



Qualitative study of the perceived causes of depression in South Asian origin women in Toronto

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STROBE Statement—Checklist of items that should be included in reports of *cross-sectional studies*

	Item No	Recommendation
Title and abstract	1	(a) Indicate the study's design with a commonly used term in the title or the abstract (b) Provide in the abstract an informative and balanced summary of what was done and what was found done PAGE 2
Introduction		
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported Pages 5-7
Objectives	3	State specific objectives, including any prespecified hypotheses pages 6/7
Methods		
Study design	4	Present key elements of study design early in the paper page Page 7
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection Page 7
Participants	6	(a) Give the eligibility criteria, and the sources and methods of selection of participants (b) Page 8
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable Not applicable
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group Page 8
Bias	9	Describe any efforts to address potential sources of bias Page 9
Study size	10	Explain how the study size was arrived at Page 9
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding Page 9 (b) Describe any methods used to examine subgroups and interactions (c) Explain how missing data were addressed (d) If applicable, describe analytical methods taking account of sampling strategy (e) Describe any sensitivity analyses
Results		
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing

		follow-up, and analysed page 7 and 9 and 10
		(b) Give reasons for non-participation at each stage
		(c) Consider use of a flow diagram
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders Page 9/10
		(b) Indicate number of participants with missing data for each variable of interest
Outcome data	15*	Report numbers of outcome events or summary measures
Main results	16	Qualitative study (a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included (b) Report category boundaries when continuous variables were categorized (c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses
Discussion		
Key results	18	Summarise key results with reference to study objectives page 18/19
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias page 20
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence Page 21
Generalisability	21	Discuss the generalisability (external validity) of the study results
Other information		
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based Page 4

*Give information separately for exposed and unexposed groups.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at <http://www.plosmedicine.org/>, Annals of Internal Medicine at <http://www.annals.org/>, and Epidemiology at <http://www.epidem.com/>). Information on the STROBE Initiative is available at www.strobe-statement.org.

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5 **Qualitative cross sectional study of the perceived causes of**
6 **depression in South Asian origin women in Toronto**
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5 **Objective:** To explore how South Asian origin women in Toronto, Canada, understand
6 and explain the causes of their depression.
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8 **Design:** Cross sectional in depth qualitative interviews
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10 **Setting:** Outpatient service in Toronto, Ontario
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12 **Participants:** Ten women with symptoms of depression aged between 22-65 years of
13 age. 7 were in India, 2 Sri-Lanka and 1 in Pakistan. 4 were Muslim, 3 Hindu and 3
14 Catholic. Two participants had university degrees, one had a high school diploma and all
15 the other participants (7) had completed less than a high school education. 8 were
16 married, 1 was unmarried and 1 a widow.
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18 **Primary outcome:** Causes of depression as presented in thematic content analysis with
19 some elements of grounded theory of in depth interviews.
20

21 **Results:** Three main factors emerged from the participant narratives as the causes of
22 depression: family and relationships; culture and migration; and, socio-economic. The
23 majority of the participants identified domestic abuse, marital problems and interpersonal
24 problems in the family as the cause of their depression with culture and migration and
25 socio-economic factors being contributory. None of our study participants reported
26 spiritual, supernatural, or religious factors as causes of depression.
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28 **Conclusion:** A “personal-social-cultural” model emerged as the aetiological paradigm
29 for depression. Given the perceived causation psycho-social treatment methods may be
30 more acceptable for South Asian origin women.
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Article focus

An exploration of the perceived causes of depression in women of South Asian origin in Toronto, Canada.

Key messages

Depression in South Asian women in Toronto may be caused by social problems that could be the target for prevention and health promotion.

Given the perceived causation, psycho-social interventions may be more acceptable for South Asian origin women in Toronto.

Links between social and health services may be important in decreasing the burden of depression in South Asian origin women in Toronto.

Strengths

This study was able to interview a diverse cross section of South Asian origin women in a community setting.

The interviewer was also a South Asian women and this may have facilitated disclosure.

Weaknesses:

The study did not disaggregate the South Asian group into different religious groups or countries of origin.

Key Words: South Asian women, causes of depression, qualitative, illness models

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All authors were involved in developing the concept, methodology, data analysis and drafting and editing the paper.

None of the authors has a conflict of interest.

Introduction

The way that people understand and explain illness depends on many factors including cultural background, education level, health beliefs, attitudes and knowledge and trust in health care systems.¹⁻³

Illness explanatory models (IEM) examine the perspectives people have of illness; mainly focusing on aetiology, symptoms, severity, prognosis, reasons for consultation, and treatment preferences⁴. Research suggest that IEM ultimately determine a number of factors including help-seeking behaviour, treatment compliance, satisfaction, selection of pathways to care and selection of treatment^{5,6}. IEM may vary between and within ethnic groups, gender groups, and different generations as well as for different types of illness⁷⁻⁹

A better understanding of conceptual models of illness may help to improve service delivery and clinical outcomes and reduce health care cost¹⁰.

Depression is one of the most under-recognized and under-treated mental illnesses in primary care globally¹¹. It is one of the most common and costly mental health problems in Canada^{12, 13}.

The rates of depression in immigrants in Canada varies; some groups such as older adults and some South and East Asian groups may be at increased risk¹⁶. Though the use of general medical care is similar for immigrants and non-immigrants but immigrants are less likely to use mental health services^{14,15}. The reasons for the increased rates of

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5 depression have not been well documented in Canada but with regards to service use
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7 studies report that ‘bio-medical’ models of health systems may act as barriers to care
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9 conflicting with the views of patients from other traditions^{17, 18}.

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14 Theoretical models of the aetiology of depression are diverse¹⁹. Bio-medical models
15
16 consist of genetic, physical, or somatic causation. Socio-cultural models include life
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18 circumstances and cultural factors, while psychological models focus on psychological or
19
20 behavioural factors. A multiple causation, ‘bio-psycho-social’, model has been widely
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22 accepted^{20, 21, 22}.

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26 The lay understanding of depression varies between cultural and ethnic groups. For
27
28 instance in European countries the majority of patients endorse ‘bio-psychiatric’ models,
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30 while in East and South East Asia psycho-social models predominate.²³ This may be
31
32 linked to differences in help seeking as the former prefer psychiatric treatment⁸ while
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34 latter prefer traditional healing, rituals, or faith healings¹⁶.

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40 Among the few Canadian studies that are focused on conceptual understandings of
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42 depression, Schreiber and Hatrick²⁴, reported that Euro-North American women
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44 predominantly report a ‘bio-medical’ explanatory models. But, to our knowledge, there
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46 are no studies conducted in Canada that have investigated the conceptual models of
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48 depression in minority ethnic groups. In order to begin to fill this gap in the literature, we
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50 conducted a qualitative study of women of South Asian origin. The aim of the study was
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5 to identify and document how South Asian origin women in Toronto, Canada, understand
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7 and explain the causes of their depression.
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10 The South Asian population is the largest visible minority in Canada²⁵. 'South Asian'
11
12 refers to people who originate from India, Sri Lanka, Bangladesh, Pakistan, and Nepal.
13
14 They are a diverse group with significant ethnic, religious, and linguistic differences; but
15
16 it has been argued that these groups share commonalities in their social networks, family
17
18 interactions, and customs and traditions^{26, 16}. This study investigated only one gender
19
20 groups because conceptual models of depression vary by gender⁹. Women were chosen
21
22 because the prevalence and incidence of depression is higher in this group^{27, 28}. Exposure
23
24 to risk factors may vary by gender group²⁹.
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31 **Method**

