that from a young age she used to help her mother with cleaning their home and was taught how to cook. Although, Sikhism preaches gender equality between men and women, cultural ideologies are reflected when the women expressed their enjoyment from completing traditional gender roles that are held by the women in the Punjabi culture. Through this learned behavior from their youth, it becomes difficult for women to escape the patriarchal gender roles found in the Punjabi culture and resulted in all of the women discussing how it brought them happiness to care for

their families through domestic chores. Many women from the South Asian culture are taught stereotypical gender roles from a young age (Palakonda & Vishwanath, 2011). Even though two of the women were baptized Sikhs, cultural ideologies of women's roles can supersede their religious beliefs. Contradictions in the Punjabi culture and Sikh religion when discussing gender roles becomes difficult as many Punjabi people believe they are upholding Sikh ideologies in the Punjabi culture. These roles focus on upholding traditions, preserving culture, and lastly being the primary caretaker of their family unit (Choudhry, 2001; Palakonda & Vishwanath, 2011), and these roles do not end upon immigrating to Canada.

Three of the women immigrated to Canada to be united with their children through the family reunification visa. They were sponsored by their children to join them in Nova Scotia due to the cultural practice of caring for aging parents. Eighty percent of immigration in later age is due to first generation immigrants sponsoring their aging parents, living with their sons in a joint household (Choudhry, 2001; Koehn, 1993, Peng & Cassie, 2015). These three women all resided with their sons and their families. Nevertheless, although they immigrated to Canada to be united with their children because of cultural norms, it is difficult for them to be separated from their native social environment. After immigrating to Canada older immigrant Punjabi women experience some loss of independence.

In India, these three women explained that they had independence and freedom because they had careers and were financially independent to purchase items with their own money. The limited freedom after immigrating to Canada may impact their confidence as older Punjabi women because they felt embarrassed asking their children

for money and transportation to go to places. They were not used to asking their children for money, even though in South Asian culture, elders typically manage finances (Choudhry, 2001). Older Punjabi women also miss the large social networks they had in Punjab, India. This is especially the case in old age when one is separated from their cultural and social environments (Choudhry, 1998; Dutt & Webber, 2009; Jhangiani, 2011). As a result, living in Nova Scotia for these older immigrant Punjabi women is challenging in some respects because of the lack of freedom and independence experienced while adjusting to the North American culture.

Because the women lost their daily contacts after immigrating to Canada, they were fully dependent on their families for any form of socialization, and some of them did indicate a desire for additional companionship outside of their family. Immigrating in later age may lead to social isolation for older South Asian women, who experience frustration over the North American values (Choudhry, 2001). Even wearing one's cultural clothing can result in a sense of discomfort being away from one's own culture and moving around one's community. Punjabi women want to preserve their culture as much as possible, however, they feel alienated from mainstream society (Choudhry, 2001; Hossen, 2012; Peng & Cassie, 2015) due to the low representation of themselves in society.

The Atlantic Immigrant Pilot Project aims to increase immigration levels in in Nova Scotia and its nearby provinces. Given this, it is important to understand how immigration, as a social determinant of health, affects the mental health and well-being of older immigrant women. In doing so, relevant supports can be put into place for these new immigrants. Because Canadian immigration policy helps keep family members

together, many first generation immigrants sponsor their aging parents to keep their kin close. Therefore, it is critical to understand this specific aging populations experience as there is a lack of knowledge on how older Punjabi women utilize existing services related to their mental health and well-being.

As stated in the introduction chapter, the WHO (2014) defines mental health as a “state of well-being in which the individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community” (p. 1). Based on these findings, it appears that these women may not be achieving the goal set by this definition. They are unable to make a contribution to their own community because they lack social support outside of their family, confined to only their family members, and socializing opportunities with non-family members appear limited to hourly religious gatherings once a week. Social support is key in helping older Punjabi women build strong social support networks with other women from their community, as it can help prohibit further emotional distress. After immigrating to Canada, the women experienced difficulties living in Nova Scotia, ranging from them wearing their culturally clothing in public to accessing culturally component health care services. Based on the WHO definition of mental health, improvements need to be made in the province to help older Punjabi women feel comfortable living in Nova Scotia. The women are not able live independently and heavily rely on family members for transportation in order for them to attend their doctors’ appointments or when attending the Sikh temple to pray and socialize with other women in the community. It is critical to focus on systematic and organizational barriers that exist for older immigrant Punjabi women accessing health care services for their

mental health and well-being. Through these barriers, help-seeking is avoided due to lack of knowledge and difficulty accessing services (Delara, 2016; Flenon et al., 2015; Ng, 2011).

Language is a central difficulty when accessing health care services. Although two of the women could speak fluently in English, they still prefer to communicate in Punjabi and discuss the difficulties of not having a doctor who spoke the same language as them. Only one participant had access to a Punjabi speaking doctor in Nova Scotia. However, transportation was still an issue when attending her doctor's appointments because of the distance and her dependence on her children and their schedules. Furthermore, some of the women feel that their doctors do not understand their health problems even when their children attend their appointments and translate for them. With language barriers, miscommunication and understandings can occur between the patient and health care professional and ultimately lead to misdiagnoses when working with older immigrant Punjabi women (Jhangiani, 2011). Because there are cultural variations in how people experience mental health problems and how they communicate that experience, it can become problematic. This supports existing literature as it discusses the value of matching ethnic patients with practitioners who are from similar cultural backgrounds (Choudhry, 1998; Dadey, 2007; Delara, 2016; Jhangiani, 2011). Matching non-English speaking patients with a health care providers who speak the same language could allow patients to feel comfortable and understood. There is a need for delivering culturally component care in Nova Scotia in order to prevent potential health care problems gradually affecting aging immigrant South Asians.

Other barriers to achieving better mental health and well-being are long wait times, the Canadian health care system not being culturally sensitive, and difficulty in navigating the health care system (Agarwal-Narale, 2005; Creatore et al, 2012; Peng & Cassie, 2015). These barriers were experienced by these women in various forms. For instance, three discuss the long wait times they experience when scheduling their doctors' appointments and the disinterest they perceive their primary health care provider to have in their health and well-being. As a result, it is important for health care providers to build strong trusting relationships with patients and an understanding of their patients' culture (Jhangiani, 2011).

Trust is an important factor in older South Asian women developing relationship with health care professionals (Choudhry, 2001; Faulkner, 2012; Hossen, 2012; Jhangiani, 2011; Uppal et al., 2014). However, a "problem" has to be identified and acknowledged first in order to then use such services. The women in this study who had been living in Canada for less than five years report that their mental health is good and that they do not experience any major health problems at this point in their lives. It is possible that recently immigrated South Asian women may not be able to recognize distress, should they experience it, because of how they define mental health and well-being. Moreover, they may not be aware of potential local services available to help them or feel hesitant seeking out those resources because of dependency on others to reach those resources. It was notable that the two women who did report experiencing some depression were those who had been in Canada for many decades. The healthy immigrant effect diminishes after five years of residing to the country one has resettled in (Delara, 2016; Flenon et al., 2015; Ng, 2011).

Culture influences the way one views their mental health and their well-being, more so for immigrants. Previous studies found that immigrant South Asian women strongly rely on religious agency and faith as a form to cope with their health because of the understanding that their *kismet*, known as destiny is controlled by God and not by themselves (Peng & Cassie, 2015; Ruprai, 2016; Uba, 1992). In this study, most of the women discussed the importance of praying and attending the Sikh temple weekly. Additionally, such attendance helped the women to connect with other older immigrant Punjabi women living in Nova Scotia, but this was only an event that happened once a week for an hour. Although only two of the women are baptized Sikhs, all of the women voiced how crucial it was attending the Sikh temple.

All of the women immigrated from Punjab, India and brought their cultural roots and religion to help with their settlement in Nova Scotia. In doing so, attending the Sikh temple for the women was a form of preserving their heritage. For instance, Jassi Kaur stated how the temple provided an opportunity for her to connect with her cultural roots. Similarly, Billo Kaur spoke about her own experience of preserving her culture when she would go to the temple because it brought her peace and she was able to volunteer and speak to other older Punjabi women. Having strong family bonds and attending the temple allowed the women to feel like they had control and independence over their lives after immigrating.

Connecting to other women in the community will help South Asian women with their resettlement in Nova Scotia and could also result in them speaking more openly about any concerns or problems. Connecting with other older Punjabi women is critical; it allows them to share their experiences with people who share the same language,

culture, values and experiences. Connecting with other women from their community may also help to build trust and stop the stigmatization of mental health often found in the South Asian culture. As a result, building a community centre where these women could spend time with one another could ultimately help these women socially, which can improve their mental health and well-being after immigrating to Nova Scotia.

Yet, because the importance of family honour, known as *izzat* in South Asian culture, older South Asian women are hesitant in sharing details about their mental health and well-being (Choudhry, 2001), and this was the case in this study as well. Women in the South Asian culture typically hold their family's reputation in society, which can lead to them suffering silently (Choudhry, 2001; Faulkner, 2012; Hossen, 2012; Jhangiani, 2011; Uppal et al., 2014). Consistent with literature suggesting that the understanding of good mental health revolves around having a happy and stable family in the South Asian culture (Jhangiani, 2011), all of the women strongly connected their family life to their mental health and well-being.

This understanding of mental health and well-being limits many South Asian women from speaking publicly about their experiences because of the stigma and taboo associated with this topic (Choudhry, 2001; Faulkner, 2012; Hossen, 2012; Jhangiani, 2011; Uppal et al., 2014). Because family reputation is held by women in the South Asian culture, it becomes difficult for women in this cultural group to communicate their mental health and well-being to people outside of their respective homes. Only one woman spoke publicly about the depression she was experiencing and articulated how difficult it is to speak to the women in her community because she did not have a social support network. Moreover, using the intersectionality feminist framework as a researcher, I was

able to understand the distinct differences and oppression the older Punjabi women experienced while living in Nova Scotia.

