A SOUTH ASIAN WOMAN'S JOURNEY THROUGH DEPRESSION

By

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Abstract

In this thesis I am sharing my personal journey with depression to illustrate how bullying, racism, and low self esteem have all been factors that contributed to my mental health and eventually led to depression. These factors were complicated by my experience of being a second generation Indo Canadian in a small town where there were not many people of colour. It is my hope that by writing and talking about these very personal problems, that there will be an increased awareness and level of comfort in being able to talk about and understand the underlying causes of depression and other mental health issues. By sharing my personal narrative, I hope to encourage open dialogue, bring awareness to these issues, find a way to talk about these challenges and to find ways to effectively deal with them. I am also looking at existing literature where I will compare/contrast findings of the review with my auto-ethnography.

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DEDICATION

For my two loves, Daya and Ryan.

CONTENTS

CHAPTER I - INTRODUCTION

Depression in middle aged South Asian women is in part, linked to cultural and historical issues (Mathur, 2009). Being a second generation Indo Canadian Sikh carried a lot of pressure and stress, which started at a very young age for me. I was raised in a very small town on Vancouver Island where there were not many people of colour; I was the minority in this town and different from the Caucasians in town. Despite being born in Canada, it was not easy to fit in, to learn a new language and culture, and to try and adapt to the western way of life. In my childhood and throughout my teen years, I experienced a lot of racism, both directly and indirectly. There was verbal and physical abuse, bullying, discrimination, social rejection, and consequently, I experienced low self esteem and depression. For this reason, I feel it is important to look at how racism, bullying and subsequent depression and low self esteem, have affected me and possibly, many other South Asian women as well. This phenomenon is also prevalent with the general population at large; these issues may have resulted in depression or are at least linked to it. This area of research has not been investigated very comprehensively; I had a difficult time finding current resources on Indo-Canadian women and depression; there was not much current information available and there was very little data that has been published, especially with respect to depression in women that are South Asian, living in Canada. Indo-Canadians have become a large part of Canadian society yet there is little research that has been conducted on the social implications of mental health on this significant population. There is a large amount of literature on bullying, depression among women and consequent low self esteem but again, very little has been studied or published with regards to South Asian women; my main focus for research.

Purpose Statement

The purpose of this study will be to explore and understand my experience of living with depression as a South Asian, second generation and middle-aged woman. I will be researching existing literature and comparing and contrasting those findings with my auto-ethnography.

Key Terms and Definitions

South Asian and East Asian: an ethnic group of people originating from the countries of India, Sri Lanka, Pakistan, Nepal and Bhutan (Inman, 2006).

Indo Canadian: referring to someone who is living in Canada but whose origins are from the nations of India, Sri Lanka, Pakistan, Nepal and Bhutan.

First generation: South Asians born and raised in India and migrated to a western nation after age 18 (Inman, Ettigi, and Tummala-Narra, 2011).

Second generation: South Asians born or raised in a western nation before and up to the age of 18 (Inman et al., 2011).

Bullying: is unwanted, aggressive behaviour that involves a real or perceived power imbalance (Gordon, 2014).

Verbal bullying: using word statements and name calling to gain power and control over a target (Gordon, 2014).

Racism: prejudice, discrimination or antagonism directed against someone of a different race based on the belief that one's own race is superior.

Collectivistic values: emphasize the needs and goals of the group as a whole over the needs and wishes of each individual.

Bicultural: having or combining the cultural attitudes and customs of two nations, peoples or ethnic groups

Situating Myself as the Author

I am a 47 year old South Asian woman who currently lives in the province of British Columbia and have happily re-married. I have been working in the field of Mental Health for nearly 20 years. Due to my past history and personal experiences, working in this helping and healing profession really resonates with me.