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33 In depth individual interviews using qualitative analysis was used.
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38 The sample included women over 18 years old, who were born in South Asia or whose
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40 parents were born in South Asia. 'South Asia' followed the Statistics Canada definition
41
42 of India, Sri Lanka, Bangladesh, Pakistan, and Nepal. Recruitment was from a
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44 community based mental health agency which provides services to racialised
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46 communities in Toronto, Ontario in 2010. Community workers referred participants to
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48 the study or participants answered an advertisement placed in the community agency.
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5 Those who were unable to read and speak in English were not included in this pilot study
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7 as there was no funding for interpreters. In order to increase the heterogeneity of the
8
9 sample, we purposively recruited participants who had migrated from different countries,
10
11 had differing marital status and belonged to different religious groups.
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16 Depression was confirmed using GHQ 12 questionnaire. Those who scored more than 12
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18 points (on a Likert scale) were invited for interview. Participants were provided with an
19
20 environment to speak freely and openly about their experiences. The aim was to get a rich
21
22 description of the perceived causes of depression from the perspective of the respondents.
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28 Interviews were conducted by the first author (SE) and lasted 45-60 minutes. A topic
29
30 guide was used to direct the flow of the interviews. The structure of the interview was as
31
32 follows: participants were first asked to explain their personal, family and household
33
34 circumstances. Then they were invited to talk about their health, their understanding of
35
36 causes of their depression, their daily lifestyles, employment, the nature of any social and
37
38 economic difficulties, and any social problems they faced. Finally, the participants were
39
40 asked to comment on how they believe that those circumstances related to their mental
41
42 health status. Interviews were taped and transcribed. All the transcripts were anonymized.
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50 Ethics approval was obtained from the Research Ethics Board of the Centre for Addiction
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52 and Mental Health in Toronto, Ontario prior to the recruitment. An informed consent was
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54 obtained prior each of the interview.
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7 Thematic content analysis with some elements of grounded theory³⁰ was used to analyse
8 the data. Data collection, coding and analysis were inter-related processes. The analyses
9 of interview transcripts was begun after the first interview. We used a modified version
10 of interview transcripts was begun after the first interview. We used a modified version
11 similar to the three step coding and analysis approach (open coding, axial coding and
12 selective coding) introduced by the Strauss and Corbin³⁰. Each transcript was read at least
13 twice and core concepts were identified. Codes were assigned for the selected texts. This
14 was further developed by adding sub-themes which were followed by the detailed coding.
15 A preliminary coding scheme was developed after indentifying the major themes. The
16 relationships and differences between codes were identified. Coding was done separately
17 by each researcher (SE and KM), and then was discussed by the research team. The
18 researchers cross-checked their coding structures and, in cases where mismatches
19 occurred, we conducted detailed discussions to achieve consensus. NVivo₉ qualitative
20 data analysis software³¹ was used for the data analysis. Recruitment was stopped when no
21 new themes were being identified fro the transcripts.
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43 **Results**

44 The sample:

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47 Participants were aged between 22-65 years of age. Seven women were born in India,
48 two in Sri Lanka and one in Pakistan. Four women were Muslim, three Hindu and three
49 Catholic. Two participants had university degrees, one had a high school diploma and all
50 the other participants (7) had completed less than a high school education. None of the
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5 women were employed, and all were dependent on some form of income support from
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7 the government such as Ontario Disability Support Program (ODSP), Employment
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9 Insurance (EI), or the Old Age Security (OAS) program. Eight women were married, one
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11 was unmarried and the other was a widow. Two of the women had some history of
12
13 mental illness other than depression.
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16 17 18 19 **Causes of depression:**

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21 Three significant factors that cause depression were emerged from participant's
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23 narratives:
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- 25
26 1) individual, family and relationships;
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28 2) culture and migration; and,
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30 3) socio-economic factors.
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36 Participants endorsed a variety of combinations of these problems with some identifying
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38 difficulties in all three as the cause of their depression. Table 1 presents a summary of
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40 themes and sub-themes emerged from the narratives.
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45 Table 1 about here:
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49 **1. Individual, family and relationship factors**

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5 Individual, family and relationship factors were identified as the primary cause of
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7 depression by the majority of the participants. Domestic abuse, infidelity, stress of
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9 divorce or separation, and bereavement were the main stressors behind the depression.
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12 13 14 *Abuse*

15
16 All members of the study group experienced some form of domestic abuse such as
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18 physical, social, psychological, verbal or economic abuses from their intimate partners.
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20 Prolonged traumatic and abusive experiences were viewed as the root cause of their
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22 depression.
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29 Financial or economic abuse was reported frequently by the participants. Many women
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31 explained that they were forced to 'find jobs', 'work all seven days, or 'earned as much
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33 as', even though they were not allowed to have their own bank accounts. Some of our
34
35 participants claimed that their husbands stole money from them, used their credit cards
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37 without authorisation and some stated that they were forced to get bank loans.
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43 *ID 6: I had very stressful life..I worked in a factory.. I used to work all 7 days. ..On*
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45 *Fridays my husband used to come to my work place. He took my cheque and asked me to*
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47 *sign the back of it. He takes all the money & gives me \$20 per week for the bus pass.. I*
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49 *felt desperate.. I had no money for anything...and he told to everybody that 'I have a*
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51 *money maker at home'...*
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5 Restriction of personal contacts and demanding that women do not talk to other people in
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7 the neighbourhood were also identified as a main stressor. When husbands abandoned
8
9 these women they were devastated as they were socially isolated and left with little or no
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11 access to money. Lack of understanding of support systems, and fear of talking to
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13 unknown people, together with language difficulties, led these women to remain silent.
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18 Physical abuse, such as beating, slapping and hair pulling was mentioned by the majority
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20 of the women in the study group. According to the participants, their children were also
21
22 victims of these incidents. The other forms of psychological or physical abuse, such as
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24 'forcing to get out of the home', 'forcing to wear hijab', and 'name calling' also were
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26 mentioned.
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33 *ID 4: In India it's perfectly normal for your husband to beat you...you have no choice*
34
35 *other than just suffering.. When I came here, I thought it's normal too... and he hit me*
36
37 *very badly to my shoulders, even blood came and my children cried... neighbors also*
38
39 *heard...I had this experience for 17 years...*
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43 44 **Health problems**

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46 The majority of the participant's had been affected by some form of physical health
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48 problem. Narratives indicated that they felt overwhelmed by the stress of their poor
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50 health status. There were some participants, who were suffering from prolonged multiple
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52 illnesses such as diabetes, high blood pressure, fibromyalgia, and osteoporosis.
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7 *ID 6: Sometime I still I feel that why all these things happened to me. My whole body is*
8 *paining. I was very active in the past..... but now both hands are not good. I had an*
9 *operation too. But still I can't even use my hand to eat food. Sometimes I keep plate on*
10 *the table and eat like a dog....*
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19 ***Bereavement***

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21 According to ID 8 (54 years old and a widow with no children), bereavement was the
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23 main cause of her depression.
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28 *"ID 8: He is a very good husband, he never leave me alone. Every time when I go to*
29 *doctors appointment he comes with me.....Now some times I don't eat, don't drink and*
30 *crying all the time... Even I can't sleep. I remember him always...I got all this condition*
31 *when he passed away.. "*
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40 Lack of extended family support, language difficulties that prevented her from attending
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42 grief counseling, and an inability to develop supportive social networks in the
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44 neighborhood made ID 8 more vulnerable to complicated grief reactions.
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49 ***Sexual infidelity***

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51 The sexual infidelity of an intimate partner can be a devastating experience. Among the
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53 seven divorced or separated women in our sample, four mentioned that they discovered
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5 that their husbands were having extra-marital relationships. They reported worry, sadness
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7 and depression following this.
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10 11 12 *Aging and isolation* 13