### **Reflexivity**

I was born and raised in Ontario to Punjabi born immigrant parents. My parents were born in Punjab and were both raised in a rural village. My mother came to Canada when she was 18 and a decade later she had an arranged marriage to my father in 1982. I learned from a young age the effects immigration can have on people's lives and the hardships many immigrants face. Watching my parents from a young age learn English and provide for my family made me become interested on how this can affect one's mental health and well-being. My curiosity led me to become interested on the experiences of immigration in older age and how it affects Punjabi women because the Punjabi culture is predominantly patriarchal. As a result, being culturally assimilated to the Punjabi culture, it was critical for me to keep a reflexivity journal throughout the research process so I might be able to recognize how my assumptions or experiences could be influencing the findings in the research study (Mortari, 2015).

Writing in my reflexive journal allowed me, as the researcher, to be transparent and alerted me about any potential influence my familiarity to this cultural group may have caused (Mortari, 2015). Some of these entries discussed my struggles during the recruitment process, my feelings after I interviewed participants, my experiences of being born and raised to immigrant parents, and my feelings about being assimilated to the Punjabi culture as an Indo-Canadian woman. In this section, I include some summary points about my general upbringing and how my own experience of growing up in the

Punjabi culture connected me to the participants at times and also the difficulties I experienced when speaking out about mental health and well-being.

My brother and I were raised in a liberal home where we were taught about Sikhism and the Punjabi culture. From a young age I was able to see the differences between religion and culture. My family would worship at the local *Gurdwara* (temple) in our city but we would not classify ourselves as religious. However, attending the prayers on Sundays, I was able to understand the importance religion had on one's social capital regarding how critical it was for connecting with other Punjabi families in the city. It was also a place where many immigrant Punjabi families could obtain general information in Punjabi regarding potential resources without experiencing any language barriers.

Attending the Sikh temple in Halifax for recruitment was critical for me because growing up in a traditional Punjabi family, I knew it would be the best location to recruit older immigrant Punjabi women. I also shared the same ethnic identity and cultural background as the participants from this study, and at times they referred to me as "one of them". They would often use the phrases "you know what I mean?" or "you know how it is" because as women, I was able to understand some of the gender specific topics they spoke out about. I felt more like an insider rather than a researcher or an outsider. However, being an insider during recruitment also had disadvantages (revisited in the limitations section). Although I was knowledgeable about the taboos and stigmas held in the Punjabi culture when speaking out about mental health and well-being, recruiting and interviewing participants from a community that did not know my family background was particularly difficult because of the tight knit Punjabi community in Nova Scotia. My

assimilation within this cultural group was noted in my reflective journal.

I witnessed how much power my last name held within the Punjabi culture. Because my last name is part of the *Jatt* caste, it is recognized as one of the highest castes in Punjab, India (Jodhka, 2002). Most people from this caste are known for owning land and farming. Although the caste system was used as a traditional social order of India (Jodhka, 2002), in Canada, the caste system does not apply to people from the Punjabi culture. It has no relevance to many immigrant Punjabi people because they work in various jobs that are not related to their specific caste. However, I realized quickly during my recruitment process at the Sikh temple in Nova Scotia that my last name gained me access to the Jatt community in the province. It was that moment when I realized how influential culture is in the Punjabi community because for even though the caste system is condemned to practice in Sikhism, it is still widely applied in an informal and subtle way. For instance, most of the women who agreed to participate in the research study were all from the Jatt caste and even one woman mentioned to me that because my last name is Dhillon, she would help me because “you help your own”, as she said to me.

I mentioned to all my participants how I could interview them wherever they feel most comfortable. To my surprise, they all suggested their homes. Before interviewing each participant within their homes, I brought a pound of Indian sweets with me. Growing up in the Punjabi culture, I was taught from a young age the disrespect of going to one’s home empty handed. Bringing a box of Indian sweets was a gesture the participants very much appreciated. The women also all prepared an Indian meal for me, representing the Punjabi hospitality.

Throughout the thesis process, I noticed how topics like patriarchy and immigration began affecting me, and writing in my reflexivity journal helped me process in a personal way the kind of issues I was reading about. I noticed micro aggressions of patriarchy in the Punjabi culture throughout the thesis process and I began paying attention to how cultural traditions and customs affected women specifically from this cultural group. For instance, because most of my recruitment was done at the Sikh temple (i.e., in a public space where many people were present), I noticed how some men at the temple would ignore my announcement and discourage their wives to participate in the study. Even though Sikhism practices equality among male and females, the patriarchal culture is so entrenched into the Punjabi culture that men were still able to influence women from participating in my study.

### **Limitations**

There were several limitations to this study. First, it was very difficult to recruit older Punjabi women. Even though I had been actively involved with the Punjabi community in Nova Scotia for the year preceding the data collection and I gave participants a choice to be interviewed in either Punjabi or English, the personal nature of the topic may also have played a role. Confidentiality was emphasized when speaking to the community about the research study but this may have made no difference for participants to feel comfortable to speak about their mental health and well-being because some found it to be “too personal”. Relatedly, it may have been women who were doing quite well living in Canada who agreed to talk with me, rather than women who might have been struggling more.

Additionally, because mental health was generally viewed as having a happy family life, it may have been difficult for participants to speak about openly about any difficulties they were experiencing as it would potentially jeopardize their reputation and social status within the Punjabi community in Nova Scotia. Probing during the interview was challenging because some participants became uncomfortable; the questions felt very personal to them and may have exposed situations that they did not want revealed. Engaging and probing the women with the content of the study became challenging, especially because they were being audio recorded. Consequently, during recruitment, a few older immigrant Punjabi women declined to participate in the study because they did not feel comfortable being audio recorded.

A second limitation is that only five women were interviewed. A sample size of eight to twelve would have provided more of an understanding of how older immigrant Punjabi women define mental health and how they experience their life in Nova Scotia (Guest et al., 2006). As a result, a larger sample size could have provided the study with more evidence for the themes identified (Guest et al., 2006).

My positionality and related reflexivity was a limitation. Because I am a young Punjabi woman, the older Punjabi women did not always recognize me as a researcher; rather, they took cues from my personal experience and connected to me more as a young daughter or woman. Also, I realized after transcribing my interviews that some of the issues the participants spoke about were shared understandings between them and myself, and I could have probed more often to make sure that we did have the same shared understanding and to gain further detail from the women. However, it was difficult at times to probe participants because I wanted them to view me as a member of the Punjabi

community in Nova Scotia. Moreover, as a younger Punjabi woman, I felt uncomfortable probing the older women. Because showing respect to elders is crucial in the Punjabi culture, I would at times feel as if I was being disrespectful further probing them.

I kept a journal to write about my biases and assumptions but over the course of the study, I realized it was difficult for me to separate my cultural understandings and experiences from the participants when they talked about their experiences and used specific phrases. The majority of the interviews conducted were done in Punjabi and translating cultural understandings from Punjabi to English was another limitation in this study. Languages spoken by ethnic minority groups often have a cultural connection with the language, as some of the terms provide a broad meaning to the word that relate to the facts, objects, and events to people from that particular cultural group (Bradby, 2002; Ruprai, 2016). As a result, translating word for word from Punjabi to English was particularly challenging because at times the cultural meaning of some of the translation did not fit. However, this was not the case for some words like *community* because it required no linguistic or cultural translation. The older immigrant Punjabi women from this study used some English terminology because the terms used in English had a similar cultural understanding in Punjabi. Overall, translating from one language to another, especially translating one cultural group's understanding to English can be difficult but it is a limitation that may miss crucial an emphasis on specific topics when translated to English (Dhaliwal-Rai, 1992; Jhangiani, 2011; Ruprai, 2016).

### **Strengths of the Research**

Although there are limitations to this study, there are also strengths. First, being a Punjabi woman helped because I was able to relate to the participants. Before the

interview began, I was able to help make them feel comfortable because we could converse with each other about culturally relevant topics. Also, I was able to give the older Punjabi women a platform to speak on the difficulties they experience while living in Nova Scotia without any language barriers, and express empathy as a member for the shared culture.

Another strength of the study was the flexibility I was able to provide the participants regarding the times and locations of the interviews. Because most of them had transportation issues, I was able to give them the option of being interviewed in their homes at their convenience, as opposed to renting a room at a public library or a room in the temples. All participants except one were interviewed in their homes and I firmly believe this allowed participants to feel comfortable in their surroundings when talking about their mental health and well-being. Conducting interviews in a person's home also helped reduce power differences between the participants and me.

### **Future Research**

Future research on this topic should focus more on how the social determinants of culture, immigration, social support, gender, and religion intersect with each other to influence older South Asian women's experiences in Canada, with the use of the intersectionality feminist framework. Future studies should focus on questions asking participants about how culture influences their health and immigration experiences. Questions could focus on asking women how their gender affects them in the Punjabi culture and also ask them specifically the positive and negative aspects of the Punjabi culture, and the role religion provides them. Once there is a greater understanding of how

culture affects women's definitions of mental health and well-being held within the Punjabi culture, individual experiences can be further investigated.

Future research can compare the experiences of older immigrant Punjabi women who have been living in Nova Scotia for more than 20 years with women who have living in the province for less than five years. This study had women from both groups, but the sample size was too small to compare the groups, which might provide further information about how immigration in later life affects one's mental health and well-being when compared to older Punjabi women who have been living in Nova Scotia for several decades. An understanding could be formed regarding what types of mental health and community services may be appropriate for both groups and the best ways for older immigrant Punjabi women can access and utilize mental health services. Moreover, interviewing health care providers working in the mental health field and people working in immigration services would provide an insight as to what they experience and witness when working with this group of older women. By interviewing health care practitioners and immigration services, a further understanding of services that are provided to older immigrant Punjabi women, which can help improve how older immigrant women access and utilize mental health services.

### **Conclusion**

This thesis articulates the importance that culture, immigration, gender, and social support has when discussing mental health. The findings will contribute to dialogues about the unique experiences of older immigrant Punjabi women living in Nova Scotia. Because no research has been done on the experiences of immigrant Punjabi women living in the East coast of Canada, this study will help further the understandings of the

experiences of immigrant women face. The study provided an opportunity for older Punjabi women to speak on their settlement in Nova Scotia and how they understand mental health and well-being. Immigration at any age can be a difficult experience. Many women referred to difficulties they have experienced while living in Nova Scotia ranging from accessing health care services to wearing their cultural clothing in public, and wanting to connect with other older Punjabi women.