Depression affects a lot of people all over the world and in particular, women (Mathur, 2009). For myself, I did not realize I was depressed until I was in my early forties. I was living a life of feeling anger, frustration, powerlessness, sadness, and assumed that this was a normal way of being. Depression has affected every day of my life but I did not start to deal with it until recently; it has had a major impact on every person in my life and my way of being in this world.

My response to living with depression as an Indo-Canadian woman was initially denying that I was feeling depressed. I chose not to cope with my depression and ignored that I had a problem for many years. Unfortunately, the experience of living with depression as a South Asian woman has been very difficult for me and I strongly suspect that I am not alone in this occurrence; there are many other women who have been suffering in silence and have not yet been able to get help. It is my hope that there will be future research and education into this phenomenon to prevent more women from having to undergo the painful experience of depression.

Structure of the Thesis

Chapter 1 of this thesis is primarily the introduction to the topic I have chosen to write about; living with depression as a second generation Indo Canadian woman. I included a purpose statement, key terms and definitions, and discussed my personal interest as the author.

In Chapter 2 I will be writing a literature review of the academic research that has been done on women and depression, then the effects of depression on South Asian women, followed by how bullying and racism and their relation to depression and lastly, interventions for depression among middle aged South Asian women.

In Chapter 3 I will discuss the methods I have used to write this thesis – I will explain auto-ethnography as a research methodology. I will also address researcher bias.

In Chapter 4 I will be sharing 'my story' of being a young girl growing up in a small town on Vancouver Island. The story will be in the form of vignettes of real life, lived experiences that I went through during my childhood and up to grade seven. These anecdotes will be written for the purpose of illustrating what it was like to be a minority Indo-Canadian child in a small town and endure bullying and racism. At the end of this chapter I will discuss the long term effects of these experiences on my life.

In the final Chapter, I will discuss a summary of my findings and implications for counsellors will be offered. I will compare and contrast the literature review to my personal story and talk about what we can learn from this study. I will look at areas for future research and discuss the limitations of this study.

CHAPTER 2 LITERATURE REVIEW

This literature review is intended to explore literature on South Asian women living with depression in India, Canada and other western nations. The initial portion of this review will consider women and depression. Next, implications of depression in women of a South Asian background will be discussed, followed by an exploration around bullying and racism and their relation to low self esteem and depression and finally, interventions for depression for middle aged South Asian women.

Women and Depression

Depression is a significant health problem associated with morbidity and death (Colvin, Richardson, Cyranowski, Youk, & Bromberger, 2011). It is estimated to be the third leading cause of disability across the world and the leading cause of health related disability in women (Colvin et al., 2014). Most people have felt sad or depressed at times. Feeling depressed can be a normal reaction to loss, life's struggles, or injured self esteem; but, when feelings of intense sadness including feeling helpless, hopeless, and worthless, last for many days to weeks and keep one from functioning normally then this sadness may very well be clinical depression (Gotlib & Hammen, 2009). According to the Diagnostic Statistics Manual Edition - 5 (American Psychological Association, 2013), a manual used to diagnose mental disorders, depression occurs when one has at least five of the following symptoms at one time:

A depressed mood during most of the day, feelings of worthlessness or guilt, fatigue or loss of energy, impaired concentration and indecisiveness, insomnia, a noticeable decreased interest or pleasure in almost all activities, a sense of restlessness, and significant weight loss or gain (American Psychological Association, 2013). A key

sign of depression is either depressed mood or loss of interest in activities that one once enjoyed (American Psychological Association, 2013). For a diagnosis of depression, these signs should be present most of the day either daily or nearly daily for at least two weeks (American Psychological Association, 2013). In addition, the depressive symptoms need to cause clinically significant distress or impairment. They cannot be due to the direct effects of a substance such as drug or medication. Nor can they be the result of a medical condition such as hypothyroidism (American Psychiatric Association, DSM-5, 2013).