14 Some older aged participants commented that their married children were not keen on
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16 caring for them, while others mentioned the burden of additional household chores such
17
18 as caring for their grandchildren. Feelings of emotional and physical isolation, fear of the
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20 future because of their reliance on others and an inability to perform their own household
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22 activities (due to poor physical and mental health) led them to feel hopelessness and
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24 despair.
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31 **2. Culture and migration** 32 33 34

35 *Stress of divorce and separation* 36

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38 With the exception of one participant aged 33 years, none of the divorced or separated
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40 women were involved in secondary relationships. Thinking of a second marriage or
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42 having romantic relationships still remains 'unsuitable' or 'out of culture' concepts
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44 among the middle-aged and older women in this community. Results indicated that
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46 knowing that their former spouses had remarried or were currently involved in some sort
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48 of relationship brought these women more worry and jealousy.
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5 Our samples claimed that traditionally in some SA cultures, divorce and separation are
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7 not acceptable and women may be blamed for a breakdown of their marriage. Participants
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9 painfully described the immense burden, stigma, and stress experienced once they were
10
11 divorced or separated from their spouses.
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17 *ID 4 “On the middle of the night he left me... I got a panic attack. I thought I am going to*
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19 *die...I was scared... How will society think now.... What will happen to my children?*
20
21 *How will my parents and my people react to me when I go to India? What am I going to*
22
23 *tell them?...When he started to get papers sent by the lawyer he phoned me and told me I*
24
25 *am a characterless woman. That was first time I went to court, your family no body do*
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27 *that...”*
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33 Participants also talked about the negative responses from their own family or other SA
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35 community members about their decision to get a divorce. Some of the women were still
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37 using their husbands’ surnames or lying about their actual family status, while others
38
39 dealt with the problem by cutting themselves off from other SA people.
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45 ***Cultural distance***

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47 Results showed that cultural distance between parent and children was also stressful for
48
49 both groups. Those with strong SA values seemed to be more depressed and were not in a
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51 position to accept their children’s out-of-culture marriages or pre-marital relationships.
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5 They further believed that they did not have power or authority to influence their
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7 children.
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11 *ID 3: “My son went out my culture and married. He married a Spanish girl. She doesn’t*
12 *want me to be in his life. Although I try hard to tell him she was not really kind of people*
13 *we need...he didn’t listen to me. ...now he is suffering. One day this woman asked me to*
14 *make a beef soup. I don’t eat or even touch beef.. I really keep rules that I was taught to*
15 *live.”.*
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24 In contrast, younger participants claimed they were suffering because of the strict rules of
25 their parents. They identified themselves as being caught between traditional and modern.
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27 Some of our participants believed that they were brought up in more restrictive family
28 environments than other Canadian girls in their age groups. Some said they had been
29 asked to ‘quit schools’ or ‘choose jobs suits to girls’ or ‘get marry through arranged
30 marriages’. Narratives further indicated that younger SA women were having more
31 difficulties in negotiating their needs and expectations with their parents.
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43 ***Stigma***

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45 The cultural stigma of being labeled as a mentally ill person was also a continuous stress
46 factor. ID 2 revealed her observation about the SA communities and explained that some
47 people believe that a person with a mental illness is ‘an out of their control person’ or
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49 ‘should be look down upon’ or they should be ‘scared to talk’ with them.
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5 *ID 2: My dad is saying that since you are mental, you should get married. And I said*
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7 *why? He said then your husband makes you happy....But if someone knows that I am a*
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9 *mentally ill, then they don't marry me. In our society there is a big label on mental*
10
11 *illness..*

Difficulties in new country

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19 Migration related stress was also identified as a reason for depression. Migration is a
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21 transformation in immigrant's lives and it is associated with high hopes. Lack of
22
23 understanding of the Canadian system, especially limited knowledge concerning the
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25 existing resources and language difficulties, made their lives more difficult and stressful.
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Socio-economic factors

Economic difficulties

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37 Almost all of the participants were living on form of government income support.
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40 Participants acknowledged that depression was often linked to financial difficulties,
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42 especially when there is insufficient income support or loss of employment.
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Discrimination and racism

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50 Subjective experiences with unfair treatment, racist acts, or acts of hatred from other
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52 Canadians, were also identified as a cause of depression and powerlessness. Poorer
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54 access to 'high standard jobs' and differential treatment in health services and other
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5 service provision agencies were also highlighted. Participants openly talked about the
6
7 challenges they faced in Canada such as loss of cultural identity and loss of social pride.
8
9
10 Many Muslim women acknowledged that wearing of a 'hijab' caused some problems,
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12 especially after the 9/11 US attack. Participants also mentioned that immediate
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14 supervisors of other cultural backgrounds believed that people of 'SA identity' were
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16 inferior.
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21 *ID 4: ... Discrimination is 100% it's every where. Even at hospitals. If we ask something*
22 *they take you easy.... When people see me they think that I don't understand or speak*
23 *English. Even at job. When I was working that lady gave me very hard time.... The way*
24 *you dress up. They don't like you. If you dress like their own dress, if you speak like them*
25 *they will like you. But if you dress your own dress they will not happy.*
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35 **Discussion**

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38 Study findings highlight the multi-dimensional nature of the aetiology models of
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40 depression among SA immigrant women in Toronto, Canada.
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45 Similar to studies in other countries³²⁻³⁴ women of SA background in Canada perceived
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47 depression as an outcome of personal, family, cultural and social circumstances. Some of
48
49 the stress factors such as abuse, bereavement, sexual infidelity, and the stress of divorce,
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51 were identified as the root causes of depression. Other stressors, like physical health
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53 problems, aging and isolation, cultural distance, stigma, difficulties faced in Canada, and
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5 socio-economic problems were identified as continuous stressors but were considered
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7 less important and were less frequent.

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10 The participants endorsed a “personal-social-cultural” model for the aetiology of
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12 depression. In contrast with those previous study findings, none of our study participants
13
14 had spiritual, supernatural or religious attributions of depression.

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16
17 The majority of past studies on IEM of depression have used primary care patients with
18
19 symptoms of depression^{8,33} or general population samples²³. In contrast, our sample was
20
21 of women who were being followed by a community mental health provider. It may be
22
23 that our sample had more chronic or severe depression or were people who were more
24
25 accepting of social and biological explanations and mental health system treatment.
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31 The findings reveal the depth of violent and traumatic living experiences suffered by
32
33 some women of SA origin. Some of their stories had remained secret for years. The
34
35 association between recent life events and depression has been well documented³⁶⁻⁴⁰. As
36
37 has the association with long-term negative self esteem, lack of social support, loss of
38
39 intimate relationship, living alone, and poor physical health conditions³⁸⁻⁴⁰.