The mental health and well-being of older immigrant Punjabi women is a phenomenon that cannot be understood by single casual factor. Rather, older Punjabi women are often faced with oppression when speaking publicly about their mental health and when accessing health care services that are culturally component. By educating mental health providers and policy makers on how this cultural group defines mental health, women from culturally diverse backgrounds can be better understood and the appropriate services can be implemented.

In conclusion, this research is critical and worth examining because of Nova Scotia's commitment to increasing immigrant rates in its province. Understanding how families reunite with older family members means that *all* members must be supported, not just those in the paid labour force, especially with the increase of new immigrants resettling in provinces like Nova Scotia. The current body of literature largely focuses on the mental health of Canadians and more specifically, Canadian women, but there is a lack of research on the mental health and well-being of older Punjabi women. The limited research on this population in Nova Scotia has created the need to better understand the health and delivery of culturally competent care throughout the Maritime region. As a result, this study is timely and can help create a dialogue for systematic changes.

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## **Appendix A**

### **In-Depth Interview Guide**

#### **Background**

So that I can describe the women who I interviewed, I'd like to ask you just a couple of quick questions to describe yourself and your background.

1. What year did you move to Canada?
2. What year did you move to Nova Scotia?
3. What is your marital status?
4. What is the highest level of education you have received? (probe: where were you educated?)
5. What is your birth date?

#### **Life Now**

1. Ok, so it sounds like you've been here in NS now for \_\_\_\_ years (months). So, what has life been like for you the past while, now that you've been here for XX amount of time. How would you, in general, describe your life? (probes: what kind of things do you do? What do you like to do? Who are the people you are closest to, and how would you describe your relationships with them right now?)
2. How do you feel about living in Nova Scotia? (probes: can you describe what your day looks like)

#### **Mental Health and Well-Being**

1. How would you define mental health? (probes: what is your understanding of good mental health?)
2. How do you feel about life these days? (probes: what makes you happy? What do you experience as a challenge?)
3. What do you do when you are experiencing challenges or difficulties with your well-being? (probes: do you pray, do you go to a doctor, do you talk to your family).
4. What is your experience like when you go to a doctor or health care professional? (probes: does it go well? Are there any things that frustrate you?)
5. When you are experiencing challenges or difficulties, is it easy for you to talk to other people about it (e.g., family, people in community, or health care professional)? Can you expand on that? Can you give me a specific example of how?
6. What kind of things make it easier or more difficult for you to talk to others or to seek help when you need it?

**Migration**

1. I'd like hear about your experience of moving here, but first, could you tell me a little bit about yourself and your life before you moved here. (probes: where did you live, who were you living with, what kind of things did you do? What was your *sehat* (health) like at that time? Do you have family who still reside in India? How do you think about their day-to-day experiences in relation to your own?)
2. Now, let's talk about the time that you moved here (the time leading up to the move, and the time immediately after). Can you tell me about moving to Nova Scotia (probes: when did you move here, what was your reason for moving to NS, what the process like of moving here (India, red tape, legal factors), what was your living arrangement when you first moved here, how did you feel? What helped you during the move)
3. After your arrival in Canada, how did your life change?

**Cultural Issues**

1. How does your life here compare to what your life was like when you were living in India? (probes: can you do the things you used to like to do, why or why not? describe your social networks of friends and family)
2. What is it like to be an older Punjabi woman living in Nova Scotia? (probes: can you tell me how the Punjabi community views mental health?)

**Conclusion**

1. Is there anything that people outside of your family (e.g., the community, your temple or spiritual group, social service agencies, or provincial government services) could do to help make you feel better or cope better about living in Nova Scotia? Please explain your answer?

Is there anything else you think would be helpful for me to know that we haven't talked already?

**Appendix B**  
In-Depth Interview Guide (Punjabi)  
ਇਨ-ਡੀਪਥ ਇੰਟਰਵਿਊ ਗਾਈਡ

**ਪਿਛੋਕੜ**

ਇਸ ਲਈ ਮੈਂ ਉਨ੍ਹਾਂ ਔਰਤਾਂ ਦਾ ਵਰਣਨ ਕਰ ਸਕਦਾ ਹਾਂ ਜਿਹੜੀਆਂ ਮੈਂ ਇੰਟਰਵਿਊ ਕੀਤੀਆਂ ਸਨ, ਮੈਂ ਤੁਹਾਡੇ ਆਪਣੇ ਅਤੇ ਆਪਣੇ ਪਿਛੋਕੜ ਦਾ ਵਰਣਨ ਕਰਨ ਲਈ ਸਿਰਫ ਕੁਝ ਕੁ ਸਵਾਲ ਪੁੱਛਣਾ ਚਾਹੁੰਦੀ ਹਾਂ।

1. ਤੁਸੀਂ ਕੈਨੇਡਾ ਵਿੱਚ ਕਿਹੜੇ ਸਾਲ ਆਏ ਸੀ?
2. ਤੁਸੀਂ ਨੌਵਾ ਸਕੋਸ਼ੀਆ ਵਿੱਚ ਕਿਹੜੇ ਸਾਲ ਆਏ ਸੀ?
3. ਤੁਹਾਡੀ ਵਿਆਹੁਤਾ ਸਥਿਤੀ ਕੀ ਹੈ?
4. ਤੁਹਾਡੇ ਦੁਆਰਾ ਪ੍ਰਾਪਤ ਕੀਤੀ ਗਈ ਸਿੱਖਿਆ ਦਾ ਸਭ ਤੋਂ ਉੱਚਾ ਪੱਧਰ ਕੀ ਹੈ?
5. ਤੁਹਾਡੀ ਜਨਮ ਤਾਰੀਖ ਕੀ ਹੈ?

**ਜ਼ਿੰਦਗੀ ਹੁਣ**

1. ਇਸ ਲਈ, ਪਿਛਲੇ ਸਮੇਂ ਤੁਹਾਡੇ ਲਈ ਜੀਵਨ ਕਿਹੋ ਜਿਹਾ ਰਿਹਾ ਹੈ, ਹੁਣ ਤੁਸੀਂ ਇੱਥੇ ਰਹਿ ਰਹੇ ਹੋ? ਤੁਸੀਂ ਆਮ ਤੌਰ ਤੇ ਆਪਣੇ ਜੀਵਨ ਦਾ ਵਰਣਨ ਕਿਵੇਂ ਕਰੋਗੇ?
2. ਤੁਸੀਂ ਨੌਵਾ ਸਕੋਸ਼ੀਆ ਵਿੱਚ ਰਹਿਣ ਬਾਰੇ ਕਿਵੇਂ ਮਹਿਸੂਸ ਕਰਦੇ ਹੋ?

**ਮਾਨਸਿਕ ਸਿਹਤ ਅਤੇ ਤੰਦਰੁਸਤੀ**

1. ਤੁਸੀਂ ਮਾਨਸਿਕ ਸਿਹਤ ਨੂੰ ਕਿਵੇਂ ਨਿਰਧਾਰਿਤ ਕਰੋਗੇ?
2. ਅੱਜ ਤੁਸੀਂ ਜ਼ਿੰਦਗੀ ਬਾਰੇ ਕਿਵੇਂ ਮਹਿਸੂਸ ਕਰਦੇ ਹੋ?
3. ਜਦੋਂ ਤੁਸੀਂ ਚੁਣੌਤੀਆਂ ਜਾਂ ਤੁਹਾਡੀ ਭਲਾਈ ਦੇ ਨਾਲ ਮੁਸ਼ਕਲਾਂ ਦਾ ਸਾਹਮਣਾ ਕਰ ਰਹੇ ਹੋ ਤਾਂ ਤੁਸੀਂ ਕੀ ਕਰਦੇ ਹੋ?
4. ਜਦੋਂ ਤੁਸੀਂ ਕਿਸੇ ਡਾਕਟਰ ਜਾਂ ਸਿਹਤ ਦੇਖ-ਰੇਖ ਪੇਸ਼ਾਵਰ ਜਾਂਦੇ ਹੋ ਤਾਂ ਤੁਹਾਡਾ ਕੀ ਅਨੁਭਵ ਹੈ?
5. ਜਦੋਂ ਤੁਸੀਂ ਚੁਣੌਤੀਆਂ ਜਾਂ ਮੁਸ਼ਕਲਾਂ ਦਾ ਸਾਹਮਣਾ ਕਰ ਰਹੇ ਹੋ, ਤਾਂ ਕੀ ਤੁਹਾਡੇ ਲਈ ਇਸ ਬਾਰੇ ਹੋਰ ਲੋਕਾਂ ਨਾਲ ਗੱਲ ਕਰਨਾ ਆਸਾਨ ਹੈ? ਕੀ ਤੁਸੀਂ ਇਸ ਬਾਰੇ ਵਿਆਖਿਆ ਕਰ ਸਕਦੇ ਹੋ? ਕੀ ਤੁਸੀਂ ਮੈਨੂੰ ਇੱਕ ਖਾਸ ਉਦਾਹਰਣ ਦੇ ਸਕਦੇ ਹੋ? ਕਿਸ ਤਰ੍ਹਾਂ ਦੀਆਂ ਚੀਜ਼ਾਂ ਇਸਦੇ ਲਈ ਆਸਾਨ ਜਾਂ ਵਧੇਰੇ
6. ਮੁਸ਼ਕਲ ਬਣਾਉਂਦੀਆਂ ਹਨ

**ਮਾਈਗਰੇਸ਼ਨ**

1. ਮੈਂ ਇੱਥੇ ਆਣ ਦਾ ਤੁਹਾਡੇ ਤਜਰਬੇ ਬਾਰੇ ਸੁਣਨਾ ਚਾਹੁੰਦਾ ਹਾਂ, ਪਰ ਪਹਿਲਾਂ, ਤੁਸੀਂ ਇੱਥੇ ਆਣ ਤੋਂ ਪਹਿਲਾਂ ਆਪਣੇ ਬਾਰੇ ਅਤੇ ਆਪਣੀ ਜ਼ਿੰਦਗੀ ਬਾਰੇ ਮੈਨੂੰ ਥੋੜਾ ਜਿਹਾ ਦਸ ਸਕਦੇ ਹੋ।
2. ਹੁਣ, ਆਓ ਅਸੀਂ ਉਸ ਸਮੇਂ ਬਾਰੇ ਗੱਲ ਕਰੀਏ ਜਦੋਂ ਤੁਸੀਂ ਇੱਥੇ ਆ ਗਏ ਸੀ (ਸਮੇਂ ਵੱਲ ਵਧਣ ਦਾ ਸਮਾਂ, ਅਤੇ ਤੁਰੰਤ ਬਾਅਦ ਦਾ ਸਮਾਂ). ਕੀ ਤੁਸੀਂ ਮੈਨੂੰ ਨੌਵਾ ਸਕੋਸ਼ੀਆ ਆਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ?
3. ਕੈਨੇਡਾ ਪਹੁੰਚਣ ਤੋਂ ਬਾਅਦ, ਤੁਹਾਡੀ ਜ਼ਿੰਦਗੀ ਕਿਵੇਂ ਬਦਲੀ ਗਈ?

ਸੱਭਿਆਚਾਰਕ ਮੁੱਦਿਆਂ

1. ਤੁਹਾਡੀ ਜ਼ਿੰਦਗੀ ਇੱਥੇ ਦੀ ਤੁਲਨਾ ਕਿਸ ਤਰਾਂ ਦੀ ਸੀ ਜਦੋਂ ਤੁਸੀਂ ਭਾਰਤ ਵਿਚ ਰਹਿ ਰਹੇ ਸੀ, ਤੁਹਾਡੀ ਜ਼ਿੰਦਗੀ ਕਿਹੋ ਜਿਹੀ ਸੀ?
2. ਨੌਵਾ ਸਕੋਸ਼ੀਆ ਵਿੱਚ ਰਹਿਣ ਵਾਲੀ ਇੱਕ ਵੱਡੀ ਪੰਜਾਬੀ ਔਰਤ ਹੋਣ ਦਾ ਕੀ ਬਣਨਾ ਹੈ?

ਸਿੱਟਾ

1. ਕੀ ਕੋਈ ਅਜਿਹੀ ਗੱਲ ਹੈ ਜੋ ਨੌਵਾ ਸਕੋਸ਼ੀਆ ਵਿਚ ਰਹਿੰਦਿਆਂ ਤੁਹਾਨੂੰ ਬਿਹਤਰ ਮਹਿਸੂਸ ਕਰਨ ਜਾਂ ਵਧੀਆ ਢੰਗ ਨਾਲ ਪੇਸ਼ ਆਉਣ ਵਿਚ ਮਦਦ ਕਰਨ ਲਈ ਤੁਹਾਡੇ ਪਰਿਵਾਰ ਦੇ ਬਾਹਰ ਕੰਮ ਕਰ ਸਕਦੀ ਹੈ? ਕਿਰਪਾ ਕਰਕੇ ਆਪਣਾ ਜਵਾਬ ਦੱਸੋ?

ਕੀ ਕੋਈ ਹੋਰ ਚੀਜ਼ ਹੈ ਜੋ ਤੁਸੀਂ ਸੋਚਦੇ ਹੋ ਕਿ ਮੇਰੇ ਲਈ ਇਹ ਜਾਣਨਾ ਮਦਦਗਾਰ ਹੋਵੇਗਾ ਜੋ ਕਿ ਅਸੀਂ ਪਹਿਲਾਂ ਗੱਲ ਨਹੀਂ ਕੀਤੀ ਹੈ?

**Appendix C**  
Informed Consent Form



DATE: \_\_\_\_\_

**A Study of The Mental Health and Well-Being of Older Immigrant Punjabi Women  
Living in Nova Scotia**

**Principal Investigator:**

Sandeep Dhillon  
Mount Saint Vincent University  
Halifax, Nova Scotia, Canada  
[REDACTED]  
E-mail: Sandeep.Dhillon@msvu.ca

**Thesis Supervisor:**

Dr. Áine Humble  
Mount Saint Vincent University  
Evaristus 321, Halifax, Nova Scotia  
902-457-6109  
Email: Aine.Humble@msvu.ca

**Eligibility Requirements:** Participants will need to be Punjabi women who are 65 years of age or older, are currently living in Nova Scotia, and have lived in Canada for a minimum of one year. Participants need to be willing to be audio recorded.

**Purpose of the Study:** The purpose of this study is to examine the mental health and well-being of older immigrant women who have immigrated from India to Canada and are living in Nova Scotia. You are invited to talk about your mental health and well-being while living in Nova Scotia. I am completing this research study for my Master of Arts thesis degree in Family Studies and Gerontology, under the supervision of Dr. Áine Humble. This research study is funded by the Nova Scotia Health Research Foundation. The results may be used to publish the study in a research journal and it will be used to present the research findings at conferences.

**Procedures involved in the Research:** With your permission, I will ask you questions about your mental health and well-being, and your experience about living in Nova Scotia. I will also ask you for some information regarding what year you were born in and your marital status. The interview will last approximately 60 minutes, and I will audio record the interview with your permission. Some sample questions that will be asked are:

1. How do you feel about living in Nova Scotia?
2. How do you define mental health?
3. What do you do when you are experiencing challenges or difficulties with your well-being?

**Potential Harms, Risks or Discomforts:** It is unlikely that there will be any harm or discomfort associated with this study, however you may feel uncomfortable with answering some of the interview questions. If this is the case, you do not need to answer questions that you do not feel comfortable answering.

**Potential Benefits:** The research will not benefit you directly, but I hope that the findings will inform health care policy and practices for health care practitioners when working with South Asian women 65 years and older.

**Confidentiality:** Your participation in this study is confidential. I will not use your name or any information that would allow you to be identified. I will remove any identifying information from your transcript in order to maintain confidentiality, your name will be replaced with a pseudonym. No one but me will know whether you were in the study unless you choose to tell others. The information/data you provide will be kept in a locked cabinet and on a password protected computer that only my thesis supervisor, Dr. Áine Humble, and I will have access to. Once I have completed my Master's degree, I will destroy all audio files, and after 5 years all transcripts and informed consent forms will be deleted and shredded.

**b) Legally Required Disclosure:** Although I will protect your privacy as outlined above, if the law requires it, I will have to reveal certain personal information. Other than that, your information will be confidential with me.

**Participation and Withdrawal:** Your participation in this study is voluntary. It is your choice to be part of the study or not. If you decide to be part of the study, you can withdraw from the interview for whatever reason, even after signing the consent form or part-way through the study. If you decide to withdraw, there will be no consequences to you. If you choose to withdraw, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

**Information about the Study Results:** If you would like a brief summary of the results, please let me know how you would like it sent to you.

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

Sandeep.Dhillon@msvu.ca  
[REDACTED]

Additionally, if you have questions about how this study is being conducted and wish to speak with someone who is not directly involved in the study, you may contact the Ethics Coordinator, c/o MSVU Research and International Office, at (902) 457-6350 or via email at research@msvu.ca.

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### CONSENT

- I have read the information presented in the information letter about a study being conducted by Sandeep Dhillon of Mount Saint Vincent University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

- I understand that if I agree to participate in this study, I may withdraw from the study at any time.
- I agree to be audio recorded
- I have been given a copy of this form.
- I agree to participate in the study.

Name of Participant (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thumb Print (Optional):

\_\_\_\_\_

Principal Investigator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Appendix D**  
Informed Consent Form (Punjabi)



ਤਾਰੀਖ: \_\_\_\_\_

ਅੰਤਿਕਾ ਬੀ

ਜਾਣਕਾਰੀ / ਸਹਿਮਤੀ ਦੀ ਚਿੱਠੀ

ਨੌਵਾ ਸਕੋਸ਼ੀਆ ਵਿੱਚ ਰਹਿ ਰਹੇ ਬਜ਼ੁਰਗ ਇਮੀਗ੍ਰੈਂਟ ਪੰਜਾਬੀ ਔਰਤਾਂ ਦੀ ਪਰਾਪਤ ਮਾਨਸਿਕ ਸਿਹਤ ਦਾ ਅਧਿਐਨ

**ਪ੍ਰਿੰਸੀਪਲ ਇਨਵੈਸਟੀਗੇਟਰ:**

ਸੰਦੀਪ ਢਿੱਲੋਂ

ਮਾਉਂਟ ਸੇਂਟ ਵਿਨਸੈਂਟ ਯੂਨੀਵਰਸਿਟੀ  
ਹੈਲੀਫੈਕਸ, ਨੌਵਾ ਸਕੋਸ਼ੀਆ, ਕੈਨੇਡਾ



ਈ-ਮੇਲ: Sandeep.Dhillon@msvu.ca

**ਬੀਸਿਸ ਸੁਪਰਵਾਇਜ਼ਰ:**

ਡਾ. ਐਨੇ ਹੁਮਬਲ

ਮਾਉਂਟ ਸੇਂਟ ਵਿਨਸੈਂਟ ਯੂਨੀਵਰਸਿਟੀ  
ਐਵਾਰਿਸਸਟਸ 321, ਹੈਲੀਫੈਕਸ,

902-457-6109

ਈਮੇਲ: Aine.Humble@msvu.ca

**ਯੋਗਤਾ ਦੀਆਂ ਜ਼ਰੂਰਤਾਂ:** ਹਿੱਸਾ ਲੈਣ ਵਾਲਿਆਂ ਨੂੰ 65 ਸਾਲ ਜਾਂ ਇਸ ਤੋਂ ਵੱਡੀ ਉਮਰ ਦੇ ਪੰਜਾਬੀ ਔਰਤਾਂ ਹੋਣ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਜੋ ਵਰਤਮਾਨ ਵਿੱਚ ਨੌਵਾ ਸਕੋਸ਼ੀਆ ਵਿੱਚ ਰਹਿ ਰਹੇ ਹਨ ਅਤੇ ਕੈਨੇਡਾ ਵਿੱਚ ਇੱਕ ਸਾਲ ਲਈ ਘੱਟੋ ਘੱਟ ਇੱਕ ਸਾਲ ਬਿਤਾ ਚੁੱਕੇ ਹਨ. ਹਿੱਸਾ ਲੈਣ ਵਾਲਿਆਂ ਨੂੰ ਆਡੀਓ ਰਿਕਾਰਡ ਕਰਨ ਲਈ ਤਿਆਰ ਹੋਣਾ ਚਾਹੀਦਾ ਹੈ.