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45 Immigrants face many challenges in their new countries; however, such challenges can
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47 be more profound during the adjustment process for women with less education and
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49 power³⁹. First generation SA women have been reported to be more likely to have lower
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51 self-evaluation and self-esteem¹⁶. The existing vulnerabilities and powerlessness of some
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53 SA women may increase after their arrival to Canada⁴¹. The degree and nature of abuse
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5 and oppression faced by SA women in Canada has been well documented by previous
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7 studies^{42, 43}. Our participants indicated that this was a major cause of depression⁴⁴.
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11 Divorce or separation is still considered unacceptable in many South Asian groups⁴⁵.
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13
14 Lack of traditional support systems to solve domestic violence and marriage disputes in
15
16 immigrant groups is problematic. These are designed to solve marriage problems and
17
18 keep the marriage together^{23, 41}. The lack of these led to some of the women in this study
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20 to get support from legal support services in Canada which led to divorce.
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26 There is some evidence that people of SA origin in Canada maintain close ties with their
27
28 country of origin and more strongly preserve their cultural heritage²⁶. This was confirmed
29
30 in by the views of old aged group. However, results further indicate that strong
31
32 attachment to the culture of their own countries has created a cultural distance and
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34 conflict between parents and children.
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40 We acknowledge the fact that this is a small study. It was based in Toronto and there
41
42 may be differences in SA populations living in rural areas and different urban areas in
43
44 Canada. The study also uses the term SA to identify a broad group of people with
45
46 significant cultural, social and historical differences. It is of interest that despite this their
47
48 narratives and the causes they thought were the main reasons for their depression were
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50 similar. We do not know how representative the results are. Indeed participants were
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52 selected from a community based mental health agency and this inevitably introduces an
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5 element of sampling bias. It may be that we selected people who had more severe
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7 depression, we may also have selected people who were more likely to accept
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9 mainstream help. However, with regards to the last point it is worth pointing out that the
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11 service we used to identify participants is a community based agency which specifically
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13 offers help to racialised groups and is run by multi-cultural staff with a SA woman as the
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15 chief executive. The service is funded by Ontario but is not considered by many as
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17 mainstream. Those who did not speak English were excluded and this may have skewed
18
19 the demographic. Despite all of this the narratives from our participants made the authors
20
21 feel compelled to share the data. This study does offer an in depth and sometimes
22
23 harrowing insight into the world of SA women in Toronto and the perceived causes of
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25 their depression. It offers possible avenues that could be further investigated for the
26
27 development of health promotion or illness prevention targeted at this population.
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36 This pilot study used a qualitative approach. However, it may be that a larger scale
37
38 mixed methods approach would allow quantification of the rates of particular risk factors
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40 and their associations and interactions. A large scale, mixed method study, involving both
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42 male and female participants, may be required to explore in more depth the IEMs among
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44 South Asians.
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49 **Summary**

50 In summary, this study provides an insight to conceptual models of depression among the
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52 SA immigrant women in Toronto, Canada. Attributions of depression heavily consisted
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54 of individual, family, relationships, social, cultural or economic consequences rather than
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5 biological or spiritual causation. The findings of this study further enhance our
6
7 understanding of the social determinants of mental health, and clearly show how
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9 individuals understand the combination of individual, family, social or environmental
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11 causation. The results of this study may have implications for policy, practice and
12
13 education. For the communities who heavily rely on personal-social-cultural models of
14
15 depression, it may be more beneficial and effective to provide a combination of psycho-
16
17 social and biomedical treatments. Culturally appropriate support to mediate domestic
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19 problems may be important in decreasing the rates and improving the outcomes for SA
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21 women.
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12 **Table1: Thematic framework of the results**
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1. Individual, family and relationship factors	Sub themes
Abuse	<p>Financial/economic: Controlling of income, forcing to work, stealing money, unauthorised use of credit cards, forcing to obtain loans.</p> <p>Psychological: Humiliation, threatening to take custody of children, restricting personal contacts, forcing not to talk family and friends.</p> <p>Physical: Beating, slapping, pulling hair and choking.</p>
Physical health problems	Multiple chronic illness, diabetes, high blood pressure, osteoporosis and fibromyalgia.
Bereavement	Lack of family support, difficulty in attending counselling, no social support networks in the neighbourhood.
Sexual infidelity	Social and emotional isolation.
Aging and isolation	Difficulties in living with children's families, isolation, extra work loads such as child caring for grandchildren.
2. Culture and migration	
Stress of divorce and separation	Negative response from family and community, cultural taboos on second marriage, loss of identity, fear and uncertainty of children.
Cultural distance	<p>Parents: worry concerning westernizing of children, out of culture marriages.</p> <p>Children: restricted family environments, strict rules, arranged marriages.</p>
Stigma	Labelling as a mentally ill, isolation from community
Difficulties in new country	Loss of expectation, lack of understanding of systems, language difficulties.
3. Socio-economic factors	
Economic difficulties	Lack of income from government income support programs, loss of jobs
Discrimination and racism	Unfair treatments, racist acts, acts of hatred, discrimination for jobs



**Qualitative study of the perceived causes of depression in
South Asian origin women in Toronto**

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Qualitative cross sectional study of the perceived causes of depression in South Asian origin women in Toronto

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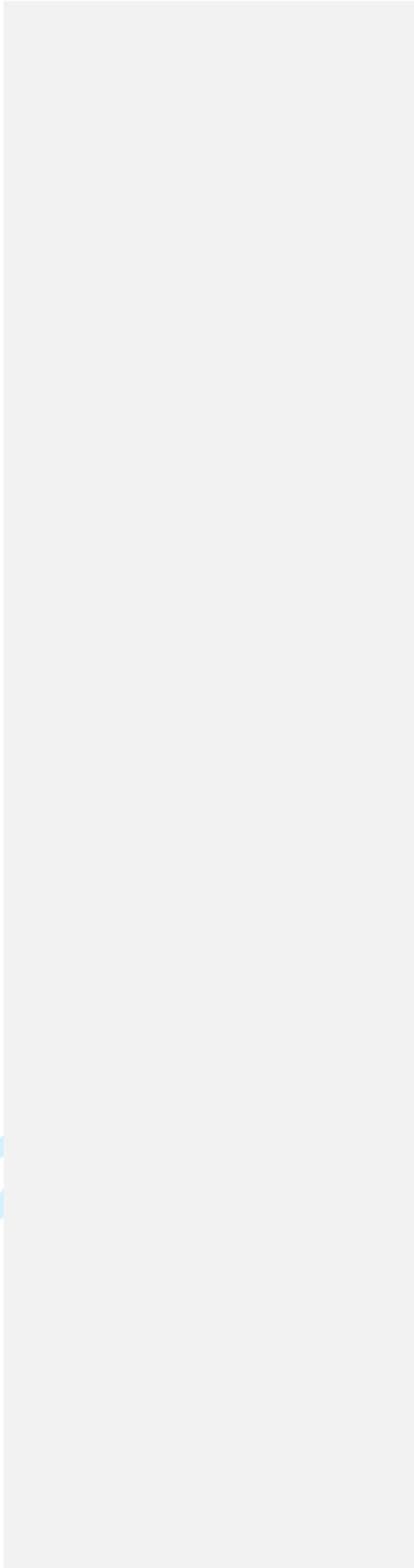
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11 **Objective:** To explore how South Asian origin women in Toronto, Canada, understand
and explain the causes of their depression.

12 **Design:** Cross sectional in depth qualitative interviews

13 **Setting:** Outpatient service in Toronto, Ontario

14 **Participants:** Ten women with symptoms of depression aged between 22-65 years of
15 age. Seven ~~7~~ were ~~from~~ -India, two ~~2~~ from 2 Sri-Lanka and one ~~1~~ ~~from~~ ~~in~~ Pakistan. Four
16 4 were Muslim, three ~~3~~ Hindu and three ~~3~~ Catholic. Two participants had university
17 degrees, one a high school diploma and seven had completed less than a high school
18 education. 8 ~~Eight~~ were married, one ~~1~~ was unmarried and one ~~1~~ a widow.

19 **Primary outcome:** ~~Causes of depression as presented in thematic content analysis with~~
20 ~~some elements of grounded theory of in depth interviews.~~

21 **Results:** Three main factors emerged from the participant narratives as the causes of
22 depression: family and relationships; culture and migration; and, socio-economic. The
23 majority of the participants identified domestic abuse, marital problems and interpersonal
24 problems in the family as the cause of their depression. Culture and migration and socio-
25 economic factors were considered contributory. None of our study participants reported
26 spiritual, supernatural, or religious factors as causes of depression.

27 **Conclusion:** A “personal-social-cultural” model emerged as the aetiological paradigm
28 for depression. Given the perceived causation psycho-social treatment methods may be
29 more acceptable for South Asian origin women.
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Article focus

An exploration of the perceived causes of depression in women of South Asian origin in Toronto, Canada.

Key messages

Depression in South Asian women in Toronto may be caused by social problems that could be the target for prevention and health promotion.