**ਅਧਿਐਨ ਦਾ ਉਦੇਸ਼:** ਇਸ ਅਧਿਐਨ ਦਾ ਮੰਤਵ ਬਜ਼ੁਰਗ ਇਮੀਗ੍ਰੈਂਟ ਔਰਤਾਂ ਦੀ ਮਾਨਸਿਕ ਸਿਹਤ ਦਾ ਮੁਲਾਂਕਣ ਕਰਨਾ ਹੈ ਜੋ ਭਾਰਤ ਤੋਂ ਕੈਨੇਡਾ ਆ ਕੇ ਆਏ ਹਨ ਅਤੇ ਨੌਵਾ ਸਕੋਸ਼ੀਆ ਵਿੱਚ ਰਹਿ ਰਹੇ ਹਨ. ਨੌਵਾ ਸਕੋਸ਼ੀਆ ਵਿੱਚ ਰਹਿੰਦਿਆਂ ਤੁਹਾਨੂੰ ਇਸ ਅਧਿਐਨ ਵਿੱਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਸੱਦਾ ਦਿੱਤਾ ਗਿਆ ਹੈ, ਜਿਸ ਵਿੱਚ ਤੁਹਾਡੀ ਮਾਨਤਾ ਪ੍ਰਾਪਤ ਮਾਨਸਿਕ ਸਿਹਤ ਬਾਰੇ ਚਰਚਾ ਕੀਤੀ ਗਈ ਹੈ. ਮੈਂ ਆਪਣੇ ਮਾਸਟਰ ਬੀਸੀਸ ਡਿਗਰੀ ਲਈ ਇਹ ਖੋਜ ਅਧਿਐਨ ਕਰ ਰਿਹਾ ਹਾਂ

**ਰਿਸਰਚ ਵਿੱਚ ਸ਼ਾਮਲ ਪ੍ਰਕਿਰਿਆ:** ਤੁਹਾਡੀ ਇਜਾਜ਼ਤ ਨਾਲ, ਮੈਂ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਮਾਨਸਿਕ ਸਿਹਤ ਬਾਰੇ ਅਤੇ ਨੌਵਾ ਸਕੋਸ਼ੀਆ ਵਿੱਚ ਰਹਿਣ ਦੇ ਤੁਹਾਡੇ ਤਜਰਬੇ ਬਾਰੇ ਸਵਾਲ ਪੁੱਛ ਰਹੀ ਹਾਂ. ਮੈਂ ਤੁਹਾਡੇ ਤੇ ਕੁਝ ਜਾਣਕਾਰੀ ਮੰਗਦਾ ਹਾਂ ਕਿ ਤੁਸੀਂ ਕਿਹੜੇ ਸਾਲ ਵਿੱਚ ਜੰਮਿਆ ਅਤੇ ਤੁਹਾਡੇ ਵਿਆਹੁਤਾ ਸਥਿਤੀ. ਇੰਟਰਵਿਊ 60 ਮਿੰਟ ਤੋਂ ਵੱਧ ਨਹੀਂ ਹੋਵੇਗੀ, ਅਤੇ ਮੈਂ ਤੁਹਾਡੀ ਇਜਾਜ਼ਤ ਨਾਲ ਇੰਟਰਵਿਊ ਰਿਕਾਰਡ ਕਰਨ ਲਈ ਆਡੀਓ ਰਿਕਾਰਡ ਕਰੇਗਾ. ਕੁਝ ਨਮੂਨੇ ਦੇ ਪ੍ਰਸ਼ਨ ਜੋ ਕਿ ਪੁੱਛੇ ਜਾਣਗੇ:

1. ਤੁਸੀਂ ਨੌਵਾ ਸਕੋਸ਼ੀਆ ਵਿੱਚ ਰਹਿਣ ਬਾਰੇ ਕਿਵੇਂ ਮਹਿਸੂਸ ਕਰਦੇ ਹੋ?

2. ਤੁਸੀਂ ਮਾਨਸਿਕ ਸਿਹਤ ਨੂੰ ਕਿਵੇਂ ਪ੍ਰਭਾਸ਼ਿਤ ਕਰਦੇ ਹੋ?

3. ਜਦੋਂ ਤੁਸੀਂ ਚੁਣੌਤੀਆਂ ਜਾਂ ਤੁਹਾਡੀ ਭਲਾਈ ਦੇ ਨਾਲ ਮੁਸ਼ਕਲਾਂ ਦਾ ਸਾਹਮਣਾ ਕਰ ਰਹੇ ਹੋ ਤਾਂ ਤੁਸੀਂ ਕੀ ਕਰਦੇ ਹੋ?

**ਸੰਭਾਵੀ ਨੁਕਸਾਨ, ਜੋਖਮ ਜਾਂ ਬੇਯਕੀਨੀ:** ਹਿੱਸਾ ਲੈਣ ਵਾਲਿਆਂ ਨੂੰ ਚਿੰਤਾ ਅਤੇ ਪਰੇਸ਼ਾਨੀ ਹੋਣ ਦੀਆਂ ਭਾਵਨਾਵਾਂ ਦਾ ਅਨੁਭਵ ਹੋ ਸਕਦਾ ਹੈ. ਇਹ ਸੰਭਾਵਨਾ ਨਹੀਂ ਹੈ ਕਿ ਇਸ ਅਧਿਐਨ ਨਾਲ ਜੁੜੇ ਕਿਸੇ ਵੀ ਨੁਕਸਾਨ ਜਾਂ ਬੇਅਰਾਮੀ ਹੋਣਗੇ, ਹਾਲਾਂਕਿ ਤੁਸੀਂ ਇੰਟਰਵਿਊ ਦੇ ਕੁੱਝ ਸਵਾਲਾਂ ਦੇ ਜਵਾਬ ਦੇ ਨਾਲ ਬੇਅਰਾਮ ਮਹਿਸੂਸ ਕਰ ਸਕਦੇ ਹੋ. ਜੇ ਅਜਿਹਾ ਹੁੰਦਾ ਹੈ, ਤਾਂ ਤੁਹਾਨੂੰ ਉਹਨਾਂ ਪ੍ਰਸ਼ਨਾਂ ਦੇ ਉੱਤਰ ਦੇਣ ਦੀ ਲੋੜ ਨਹੀਂ ਹੁੰਦੀ ਜਿਹੜੇ ਤੁਸੀਂ ਅਰਾਮਦੇਹ ਮਹਿਸੂਸ ਨਹੀਂ ਕਰਦੇ.

**ਸੰਭਾਵੀ ਲਾਭ:** ਇਹ ਖੋਜ ਤੁਹਾਨੂੰ ਸਿੱਧੇ ਤੌਰ 'ਤੇ ਲਾਭ ਨਹੀਂ ਪਹੁੰਚਾਏਗਾ, ਪਰ ਮੈਂ ਬਜ਼ੁਰਗ ਦੱਖਣ ਏਸ਼ੀਅਨ ਮਹਿਲਾਵਾਂ ਨਾਲ ਕੰਮ ਕਰਨ ਵੇਲੇ ਸਿਹਤ ਦੇਖ-ਰੇਖ ਨੀਤੀ ਅਤੇ ਖੋਜਾਂ ਬਾਰੇ ਅਮਲ ਅਤੇ ਸਿਹਤ ਸੰਬੰਧੀ ਪ੍ਰੈਕਟੀਸ਼ਨਰਾਂ ਲਈ ਇਕ ਨਵੀਂ ਗੱਲਬਾਤ ਤਿਆਰ ਕਰਨ ਦੀ ਉਮੀਦ ਕਰਦਾ ਹਾਂ.

**ਗੁਪਤਤਾ:** ਇਸ ਅਧਿਐਨ ਵਿਚ ਤੁਹਾਡੀ ਭਾਗੀਦਾਰੀ ਗੁਪਤ ਹੋਵੇਗੀ. ਮੈਂ ਤੁਹਾਡੇ ਨਾਂ ਜਾਂ ਕਿਸੇ ਵੀ ਜਾਣਕਾਰੀ ਦੀ ਵਰਤੋਂ ਨਹੀਂ ਕਰਾਂਗਾ ਜੋ ਤੁਹਾਨੂੰ ਪਛਾਣ ਕਰਨ ਦੀ ਇਜਾਜ਼ਤ ਦੇਵੇਗਾ. ਕੋਈ ਨਹੀਂ, ਪਰ ਮੈਨੂੰ ਪਤਾ ਹੋਵੇਗਾ ਕਿ ਤੁਸੀਂ ਅਧਿਐਨ ਵਿਚ ਸੀ ਜਦ ਤੱਕ ਕਿ ਤੁਸੀਂ ਉਸ ਨੂੰ ਦੱਸਣਾ ਪਸੰਦ ਨਹੀਂ ਕਰਦੇ. ਤੁਹਾਡੇ ਦੁਆਰਾ ਪ੍ਰਦਾਨ ਕੀਤੀ ਜਾਣ ਵਾਲੀ ਜਾਣਕਾਰੀ / ਡੇਟਾ ਨੂੰ ਤਾਲਾਬੰਦ ਕੈਬਨਿਟ ਵਿਚ ਰੱਖਿਆ ਜਾਵੇਗਾ ਜਿੱਥੇ ਸਿਰਫ ਮੇਰੇ ਘਰ ਵਿਚ ਹੀ ਇਸ ਦੀ ਪਹੁੰਚ ਹੋਵੇਗੀ. ਇੱਕ ਵਾਰ ਅਧਿਐਨ ਮੁਕੰਮਲ ਹੋ ਜਾਣ ਤੋਂ ਬਾਅਦ, ਡਾਟਾ ਨਸ਼ਟ ਹੋ ਜਾਵੇਗਾ.

**ਅ) ਕਾਨੂੰਨੀ ਤੌਰ 'ਤੇ ਲੋੜੀਂਦਾ ਪ੍ਰਗਟਾਵਾ:** ਹਾਲਾਂਕਿ ਮੈਂ ਤੁਹਾਡੀ ਗੋਪਨੀਯਤਾ ਦੀ ਰੱਖਿਆ ਕਰਾਂਗਾ ਜਿਵੇਂ ਉਪਰ ਦੱਸੇ ਗਏ ਹਨ, ਜੇ ਕਾਨੂੰਨ ਲਈ ਇਹ ਜ਼ਰੂਰੀ ਹੈ, ਤਾਂ ਮੈਨੂੰ ਕੁਝ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਪ੍ਰਗਟ ਕਰਨੀ ਪਵੇਗੀ. ਇਸ ਤੋਂ ਇਲਾਵਾ, ਤੁਹਾਡੀ ਜਾਣਕਾਰੀ ਮੇਰੇ ਨਾਲ ਗੁਪਤ ਹੋਵੇਗੀ.

**ਸ਼ਮੂਲੀਅਤ ਅਤੇ ਕਢਵਾਉਣਾ:** ਇਸ ਅਧਿਐਨ ਵਿੱਚ ਤੁਹਾਡੀ ਭਾਗੀਦਾਰੀ ਸਵੈ-ਇੱਛਤ ਹੈ. ਇਹ ਤੁਹਾਡੀ ਪਸੰਦ ਦਾ ਅਧਿਐਨ ਦਾ ਹਿੱਸਾ ਹੈ ਜਾਂ ਨਹੀਂ. ਜੇ ਤੁਸੀਂ ਅਧਿਐਨ ਦਾ ਹਿੱਸਾ ਬਣਨ ਦਾ ਫੈਸਲਾ ਕਰਦੇ ਹੋ, ਤਾਂ ਤੁਸੀਂ ਕਿਸੇ ਵੀ ਕਾਰਨ ਕਰਕੇ ਇੰਟਰਵਿਊ ਤੋਂ ਵਾਪਸ ਲੈ ਸਕਦੇ ਹੋ, ਭਾਵੇਂ ਕਿ ਸਟੱਡੀ ਰਾਹੀਂ ਸਹਿਮਤੀ ਫਾਰਮ ਤੇ ਹਸਤਾਖਰ ਕਰਨ ਜਾਂ ਅੰਸ਼ਕ ਤੌਰ 'ਤੇ ਸਾਈਨ ਕਰਨ ਤੋਂ ਬਾਅਦ. ਜੇ ਤੁਸੀਂ ਵਾਪਸ ਜਾਣ ਦਾ ਫੈਸਲਾ ਕਰਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਕੋਈ ਨਤੀਜਾ ਨਹੀਂ ਹੋਵੇਗਾ. ਕਢਵਾਉਣ ਦੇ ਮਾਮਲਿਆਂ ਵਿੱਚ, ਤੁਹਾਡੇ ਦੁਆਰਾ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕੋਈ ਵੀ ਡੇਟਾ ਉਦੋਂ ਤੱਕ ਨਸ਼ਟ ਹੋ ਜਾਵੇਗਾ ਜਦੋਂ ਤੱਕ ਤੁਸੀਂ ਹੋਰ ਨਹੀਂ ਵੇਖਾਉਂਦੇ. ਜੇ ਤੁਸੀਂ ਉਨ੍ਹਾਂ ਕੁਝ ਪ੍ਰਸ਼ਨਾਂ ਦੇ ਉੱਤਰ ਨਹੀਂ ਦੇਣਾ ਚਾਹੁੰਦੇ ਜਿਹੜੇ ਤੁਹਾਡੇ ਕੋਲ ਨਹੀਂ ਹਨ, ਪਰ ਤੁਸੀਂ ਅਜੇ ਵੀ ਅਧਿਐਨ ਵਿੱਚ ਹੋ ਸਕਦੇ ਹੋ.

**ਅਧਿਐਨ ਨਤੀਜਿਆਂ ਬਾਰੇ ਜਾਣਕਾਰੀ:** ਜੇ ਤੁਸੀਂ ਨਤੀਜਿਆਂ ਦਾ ਸੰਖੇਪ ਸਾਰਾਂਸ਼ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਮੈਨੂੰ ਦੱਸੋ ਕਿ ਤੁਹਾਨੂੰ ਇਹ ਕਿਵੇਂ ਭੇਜੀ ਜਾਵੇਗੀ.

**ਅਧਿਐਨ ਬਾਰੇ ਪ੍ਰਸ਼ਨ:** ਜੇਕਰ ਤੁਹਾਡੇ ਕੋਲ ਸਵਾਲ ਹਨ ਜਾਂ ਅਧਿਐਨ ਬਾਰੇ ਵਧੇਰੇ ਜਾਣਕਾਰੀ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਮੈਨੂੰ ਇੱਥੇ ਸੰਪਰਕ ਕਰੋ:

Sandeep.Dhillon@msvu.ca

ਇਸ ਅਧਿਐਨ ਦੀ ਸਮੀਖਿਆ ਯੂਨੀਵਰਸਿਟੀ ਦੀ ਰਿਸਰਚ ਐਥਿਕਸ ਬੋਰਡ (ਯੂਰੇਬੀ) ਨੇ ਕੀਤੀ ਹੈ ਅਤੇ ਨੈਤਿਕ ਪ੍ਰਵਾਨਗੀ ਪ੍ਰਾਪਤ ਕੀਤੀ ਹੈ। ਜੇ ਤੁਹਾਡੇ ਕੋਲ ਇੱਕ ਭਾਗੀਦਾਰ ਦੇ ਤੌਰ 'ਤੇ ਜਾਂ ਤੁਹਾਡੇ ਅਧਿਐਨ ਦੇ ਤਰੀਕੇ ਬਾਰੇ ਤੁਹਾਡੇ ਹੱਕਾਂ ਬਾਰੇ ਕੋਈ ਸਰੋਕਾਰ ਜਾਂ ਸਵਾਲ ਹਨ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸੰਪਰਕ ਕਰੋ:

ਰਿਸਰਚ ਐਥਿਕਸ ਕੋਆਰਡੀਨੇਟਰ, ਬੁੱਡਾ ਗਗਨੇ

ਟੈਲੀਫੋਨ: (902) 457-6350

ਦਫਤਰ: ਈਵਾਰੀਸਟਸ 223 ਏ

ਈ ਮੇਲ: ਬੁੱਡਾ: research@msvu.ca

### ਸਹਿਮਤੀ

- ਮੈਂ ਮਾਊਟ ਸੇਂਟ ਵਿਨਸੈਂਟ ਯੂਨੀਵਰਸਿਟੀ ਦੇ ਸੰਦੀਪ ਢਿਲੋਂ ਦੁਆਰਾ ਕਰਵਾਏ ਗਏ ਇਕ ਅਧਿਐਨ ਬਾਰੇ ਜਾਣਕਾਰੀ ਪੱਤਰ ਵਿਚ ਪੇਸ਼ ਕੀਤੀ ਗਈ ਜਾਣਕਾਰੀ ਪੜ੍ਹੀ ਹੈ।
- ਮੇਰੇ ਕੋਲ ਇਸ ਅਧਿਐਨ ਵਿਚ ਮੇਰੀ ਸ਼ਮੂਲੀਅਤ ਬਾਰੇ ਸਵਾਲ ਪੁੱਛਣ ਅਤੇ ਮੈਂ ਬੇਨਤੀ ਕੀਤੀ ਵਧੀਕ ਵੇਰਵੇ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਮੌਕਾ ਮਿਲਿਆ ਹੈ।
- ਮੈਂ ਸਮਝਦਾ ਹਾਂ ਕਿ ਜੇ ਮੈਂ ਇਸ ਅਧਿਐਨ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਸਹਿਮਤ ਹਾਂ, ਤਾਂ ਮੈਂ ਕਿਸੇ ਵੀ ਸਮੇਂ ਅਧਿਐਨ ਤੋਂ ਵਾਪਸ ਲੈ ਸਕਦਾ ਹਾਂ।
- ਮੈਨੂੰ ਇਸ ਫਾਰਮ ਦੀ ਕਾਪੀ ਦਿੱਤੀ ਗਈ ਹੈ।
- ਮੈਂ ਅਧਿਐਨ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਸਹਿਮਤ ਹਾਂ।

ਦਸਤਖਤ: \_\_\_\_\_ ਤਾਰੀਖ: \_\_\_\_\_

ਭਾਗ ਲੈਣ ਵਾਲੇ ਦਾ ਨਾਮ (ਛਾਪਿਆ ਗਿਆ)

\_\_\_\_\_

ਬੰਪ ਪ੍ਰਿੰਟ: \_\_\_\_\_ ਤਾਰੀਖ: \_\_\_\_\_

**Appendix E**  
Sample Text for Recruitment Poster

**PARTICIPANTS NEEDED**

This study is researching the mental health and well-being of older immigrant Punjabi women living in Nova Scotia.

**Are you a Punjabi woman aged 65 years or older? Have you lived in Canada for at least 1 year and are you currently living in Nova Scotia? If so, I would like to hear from you about your mental well-being while living in Nova Scotia!**

You would be asked to join me for an interview at your convenience and your participation will involve approximately 60 minutes of your time. Interviews can take place over the phone, Skype, or in person.

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

Sandeep Dhillon



Email: Sandeep.Dhillon@msvu.ca



**This research study is being completed as part of the requirement of my Master of Arts Degree in Family Studies and Gerontology and is funded by the Nova Scotia Health Research Foundation. This study has been reviewed by and received ethics clearance by the Mount Saint Vincent University Research Ethics Board.**

**Appendix F**  
Sample Text for Recruitment Poster (Punjabi)

**ਅੰਤਿਕਾ ਬੀ: ਭਰਤੀ ਪੋਸਟਰ**

ਪ੍ਰਵਾਸੀ ਵਿਧਵਾ ਬੁਜੁਰਗ ਪੰਜਾਬੀ ਭਾਰਤੀ ਔਰਤਾਂ ਦੀ ਲੋੜ ਹੈ ਜੋ ਕਿ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਤਾਂਕਿ ਉਨ੍ਹਾਂ ਦੀ ਸਿਹਤ ਬਾਰੇ ਸਮਝ ਨੂੰ ਜਾਣਿਆ ਜਾ ਸਕੇ!