Given the perceived causation, psycho-social interventions may be more acceptable for South Asian origin women in Toronto.

Links between social and health services may be important in decreasing the burden of depression in South Asian origin women in Toronto.

Strengths

This study was able to interview a diverse cross section of South Asian origin women in a community setting.

The interviewer was also a South Asian woman and this may have facilitated disclosure.

Weaknesses:

The study did not disaggregate the South Asian group into different religious groups or countries of origin.

[This study only included participants who could speak English.](#)

Key Words: South Asian, women, causes of depression, qualitative, illness models

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All authors were involved in developing the concept, methodology, data analysis and drafting and editing the paper.

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None of the authors has a conflict of interest.

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Introduction

The way that people understand and explain illness depends on many factors including cultural background, education level, health beliefs, attitudes and knowledge and trust in health care systems.¹⁻³

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Illness explanatory models (IEM) examine the perspectives people have of illness; mainly focusing on aetiology, symptoms, severity, prognosis, reasons for consultation, and treatment preferences.⁴ Research suggest that IEM ultimately determine a number of factors including help-seeking behaviour, treatment compliance, satisfaction, selection of pathways to care and selection of treatment.^{5 6} IEM may vary between and within ethnic groups, gender groups, and different generations as well as for different types of illness.⁷⁻

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⁹ A better understanding of conceptual models of illness may help to improve service delivery and clinical outcomes and reduce health care cost.¹⁰

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Depression is one of the most under-recognized and under-treated mental illnesses in primary care globally.¹¹ It is one of the most common and costly mental health problems in Canada.^{12 13}

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The rates of depression in immigrants in Canada varies; some groups such as older adults and some South and East Asian groups may be at increased risk.¹⁴ Though the use of general medical care is similar for immigrants and non-immigrants but immigrants are less likely to use mental health services.^{15 16} The reasons for the increased rates of

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depression have not been well documented in Canada but with regards to service use studies report that ^{17+7 18 19+8} "bio-medical" models of health systems may act as barriers to care by conflicting with the views of patients from other traditions.

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Theoretical models of the aetiology of depression are diverse.²⁰⁺⁹ Bio-medical models consist of genetic, physical, or somatic causation. Socio-cultural models include life circumstances and cultural factors, while psychological models focus on psychological or behavioural factors. A multiple causation, "bio-psycho-social", model has been widely accepted.²¹⁻²³

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The lay understanding of depression varies between cultural and ethnic groups. For instance in European countries the majority of patients endorse "bio-psychiatric" models, while in East and South East Asia psycho-social models predominate.²⁴ Some argue that this may be linked to differences in help seeking as the former prefer psychiatric treatment⁸ while latter prefer more traditional socially focussed healing modalities.^{14, 19+6}

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Though it should be noted that patients may not seek help when there is clearly a need.¹⁹

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Among the few Canadian studies that are focused on conceptual understandings of depression, Schreiber and Hatrick²⁵, reported that Euro-North American women predominantly report a "bio-medical" explanatory models. But, to our knowledge, there are no studies conducted in Canada that have investigated the conceptual models of depression in minority ethnic groups. In order to begin to fill this gap in the literature, we

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10 conducted a qualitative study of women of South Asian origin. The aim of the study was
11 to identify and document how South Asian origin women in Toronto, Canada, understand
12 and explain the causes of their depression. This was an initial study to test the feasibility
13 of recruitment, to see whether South Asian women with depression would speak with
14 researchers about causation and to map out the range of models of causation in
15 population to aid the development of questionnaires and hypotheses for possible larger
16 mixed methods studies.
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25 The South Asian population is the largest visible minority in Canada.²⁶ 'South Asian'
26 refers to people who originate from India, Sri Lanka, Bangladesh, Pakistan, and Nepal.
27 They are a diverse group with significant ethnic, religious, and linguistic differences; but
28 it has been argued that these groups share commonalities in their social networks, family
29 interactions, and customs and traditions.^{14+6 27} This study investigated only one gender
30 groups because conceptual models of depression vary by gender.⁹ Women were chosen
31 because the prevalence and incidence of depression is higher in this group.^{28 29} Exposure
32 to risk factors may vary by gender group.³⁰
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43 Method

44 The study used qualitative techniques to analyse in depth individual interviews.
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48 The sample included women over 18 years old, who were born in South Asia or whose
49 parents were born in South Asia. 'South Asia was defined as per² Statistics Canada as
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India, Sri Lanka, Bangladesh, Pakistan, and Nepal. Recruitment was from a community based mental health agency which provides services specifically to racialised communities in Toronto, Ontario in 2010. Community workers referred participants to the study or participants answered an advertisement placed in the community agency.

Participants were informed about researcher' ethnic background, occupation and credentials. Also a description of purpose of the research was given with the study information materials. They were then approached face to face by the researchers and consented.

Those who were unable to read and speak in English were not included in this pilot study as there was no funding for interpreters. In order to increase the heterogeneity of the sample, we purposively recruited participants who had migrated from different countries, had differing marital status and belonged to different religious groups.

Depression was confirmed using GHQ 12 questionnaire. Those who scored more than 12 points (using the Likert scale) were invited for interview. Participants were interviewed alone at the community mental health agency offices. It provided them with an environment to speak freely and openly about their experiences. The aim was to get a rich description of the perceived causes of depression from the perspective of the respondents.

Interviews were conducted by the first author (SE), a South Asian immigrant woman, and lasted 45-60 minutes. A topic guide was used to direct the flow of the interviews. The structure of the interview was as follows: participants were first asked to explain their

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10 personal, family and household circumstances. Then they were invited to talk about their
11 health, their understanding of causes of their depression, their daily lifestyles,
12 employment, the nature of any social and economic difficulties, and any social problems
13 they faced. Finally, the participants were asked to comment on how they believe that
14 those circumstances related to their mental health status. Interviews were taped and
15 transcribed. All the transcripts were anonymized. Field notes were also made during
16 the interview.
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25 Ethics approval was obtained from the Research Ethics Board of the Centre for Addiction
26 and Mental Health in Toronto, Ontario prior to the recruitment. Informed consent was
27 obtained prior each of the interview.
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33 Thematic content analysis with some elements of grounded theory³¹ was used to analyse
34 the data. Data collection, coding and analysis were inter-related processes. The analyses
35 of interview transcripts were begun after the first interview. We used a modified version
36 similar to the three step coding and analysis approach (open coding, axial coding and
37 selective coding) introduced by the Strauss and Corbin.³¹ Each transcript was read at least
38 twice and core concepts were identified. Codes were assigned for the selected texts. This
39 was further developed by adding sub-themes which were followed by the detailed coding.
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46 A preliminary coding scheme was developed after indentifying the major themes. All
47 three researchers have post doctoral training in qualitative research and have published
48 qualitative papers in peer reviewed journals. The relationships and differences between
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10 codes were identified. Coding was done separately by each researcher (SE and KM), and
11 then was discussed by the research team. The researchers cross-checked their coding
12 structures and, in cases where mismatches occurred, we conducted detailed discussions to
13 achieve consensus. NVivo qualitative data analysis software³² was used for the data
14 analysis. Recruitment was stopped when no new themes were being identified from the
15 transcripts.
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23 Results

24 The sample:

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27 There were ten participants in the study. Everyone who was referred took part. There
28 were no dropouts. They were aged between 22-65. Seven women were born in India, two
29 in Sri Lanka and one in Pakistan. Four women were Muslim, three Hindu and three
30 Catholic. Two participants had university degrees, one had a high school diploma and
31 seven had completed less than a high school education. None of the women were
32 employed, and all were dependent on some form of income support from the government
33 such as Ontario Disability Support Program (ODSP), Employment Insurance (EI), or the
34 Old Age Security (OAS) program. Eight women were married, one was unmarried and
35 the other was a widow. Two of the women had some history of mental illness other than
36 depression.
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48 **Causes of depression:**
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Three significant factors that cause depression were emerged from participant's narratives:

- 1) individual, family and relationships;
- 2) culture and migration; and,
- 3) socio-economic.