ਮੈਂ ਇਸ ਅਧਿਐਨ ਵਿੱਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਵਲੰਟੀਅਰਾਂ ਦੀ ਤਲਾਸ਼ ਕਰ ਰਿਹਾ ਹਾਂ

ਇਹ ਅਧਿਐਨ ਇਮੀਗ੍ਰੈਂਟ ਬੁਜੁਰਗਾਂ ਦੀਆਂ ਪੰਜਾਬੀ ਔਰਤਾਂ ਦੀ ਮਾਨਸਿਕ ਸਿਹਤ ਦਾ ਮੁਲਾਂਕਣ ਕਰਨ ਲਈ ਖੋਜ ਕਰ ਰਿਹਾ ਹੈ ਜਿਨ੍ਹਾਂ ਨੇ ਭਾਰਤ ਤੋਂ ਕੈਨੇਡਾ ਆਵਾਸ ਕਰ ਲਿਆ ਹੈ.

**ਕੀ ਤੁਸੀਂ 65 ਸਾਲ ਜਾਂ ਇਸ ਤੋਂ ਵੱਧ ਉਮਰ ਦੇ ਪੰਜਾਬੀ ਔਰਤ ਹੋ? ਕੀ ਤੁਸੀਂ ਘੱਟ ਤੋਂ ਘੱਟ ਇਕ ਸਾਲ ਲਈ ਕੈਨੇਡਾ ਵਿਚ ਰਹੇ ਹੋ? ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਖੋਜ ਵਿੱਚ ਹਿੱਸਾ ਲਓ!**

ਤੁਹਾਨੂੰ ਇੱਕ ਇੰਟਰਵਿਊ ਲਈ ਮੇਰੇ ਨਾਲ ਸ਼ਾਮਲ ਹੋਣ ਲਈ ਕਿਹਾ ਜਾਵੇਗਾ ਅਤੇ ਤੁਹਾਡੀ ਭਾਗੀਦਾਰੀ ਸਿਰਫ ਤੁਹਾਡੇ 60 ਮਿੰਟ ਦਾ ਸਮਾਂ ਹੀ ਸ਼ਾਮਲ ਕਰੇਗੀ!

ਇਸ ਅਧਿਐਨ ਬਾਰੇ ਹੋਰ ਜਾਣਕਾਰੀ ਲਈ, ਜਾਂ ਇਸ ਅਧਿਐਨ ਲਈ ਵਲੰਟੀਅਰ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਸੰਪਰਕ ਕਰੋ:

ਸੰਦੀਪ ਢਿੱਲੋਂ

ਈਮੇਲ: Sandeep.Dhillon@msvu.ca



ਇਸ ਅਧਿਐਨ ਦੀ ਸਮੀਖਿਆ ਕੀਤੀ ਗਈ ਹੈ, ਅਤੇ ਨੈਤਿਕ ਪ੍ਰਵਾਨਗੀ ਪ੍ਰਾਪਤ ਕੀਤੀ ਗਈ ਹੈ  
ਐਮਐਸਵੀਯੂਯੂ ਰਿਸਰਚ ਐਥਿਕਸ ਬੋਰਡ ਦੁਆਰਾ

## Appendix G Reflectivity Posts

### *Humility*

A few weeks ago I attended the local Sikh temple in Halifax, known as the Maritime Sikh Society. When I entered this temple, I could tell it was built by the first Punjabi settlers who created a space where they could all come together to pray as a community. It made me appreciate this small city, Halifax, all the way on the east side of Canada, people came together to make this a community home for themselves. It made me feel so proud of these Sikhs. It may not be glamorous as other Sikh temples I have seen throughout Canada and in India, but you can see the humility in this building.

Attending the prayer on that Sunday made me reflect on how I need to become an active member in my community. I sometimes wonder who these people were that came to Nova Scotia and decided to dedicate their time and money to build this community home for us, which focused on the core foundations of our religion. These foundations were all brought to Canada from Punjab, where our ancestors all originated from. At the end of the prayer, my friend and I went to eat *langar*, a concept that was created by Guru Nanak Dev Ji to uphold the principle of equality between all people regardless of religion, caste, colour, creed, age, gender, or social status. As I was eating the *langar* that was prepared after the religious ceremony, it made me appreciate whoever this person was that spent time out of their day to nourish my body. We now live in a world where the amount of hours we have in a day is valued in a different form. We all only have 24 hours in a day but somehow some people's days are viewed as if they are busier. But as I was eating and enjoying my meal, it made me reflect on myself. Why do I always say I am busy, when I have time to talk with others on the phone, go for drinks, attend dinner

parties but how do I not have time to give back to the community. The concept of being 'busy' is too exaggerated in today's world. Almost as if other people's time isn't as important as yours. Made me sad that we have somehow come into this world believing we are more important than the person that is sitting next to you.

In ancient India, *seva* was believed to help one's spiritual growth and at the same time contribute to the improvement of community. When did we stop caring for each other and start believing we are too important? Are we losing the sense of community in today's day and age? Will the next generation learn this critical values but who will actually act upon these foundations?

### *Anger*

My mom called me a few weeks ago and was telling me that she went to the *gurdwara* (temple) to do *seva* (volunteering) in the early morning. During her time of service, the other women around her starting asking her questions about me. How old I was, if I was dating, and if I was in school. My mom answered the questions but told them I am single and I haven't met anyone/not really interested in anyone. The women were shocked and told my mom that I should be worrying because I am now turning 27 and I'm not in a *serious* relationship. Not once were my educational attainments mentioned or how successful I could be but rather me not having the title of having a boyfriend were judged. The irony of all of this is that this conversation took place at the *gurdwara*, where our religion preaches about equality and helping others and here these women were judging me because of cultural standards. Why is my value as a woman always justified through a man? Fuck these cultural standards.

*Recruitment: Part 1*

When I first began my research study, I knew that interviewing older Punjabi women would be an issue because they may not feel comfortable to speak out about the issues they are experiencing or even speak about what mental health is and the issues they may be experiencing. The temple made an announcement this past Sunday and they invited me to speak a few words on what I'm doing my thesis on and who my target population is. After informing the community about the study a woman approached me and asked me where I'm from and wanted to inquire more about this study. I told the woman that I'm conducting this research study for my master's degree and that I'm interested in learning about her experience of living in Nova Scotia and what are the good things or difficulties she has experienced. This woman told me she has been living in Nova Scotia since the 1970s and was a teacher back in India, where she had specialized in English. She was offered teaching positions in Newfoundland, Prince Edward Island, and in New Brunswick however, not in Nova Scotia. She blamed the fact that she was an "East Indian" to be the issue but her husband on the other hand was offered a teaching position in Nova Scotia. She began telling me that it was merely because she was a woman of colour and that she was not viewed to be equivalent to a man—that was the reason why she didn't get the position, in her opinion. I had told her that I would be greatly interested in interviewing her if she was comfortable. She asked to see my interview guide and with one glance of seeing the "Mental-Health" section, she told me she wouldn't answer those because it is too personal and doesn't want me to report my findings and tell people in the community or to the government. It surprised me so much for even though I was expecting this, I didn't think it would've happened? If that makes

any sense. Later at the temple, this woman approached me said “Sandeep Dhillon, how are you? I’m also a Dhillon!”. I spoke with this woman and told her about my study and she responded to me “Because we are from the same “family” I will for sure do anything in my power to help you”. Now that was interesting. My last name had so much power that this woman was open to helping me. There’s that underlying sense of community that I felt. I wonder if this woman would have approached me if I didn’t have the last name Dhillon. Very interesting.

*Beloved Aunty*

I was so happy to have my first interview and finally be able to get my research started and in traditional Punjabi culture, I brought a box of sweets with me. As I approached the front door of the participant’s home I was a little nervous of how things would go since this was my first time interviewing a Punjabi woman who is living in Nova Scotia. Before the interview began the participant’s daughter-in-law brought me water and asked me if I would like anything to eat. True South Asian hospitality. It made me reflect on the things I had witnessed growing up in the Punjabi culture like always catering to the guest and making sure the person in your home is comfortable and treated like your own. During the interview the participant brought up some critical points about educated and uneducated women from the Punjabi culture and spoke to how women in the villages in Punjab, India discuss their health problems differently when compared to the women who are living in the city. This participant was educated and was a nursing instructor in Punjab, in a major city. She told me about how her sister who is a doctor in the city went to assess some women who live in the village and how her sister was unable to understand their terminology when discussing their symptoms. For even though they

are culturally from the same society and even live in the same state, there is still a huge difference between these two types of women (educated vs noneducated). She pointed out that understanding what good mental health is, it depends on the individual and their educational attainments, which I found interesting.

The participant also spoke to the fact that she tries to be as independent as she can be. She told me she keeps herself busy as much as possible since she is alone in Canada and her children gone to work during the day. She showed me a bunch of her crafts that she made by hand by watching YouTube tutorial videos. She even showed me the garden she has been working on. I was very impressed to see an older Punjabi woman utilizing her time doing things I had never witnessed seeing. The participant told me that she tried to get another older Punjabi woman to join her with these leisure activities and she lived on her street but she was not interested at all and actually left to go back to India. Her friend hated Nova Scotia that much that she left back to Punjab. Even though all her children had resettled in Canada, she wanted to live in a country where she didn't feel so lonely and isolated. That stood out to me because it made me think about how many women even have the opportunity to even leave with the permission of their children.

I also did not address the participant by her name rather I called her Aunty to show my respect to her. Growing up in the Punjabi culture, I was taught from a young age that you address an older man as "uncle" and older woman as "aunty" to show respect and I was told to never use their first name. After the interview, After the interview was completed, Aunty had made me some food where she insisted for me to eat since she had prepared this before my arrival. This truly left me feeling very grateful and humbled. Thank you Aunty.

*Recruitment: Part 2*

Today I went to the *gurdwara* (temple) to recruit participants and typically an announcement is made on my research study and I will stand up and say hello to everyone to make the community aware of who almost 'make face'. After today's scheduled prayer, one of the uncles at the *gurdwara* approached me and told me that he will help me as much as he can since he believes my research study is very critical. He told me that he will influence the ladies to participate and that once I have interviewed one woman, it will become a snowball effect where more women will become open to participating. As I was leaving today, this woman approached me and asked for more information about this study. I explained to her what this study was about and I showed her my informed consent form and the interview questions. While she was looking at these documents, I expressed to her that she can take these forms home and we can speak more about this study outside of the *gurdwara* because it was very loud and noisy. As she was leaving and telling me that she will be in touch with me shortly, her husband approached her and asked her what those documents were. Before I could explain, the husband returned the documents back to me and told me that his wife will not be participating. I was so confused and angered that I was staring at the wife to see her reaction. The woman just stared at the floor and quietly got up and left. Her husband clearly showcased his patriarchy and told his wife what she was able to do and not do. It made me so frustrated for even though I have read about this and written about this in my thesis, seeing it first-hand made me feel so hopeless as I was unable to convince this man to allow his wife to speak about her mental health. What was it that he was trying to hide? Was he scared that his wife could potentially speak out about something? When will this

level of disrespect of women come to an end? It's so frustrating because we have glamorized the Punjabi culture with our over the top weddings and perfecting our presence of ourselves to others but when will we speak to the harsh realities that are masked in our culture?

Why is it that men needed to push for my research study and no other women from the gurdwara to help support me. The uncle from the gurdwara told me that he will tell the women to support me but why do they need this "push" from a man that it is ok to participate in this study? Why is it Punjabi culture has pinned our women against each other? Why am I seeing this in the relationships with other women in 2018 as well? This is a big issue in the Punjabi culture that is almost unspoken about. We don't have enough women supporting each other and is it because we've been adjusted to this patriarchal culture? Is it ingrained in us?

*Apna (our own)*

I recently watched a documentary by a British film director, Gurinder Chadha, who is a Punjabi-Sikh, Kenyan South Asian descent, titled "I'm British But...". This documentary explored a working-class town on the outskirts of West London, United Kingdom, home to a large South Asian community that first began taking shape in the late 1950s and early 1960s. The film director Chadha captures the lives of the sons and daughters of South Asian immigrants and how their lives have been infused with British identity.

While I was watching this documentary, it played a song that referenced how many immigrants from India have left "their Punjab" to only come to a foreign land where they're not respected, rather mocked, and the soil is contaminated. This song made

me start reflecting on how one of my participants spoke about how she very much enjoyed listening to old Punjabi folk music when she was struggling with her migration to Canada. I began exploring Punjabi music from the 1970's and 1980's and the one things that all these different artists had in common was their references regarding the hardships many people have experienced when immigrating to various countries. These folk songs all spoke to these Punjabi immigrants leaving their homes to make money to help their families back in Punjab and their inability to turn back without financially supporting their families. The songs also referenced taking insults from "goray" (white people) and losing their disconnect with their beloved Punjab and feeling like they don't necessarily fit in the new country they migrated to. It made me start thinking about these first generation immigrants about how they were able to put their heads down and literally grind. How were they able to do this? For even though I'm born and raised in Canada and do not experience any language barriers, I at times wake up in the middle of the night with severe anxiety about my future and it made me start thinking about these immigrants that couldn't turn back but had to almost just "figure it out" and put aside their mental health and well-being for the sake of their families well-being. Are we just too spoiled now or are we just acknowledging the symptoms of poor mental health? I have too much respect for these first generation immigrants. Us second generation immigrants will never understand that struggle and their hard work. Thank you for your hard work.

*Feels Like Home*

Every time I go to a participant's home, I always bring a box of sweets with me to show my hospitality. Similar to my past experience I was greeted at the door with a big

hug, a glass of water, and some short conversation about the weather in Halifax and how it is similar to India's weather right now. I went through the research study with her and she told there is no issue and that she is happy to help. Throughout the interview, the participant's daughter-in-law made a smoothie for me to drink and I couldn't stop thinking about the whole concept of hospitality in the Punjabi culture. The sense of making people feel comfortable. After the interview the participant even offered for her son to drive me home and I kindly declined. I have lived in Halifax for over two years and just interacting with these participants and even interacting with the people at the temple has made me feel so comfortable. Feels like I have my own, which is a term that my own participants use. I wonder if I would feel the same way had I not been a Punjabi woman or from another ethnic group. But a part of me is thankful as well.

### *Belonging*

After interviewing a participant, I was greeted by some of her family members in her home. They were all so welcoming to me and were very much interested in my research study and some of the second generation family members voiced how crucial it is to speak about mental health in the Punjabi community. One of the family members was a second generation woman who appeared to be in her mid 30's and she made a statement that expressed hurt and anger. She was speaking to me in Punjabi and translated she said "You know you made it in this country when you get educated, get a good job, stand on your own two feet, get married to your own kind, and practice your culture. That's how you show them that you've made it that we came to your country, practiced our culture, and we stuck to our own". As she was saying this I noticed her voice became louder, her body language become tense, and she overall became very

aggressive. When she spoke to me, all I could feel was her pain of her being an Indo-Canadian woman who was living in Nova Scotia and I felt as if she was expressing the importance of the Punjabi community members to stick together since it sounded like they weren't accepted here. I felt sad listening to her speak because she must've experienced some kind of trauma that must've caused her to make such a strong statement, especially when she referred to white people as "them" and referred to Canada as "your country". I wonder how many generations it will take for these Indo-Canadians that are living in Nova Scotia to feel like this is their home as well and that we are all one?

#### *Developing a Connection*

While recruiting participants from the Sikh temple, I found it very challenging to connect with the older women in the community. I was this unmarried "Canadian girl" (in their eyes). Every time I would attend the religious services on Sunday I would always get this rush of anxiety because when I would enter the temple it was all eyes on me. Majority of the people at the temple would just stare at me, curious of who I am. When I would speak to the community after the prayers about my research study and how I'm looking for participants, the older Punjabi women would listen attentively but would never come and speak to me about it. At one point I even contemplated flying my mom to Halifax so that these women could have representation of themselves and that my mom could help bridge the gap between these older Punjabi women and myself. Since reputation and status is a major concept in the Punjabi culture, it made me think that maybe if my mom was here to speak to these women about what kind of family we come from that it would help with recruiting participants. Was this a limitation in my research

study? Would it have made a difference if my mom came here and attending the prayer services with me? I find it appalling that even though our religion preaches about equality and about not passing judgement on others, why is that culturally values are still practiced in these religious institutions?

*The Hidden Truth*

During one of my interviews with a participant, she expressed to me that some Punjabi women may not have good mental health because their husbands could be alcoholics and are living in chaotic home. When she made this statement I wanted to probe her and ask her if that was the case for her because I was not expected any participant to mention anything about alcoholism and mental health in the Punjabi culture. I felt as if probing her would make her feel uncomfortable since it is such a personal question about her home life. I suddenly became drawn to this illustration provided by Vik Kainth which showcases four Punjabi men getting together and enjoying their classic booze filled 'boy's night' while their wives sit in the corner with their children hoping their husbands behave and are able to go home safely.

Alcohol abuse in the Punjabi culture is a topic that is heavily stigmatized to speak out about since it could ruin a family's reputation that is held with strong pride and honour. It made me think about these poor Punjabi women who had to accept their husbands being alcoholics, and at times suffer from physical and emotional abuse, all while caring for their children. With the traditional Punjabi family life surrounding patriarchal structure, many Punjabi women experience social isolation and are left to deal with mental illnesses like depression on their own.

Statistically, depression largely affects immigrant Punjabi women when compared to Canadian born women. Why is it that the patriarchal Punjabi culture has normalized bad behavior and left our women to suffer silently? As a Punjabi woman, I believe it is important to challenge people in our lives to stop perpetuating their patriarchy through microaggressions. If we know it is taboo to speak out about alcohol abuse or topics surrounding mental health, then it is vital we as active members in the Punjabi culture take a stand and help stop this reoccurring matter.

These women do not deserve to accept their husbands excessive drinking and suffer in silence. Many Punjabi women are the backbones to keeping their families together, and I hope as the immigrant Punjabi population increases throughout Canada, we as a society can help our men and women who may be enduring this abuse and suffering from alcohol abuse to become better and stronger.

### *The Immigrant Struggle*

While hanging out with my dad one day, we began discussing the struggles we both have faced as him being an immigrant man and me as an Indo-Canadian. Obviously there was a clear difference of what I considered to be a struggle, compared to what my dad has been through. The topic of school came up and I started explaining to my dad about how I found school very challenging because of my limited English vocabulary especially when I was in school from kindergarten to grade 5. Asking for help in school made me feel embarrassed because some English words did not make any sense to me. I also didn't want to raise my hand for help since some of my teachers were quick to get frustrated and I didn't want my classmates to think I was not that bright. My marks in grade five dropped significantly because of this fear. When I told my dad about my fear

when I was in elementary school, he told me a story about how he was very fearful for my future and my brothers.

Because my dad never got the chance to pursue an education in Punjab, the ability to send his children to the best schools possible became his life mission. My dad enrolled my brother into a prestigious private school 'St. John Kilmarnock', a school where it costed approximately \$25,000 a year not including the school uniform, transportation (it was 35 minutes away from our home) and textbooks (each class required students to purchase the required textbooks). It was crucial for my dad to enroll my brother in that private school because he thought it was the only way my brother would be able to pursue a post-secondary degree. My dad, who is a labourer made his life mission to send my brother to this private school for his Grade 12 and OAC year (grade 13). He told me that when my brother started attending St. John Kilmarnock, he recently bought a home for our family, where he made monthly mortgage payments of \$1800, while investing monthly in my education fund and paying for the utilities, groceries, and everyday living costs. To make ends meet, my dad worked over time to make sure my brother and I were taken care of. He began telling me that his body hurts today from the stress he had put on his body during those tough times and how he has worked in shift work for the past 25 years. He told me that he worked all 3 shifts in one weekend since he would receive over time (meaning more pay). He worked one Friday night from 11pm till 7am, came home Saturday morning, slept from 8am till 1pm and then left to work at 1:30pm to begin his afternoon shift from 3pm till 11pm, reached home on Sunday night at midnight, slept till 5am and went to work for the day shift from 7am till 3pm. As he was telling me this story, his eyes were filled with tears, and proceeded to tell me that when he was driving

home on that Sunday afternoon at 3:30pm he was unsure which directions the cars were approaching him on the 401. He had to pull his car over on the busy highway because he was terrified to drive. My dad worked that hard only because he had the fear that his children wouldn't reach their fullest potential or would miss out on the opportunity to get educated. I sometimes wonder about his mental health during those times. Did he have any anxieties? And if he did, how was he able to cope and keep going? When I look at my dad today, this strong 6'3 man, who is 63 years old and is physically exhausted, I start to think, will I ever be able to thank you?