Participants endorsed a variety of combinations of these problems with some identifying difficulties in all three as the cause of their depression. Table 1 presents a summary of themes and sub-themes emerged from the narratives.

Table 1 about here:

1. Individual, family and relationship factors

Individual, family and relationship factors were identified as the primary cause of depression by the participants. Domestic abuse, infidelity, stress of divorce or separation, and bereavement were the main stressors behind the depression.

Abuse

All members of the sample group experienced some form of domestic abuse such as physical, social, psychological, verbal or economic abuses from their intimate partners.

Prolonged traumatic and abusive experiences were viewed as the root cause of their depression.

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10 Financial or economic abuse was reported frequently by the participants. Seven Many
11 women explained that they were forced to “find jobs”, “work all seven days”, or², that
12 they were not allowed to have their own bank accounts. Three Some of our participants
13 claimed that their husbands stole money from them, used their credit cards without
14 authorisation and that they were forced to get bank loans.
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21 *ID 6 (45 years): "I had very stressful life..I worked in a factory. I used to work all 7*
22 *days. On Fridays my husband used to come to my work place. He took my cheque and*
23 *asked me to sign the back of it. He takes all the money and gives me \$20 per week for the*
24 *bus pass. I felt desperate. I had no money for anything...and he told to everybody: “I*
25 *have a money maker at home*” “²
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33 Restriction of personal contacts and demanding that women do not talk to other people in
34 the neighbourhood were also identified as a main stressor. When husbands abandoned
35 these women they were devastated as they were socially isolated and left with little or no
36 access to money. Lack of understanding of support systems, and fear of talking to
37 unknown people, together with language difficulties, led these women to remain silent.
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44 Physical abuse, such as beating, slapping and hair pulling was mentioned by eight the
45 majority of the women in the study group. According to the participants, their children
46 were also victims of these incidents. The other forms of psychological or physical abuse,
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10 such as being forced to get out of their home, being forced to wear hijab and being
11 called names were also mentioned.
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15 *ID 4 (45 years): "In India it's perfectly normal for your husband to beat you...you have*
16 *no choice other than just suffering. When I came here, I thought it's normal too and he*
17 *hit me very badly to my shoulders, even blood came and my children cried. Neighbors*
18 *also heard. I had this experience for 17 years."*
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24 25 **Health problems**

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27 Seven of the participant's had been affected by some form of physical health problem.

28 Narratives indicated that they felt overwhelmed by the stress of their poor health status.

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30 There were five some participants, who were suffering from prolonged multiple illnesses
31 such as diabetes, high blood pressure, fibromyalgia, and osteoporosis.
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37 *ID 6 (45 years): "Sometimes I still I feel that why all these things happened to me. My*
38 *whole body is paining. I was very active in the past... but now both hands are not good. I*
39 *had an operation too. But still I can't even use my hand to eat food. Sometimes I keep*
40 *plate on the table and eat like a dog."*
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46 47 **Bereavement**

48 According to ID 8 (54 years old and a widow with no children), bereavement was the
49 main cause of her depression.
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11 | *“ID 8 (54 years): “He is a very good husband, he never leave me alone. Every time when*
12 | *I go to doctors appointment he comes with me. Now some times I don’t eat, don’t drink*
13 | *and crying all the time. Even I can’t sleep. I remember him always. I got all this*
14 | *condition when he passed away.”*
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21 Lack of extended family support, language difficulties that prevented her from attending
22 grief counseling, and an inability to develop supportive social networks in the
23 neighborhood made ID 8 more vulnerable to complicated grief reactions.
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28 ***Sexual infidelity***

29 The sexual infidelity of an intimate partner can be a devastating experience. Among the
30 seven divorced or separated women in our sample, four mentioned that they discovered
31 that their husbands were having extra-marital relationships. They reported worry, sadness
32 and depression following this.
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40 ***Aging and isolation***

41 | *Two of the ~~Some~~ older aged participants commented that their married children were not*
42 | *keen on caring for them, while others mentioned the burden of additional household*
43 | *chores such as caring for their grandchildren. Feelings of emotional and physical*
44 | *isolation, fear of the future because of their reliance on others and an inability to perform*
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10 their own household activities (due to poor physical and mental health) led them to feel
11 hopelessness and despair.

12 13 14 15 **2. Culture and migration**

16 17 18 19 *Stress of divorce and separation*

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21 With the exception of one participant aged 33 years, none of the divorced or separated
22 women were involved in secondary relationships. Thinking of a second marriage or
23 having romantic relationships after marriage remains an 'unsuitable' or 'out of culture'
24 concepts among the middle-aged and older women in this community. Results indicated
25 that knowing that their former spouses had remarried or were currently involved in some
26 sort of relationship brought these women more worry and jealousy.
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35 Our samples claimed that traditionally in some South Asian cultures, divorce and
36 separation are not acceptable and women may be blamed for a breakdown of their
37 marriage. Participants painfully described the immense burden, stigma, and stress
38 experienced once they were divorced or separated from their spouses.
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44 *ID 4 (45 years):* "—On the middle of the night he left me. I got a panic attack. I thought I
45 am going to die. I was scared. How will society think now? What will happen to my
46 children? How will my parents and my people react to me when I go to India? What am I
47 going to tell them? When he started to get papers sent by the lawyer he phoned me and
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11 *told me I am a characterless woman. That was first time I went to court, your family no*
12 *body do that.””.*
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15 Participants also talked about the negative responses from their own family or other
16 South Asian community members about their decision to get a divorce. Two Some of
17 these women were still using their husbands’ surnames or lying about their actual family
18 status, while others dealt with the problem by cutting themselves off from other South
19 Asian people.
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27 ***Cultural distance***

28 Results showed that cultural distance between parent and children was also stressful for
29 both groups. Those with strong South Asian values seemed to be more depressed and
30 were not in a position to accept their children’s out-of-culture marriages or pre-marital
31 relationships. They further believed that they did not have power or authority to influence
32 their children.
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41 *ID 3 (65 years): ““My son went out my culture and married. He married a Spanish girl.*
42 *She doesn’t want me to be in his life. Although I try hard to tell him she was not really*
43 *kind of people we need he didn’t listen to me. Now he is suffering. One day this woman*
44 *asked me to make a beef soup. I don’t eat or even touch beef. I really keep rules that I*
45 *was taught to live.””.*
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10 In contrast, younger participants claimed they were suffering because of the strict rules of
11 their parents. They identified themselves as being caught between traditional and modern.

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13 ~~Two of Some of~~ our participants believed that they were brought up in more restrictive
14 family environments than other Canadian girls in their age groups. Some said they had
15 been asked to ‘quit schools’ or ‘choose jobs that are suited to girls’ or have an arranged
16 marriage². Narratives further indicated that younger South Asian women were having
17 more difficulty in negotiating their needs and expectations with their parents.
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24 25 **Stigma**

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27 The cultural stigma of being labeled as a mentally ill person was also a continuous stress
28 factor. ID 2 (30 years) revealed her observation about the South Asian community and
29 explained that some people believe that a person with a mental illness is ‘an out control
30 person’ or ‘should be looked down upon’ or they should be ‘scared to talk’ with them.
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37 *ID 2: “My dad is saying that since you are mental, you should get married. And I said*
38 *why? He said then your husband makes you happy. But if someone knows that I am a*
39 *mentally ill, then they don’t marry me. In our society there is a big label on mental*
40 *illness.”*
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45 46 **Difficulties in new country**

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48 Migration related stress was also identified as a reason for depression. Migration is a
49 transformation in immigrant’s lives and it is associated with high hopes. Lack of
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10 understanding of the Canadian system, especially limited knowledge concerning the
11 existing resources and language difficulties, made their lives more difficult and stressful.
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13 14 15 **Socio-economic factors** 16

17 18 19 *Economic difficulties* 20

21 Almost all of the participants were living on form of government income support.

22 Participants acknowledged that depression was often linked to financial difficulties,
23 especially when there is insufficient income support or loss of employment.
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28 29 *Discrimination and racism* 30

31 Subjective experiences with unfair treatment, racist acts, or acts of hatred from other
32 Canadians were also identified as a cause of depression and powerlessness. Poorer access
33 to 'high standard jobs' and differential treatment in health services and other service
34 provision agencies were also highlighted. Participants openly talked about the challenges
35 they faced in Canada such as loss of cultural identity and loss of social pride. Many
36 Muslim women acknowledged that wearing of a 'hijab' caused some problems,
37 especially after the 9/11 terrorist attack in the USA. Participants also mentioned that
38 immediate supervisors of other cultural backgrounds believed that people of South Asian
39 'ethnicity' were inferior.
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ID 4 (45 years): “Discrimination is 100% it’s every where. Even at hospitals. If we ask something they take you easy. When people see me they think that I don’t understand or speak English. Even at job. When I was working that lady gave me very hard time. The way you dress up. They don’t like you. If you dress like their own dress, if you speak like them they will like you. But if you dress your own dress they will not happy. “

Discussion

The study findings highlight the multi-dimensional nature of the aetiological models of depression among South Asian immigrant women in Toronto, Canada.

Similar to studies in other countries³³⁻³⁵ women of South Asian background in Canada perceived depression as an outcome of personal, family, cultural and social circumstances. Some of the stress factors such as abuse, bereavement, sexual infidelity, and the stress of divorce, were identified as the root causes of depression. Other stressors, like physical health problems, aging and isolation, cultural distance, stigma, difficulties faced in Canada, and socio-economic problems were identified as continuous stressors but were considered less important and were less frequent.

The participants endorsed a personal-social-cultural model for the aetiology of depression. In contrast with those previous study findings, none of our study participants offered spiritual, supernatural or religious causes of their depression.³⁶

The majority of past studies on IEM of depression have used primary care patients with symptoms of depression^{8, 34} or general population samples.²⁴ In contrast, our sample was

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10 of women who were being followed by a community mental health provider. It may be
11 that our sample had more chronic or severe depression or were people who were more
12 accepting of social and biological explanations and mental health system treatment.
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17 The findings reveal the depth of violent and traumatic living experiences suffered by
18 some women of South Asian origin. Some of their stories had remained secret for years.
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21 Such silence in the face of psychological trauma has been identified in other studies of
22 women in other parts of the world.¹⁹ The association between recent life events and
23 depression has been well documented.^{37-41,37-41,37,38} - As has the association with long-term
24 negative self esteem, lack of social support, loss of intimate relationship, living alone,
25 and poor physical health conditions.^{42-44,37,41,42}
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33 The results of studies conducted with South Asian immigrant women in the UK are
34 consistent with some of our findings.^{43,44,45,46} The belief that depression has social
35 origins seems to be common in South Asian groups. Many women from these groups
36 link their depression with losses such as bereavement, ill-health or job related events.^{44,46}
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42 Immigrants face many challenges in their new countries; however, such challenges can
43 be more profound during the adjustment process for women with less education and
44 power.^{42,45,37,43} First generation South Asian origin women have been reported to be
45 more likely to have lower self-evaluation and self-esteem.^{14,16} The existing vulnerabilities
46 and powerlessness of some South Asian women may increase after their arrival to
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10 Canada,^{45,47} The degree and nature of abuse and oppression faced by South Asian women
11 in Canada has been well documented by previous studies.^{46, 47,48, 49} Our participants
12 indicated that this was a major cause of depression.^{48,50}

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17 Divorce or separation is still considered unacceptable in many South Asian groups.^{49,51}
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19 Lack of traditional support systems to solve domestic violence and marriage disputes in
20 immigrant groups is problematic. These are designed to solve marriage problems and
21 keep the marriage together.^{23, 41} Lack of these led to some of the women in this study to
22 get support from legal support services in Canada which led to divorce.
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29 There is some evidence that people of South Asian origin in Canada maintain close ties
30 with their country of origin and more strongly preserve their cultural heritage.²⁷ This was
31 confirmed in by the views of old aged group. However, results further indicate that strong
32 attachment to the culture of their own countries has created a cultural distance and
33 conflict between parents and children. The cultural vulnerability faced by immigrants,
34 specially by the South Asian immigrant women has been identified as a main cause for
35 depression by studies conducted in the UK.^{43, 50,45, 52}

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44 We acknowledge the fact that this is a small study. It was based in Toronto and there
45 may be differences in SA populations living in rural areas and different urban areas in
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48 Canada. The study was conducted in English and this may have imposed some limitations
49 on the findings as the participants may have felt more comfortable describing their
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10 | perceived causes of depression in their own languages. The study also uses the term
11 South Asian to identify a broad group of people with significant cultural, social and
12 historical differences. It is of interest that despite this their narratives and the causes they
13 thought were the main reasons for their depression were similar.
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19 We do not know how representative the results are. Indeed participants were selected
20 from a community based mental health agency and this inevitably introduces an element
21 of sampling bias. It may be that we selected people who had more severe depression, we
22 may also have selected people who were more likely to accept mainstream help.
23
24 However, with regards to the last point it is worth pointing out that the service we used to
25 identify participants is a community based agency which specifically offers help to
26 racialised groups and is run by multi-cultural staff with a South Asian woman as the chief
27 executive. The service is funded by Ontario but is not considered by many as mainstream.
28
29 Those who did not speak English were excluded and this may have skewed the
30 demographic. Despite all of this the narratives from our participants made the authors feel
31 compelled to share the data. This study offers an in depth and sometimes harrowing
32 insight into the world of South Asian women in Toronto and the perceived causes of their
33 depression. If these factors are the cause of depression for some in the community then
34 decreasing their impact may be a possible avenue that could be further investigated for
35 the development of health promotion or illness prevention targeted at this population.
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10 This pilot study used a qualitative approach. It demonstrated that recruitment of South
11 Asian women with depression is possible, that this group will discuss causation of
12 depression and it has led to a model for the types of causes identified. It has been used to
13 write a grant for a larger -scale mixed methods approach which would allow
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18 quantification of the rates of particular risk factors and their associations and interactions.

20 21 **Summary**

22 In summary, this study provides an insight to conceptual models of depression among the
23 South Asian origin women in Toronto, Canada. Attributions of depression heavily
24 consisted of individual, family, relationships, social, cultural or economic consequences
25 rather than biological or spiritual causation. The findings of this study further enhance
26 our understanding of the social determinants of mental health, and clearly show how
27 individuals understand the combination of individual, family, social or environmental
28 causation. Communities that perceive their illnesses as caused by social factors often
29 prefer social remedies. ~~The results of this study may have implications for policy,~~
30 ~~practice and education. For the communities who heavily rely on personal social cultural~~
31 ~~models of depression, it may be more beneficial and effective to provide a combination~~
32 ~~of psycho-social and biomedical treatments. Culturally appropriate support to mediate~~
33 ~~domestic problems may be important in decreasing the rates and improving the outcomes~~
34 ~~for SA women.~~

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47 Understanding the perceived causes of depression in the South Asian origin population of
48 Toronto may help in the development of culturally appropriate prevention strategies.
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32 **Table1: Thematic framework of the results**

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1. Individual, family and relationship factors	Sub themes
Abuse	<p>Financial/economic: Controlling of income, forcing to work, stealing money, unauthorised use of credit cards, forcing to obtain loans.</p> <p>Psychological: Humiliation, threatening to take custody of children, restricting personal contacts, forcing not to talk family and friends.</p> <p>Physical: Beating, slapping, pulling hair and choking.</p>
Physical health problems	Multiple chronic illness, diabetes, high blood pressure, osteoporosis and fibromyalgia.
Bereavement	Lack of family support, difficulty in attending counselling, no social support networks in the neighbourhood.
Sexual infidelity	Social and emotional isolation.
Aging and isolation	Difficulties in living with children's families, isolation, extra work loads such as child caring for grandchildren.
2. Culture and migration	

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Stress of divorce and separation	Negative response from family and community, cultural taboos on second marriage, loss of identity, fear and uncertainty of children.
Cultural distance	Parents: worry concerning westernizing of children, out of culture marriages. Children: restricted family environments, strict rules, arranged marriages.
Stigma	Labelling as a mentally ill, isolation from community
Difficulties in new country	Loss of expectation, lack of understanding of systems, language difficulties.
3. Socio-economic factors	
Economic difficulties	Lack of income from government income support programs, loss of jobs
Discrimination and racism	Unfair treatments, racist acts, acts of hatred, discrimination for jobs

Consolidated criteria for reporting qualitative research (COREQ): a 32- item checklist for interviews and focus groups

**Allison Tong, Peter Sainsbury and Jonathan Craig.
International Journal for Quality in Health Care, 2007. 19(6) 349-357**

No Item	Guide questions/description
Domain 1: Research team and reflexivity	
Personal Characteristics	
1. Interviewer/facilitator	Which author/s conducted the interview of focus group Samanthika Ekanayake page 9
2. Credentials	What were the researcher's credentials? <i>E.g. PhD, MD</i> Samanthika Ekanayake, PhD Farah Ahmad, PhD Kwame McKenzie, MD page 1
3. Occupation	What was their occupation at the time of the study? Samanthika Ekanayake- Post Doctoral Research Fellow Farah Ahmad - Assistant Professor Kwame McKenzie- Psychiatrist/ Professor page 1
4. Gender	Was the researcher male or female? Samanthika Ekanayake- Female page 9 Farah Ahmad – Female Kwame McKenzie- Male
5. Experience and training	What experience or training did the researcher have? All three researchers have post doctoral training in qualitative research and have published qualitative papers in peer reviewed journals. Page 10
Relationship with participants	
6. Relationship established	Was a relationship established prior to study commencement? Participants were referred to the study by community mental health case workers or by answering an advertisement in the community mental health agency. Page 8
7. Participant knowledge of the interviewer	What did the participants know about the researcher? <i>e.g. personal goals, reasons for doing the research</i>

	Participants were informed about researcher' ethnic background, occupation and credentials. Also a description of purpose of the research was given with the study information materials. Page 8-9
8. Interviewer characteristics	<p>What characteristics were reported about the interviewer/facilitator? <i>e.g. Bias, assumptions, reasons and interests in the research topic</i></p> <p>The Interviewer is a South Asian immigrant, woman page 9</p>
Domain 2: study design	
Theoretical framework	
9. Methodological orientation and theory	<p>What methodological orientation was stated to underpin the study? <i>e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis</i></p> <p>Thematic content analysis with some elements of grounded theory page 10</p>
Participant selection	
10. Sampling	<p>How were participants selected? <i>e.g. purposive, convenience, consecutive, snowball</i></p> <p>Purposive page 9</p>
11. Method of approach	<p>How were participants approached? <i>e.g. face-to-face, telephone, mail, email</i></p> <p>Participants were referred by case workers or answered and advertisement place at a community mental health centre, they were then approached face to face page 8-9</p>
12. Sample size	<p>How many participants were in the study?</p> <p>There were 10 participants – page 11</p>
13. Non-participation	<p>How many people refused to participate or dropped out? Reasons?</p> <p>There were no dropouts – page 11</p>
Setting	
14. Setting of data collection	<p>Where was the data collected? <i>e.g. home, clinic, workplace</i></p> <p>Participants were interviewed at the community mental health agency offices. Page 9</p>
15. Presence of non-participants	Was anyone else present besides the participants and researchers?

	Participants were interviewed alone. Page 9
16. Description of sample	<p>What are the important characteristics of the sample? <i>e.g. demographic data, date</i></p> <p>Participants were aged between 22-65 years of age. Seven women were born in India, two in Sri Lanka and one in Pakistan. Four women were Muslim, three Hindu and three Catholic. Two participants had university degrees, one had a high school diploma and all the other participants (7) had completed less than a high school education. None of the women were employed, and all were dependent on some form of income support from the government such as Ontario Disability Support Program (ODSP), Employment Insurance (EI), or the Old Age Security (OAS) program. Eight women were married, one was unmarried and the other was a widow. Two of the women had some history of mental illness other than depression. Page 11</p>
Data collection	
17. Interview guide	<p>Were questions, prompts, guides provided by the authors? Was it pilot tested? A topic guide was used to direct the flow of the interviews. Page 9 The study was a pilot.</p>
18. Repeat interviews	<p>Were repeat interviews carried out? If yes, how many?</p> <p>No</p>
19. Audio/visual recording	<p>Did the research use audio or visual recording to collect the data?</p> <p>Interviews were taped and transcribed. Page 9</p>
20. Field notes	<p>Were field notes made during and/or after the interview or focus group?</p> <p>Field notes were made during the interview. Page 10. They were not included in this data analysis</p>
21. Duration	<p>What was the duration of the interviews or focus group?</p> <p>Interviews lasted 45-60 minutes page 9</p>
22. Data saturation	<p>Was data saturation discussed?</p> <p>Recruitment was stopped when no new themes emerged. page 11.</p>

23. Transcripts returned	<p>Were transcripts returned to participants for comment and/or correction?</p> <p>Transcripts were not returned to the participants.</p>
<p>Domain 3: analysis and findings</p> <p>Data analysis</p>	
24. Number of data coders	<p>How many data coders coded the data?</p> <p>All three authors involved in coding. Coding separately conducted by Samantha Ekanayake and Kwame McKenzie and then it discussed with the research team. Page 10</p>
25. Description of the coding tree	<p>Did authors provide a description of the coding tree?</p> <p>Table 1 presents the thematic framework of the themes.</p>
26. Derivation of themes	<p>Were themes identified in advance or derived from the data?</p> <p>Themes were identified from the data. Page 10</p>
27. Software	<p>What software, if applicable, was used to manage the data?</p> <p>NVivo9, qualitative data analysis software. Page 10</p>
28. Participant checking	<p>Did participants provide feedback on the findings?</p> <p>Subsequent to writing the paper results were presented to some of the participants. But formal participant checking was not undertaken.</p>
Reporting	
29. Quotations presented	<p>Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? <i>e.g. participant number</i></p> <p>Yes. Results section pages 12-19</p>
30. Data and findings consistent	<p>Was there consistency between the data presented and the findings?</p> <p>We believe there is consistency between the presented data and the findings.</p>
31. Clarity of major themes	<p>Were major themes clearly presented in the findings?</p> <p>We have presented three major themes. : family and</p>

	relationships; culture and migration; and, socio-economic Page 11
32. Clarity of minor themes	<p>Is there a description of diverse cases or discussion of minor themes?</p> <p>Within the major themes we have discussed as separate subheadings minor themes. Page 12-19 and in our thematic framework.</p> <p>Individual and family (abuse, physical health, bereavement. Sexual infidelity, aging and isolation) Culture and migration (stress divorce and separation, cultural distance, stigma, difficulties in the new country) Socio-economic factors (economic difficulties, discrimination and racism)</p>