Women are twice as likely to be diagnosed with a depressive disorder as men (Roseth, Binder, & Malt, (2013), although it is important to mention that being diagnosed does not necessarily mean that women experience depression more than men. A study by Roseth et al., (2013) focused on the role of emotions and extreme sensitivity in depression. In this study Roseth et al., (2013) randomly recruited women from two psychiatric outpatient clinics from two areas in Norway. The final selection consisted of women who met the criteria for melancholic depression (American Psychiatric Association, 1994). Two of the women had no children and the third had a preschool child. In addition, two of the women had no psychiatric history while one had experienced a previous depressive episode. The women were in ages ranging from 29-45 and were all in relationships with only one of the three living with her partner. The women were interviewed twice with each interview lasting 45-90 minutes in length and the interview was transcribed verbatim. They used Giorgio's descriptive phenomenological method (1970-2009) to interpret the results (Roseth, et al., 2013).

The analysis by Roseth et al., (2013) revealed that guilt and shame are almost always present and that women's emotions tend to be physically or bodily based. The women had a tendency to over invest in the work of others' emotions to relieve internal pain. The women were inclined to feel deeply sensitive to, and responsible for, another person's distress while ignoring their own feelings and needs. Gradually their own bodies would start to deteriorate immersing the negative feelings in their body and then they would surrender to depression (Roseth et al., 2013).

As women age, they are prone to different types of hormonal disorders; the reproductive cycle brings fluctuations in moods, including depression (Mathur, 2009). These disorders may lead to depression by the development of low self esteem, a sense of helplessness, self blame, social isolation, and low morale (Mathur, 2009). Depressive illness in turn makes women feel exhausted, worthless, hopeless, and sometimes develop the feelings to give up (Mathur, 2009). In a study by Mathur (2009), it was found that women often suppress their need for autonomy, neglect their health, and fail to acquire the skills to feel competence and self-confident. The qualitative study sample included 400 non-working, married women from ages 55-65 residing in a major city of India, Meerut City. Eighty five percent of the women had gone to graduate education and belonged to a lower and middle class background. The Beck Depression Inventory - BD II (Beck, 1979): Self report Questionnaire assesses the level of current depressive symptoms. Mathur's study (2009) indicated that poor lifestyle patterns such as poor nutrition and low economic status were significantly related with depression. Mathur (2009) explained this by mentioning that higher economic status women tend to have better resources and the means to maintain that life style and to participate in activities

that influence their well being. He further went on to say that middle economic class women poorly adjust to their circumstances as they are conscious of their identity and sometimes lose importance in the family. They tend to fail at maintaining their image in the family as they become so busy in rearing the next generation (Mather, 2009).

Sowislo and Orth, (2013) did a study on self esteem and its relationship to depression. They investigated the question of a relationship of self esteem with depression and anxiety by meta-analyzing 77 longitudinal studies providing information on the connection between self esteem and depression. This was done with 18 longitudinal studies on the relationship between self esteem and anxiety. The studies included sample characteristics such as sample size, country of origin, sample type, mean age of participants and proportion of female participants. Sowislo and Orth, (2013) found that there is a strong correlation between the two and suggested that the relationship between depression and self esteem has important implications for research. If future research can support this correlation, then there may be more interventions aimed at increasing self esteem to reduce the risk of depression resulting in a long-lasting, positive influence.

Implications of Depression in Women of a South Asian Background

Asian Indians are the third largest population group in the United States of America (U. S. Census Bureau, 2004). Indians are demographically and historically different from other Asian immigrant groups (Kumar & Nevid, 2010). In the U.S., Indians have the greatest percentage of individuals who speak English 'very well' and the highest educational achievement (US Census Bureau, 2004). Asian Indians retain a strong ethnic identity, while also adapting to the norms of their new country, resulting in

a unique combination of individualistic and collectivistic traits (Kumar and Nevid, 2010). Asian Indians have found a way to adapt to the western culture with respect to education and employment due to their tendency to have a high educational achievement, while at the same time they manage to follow their collectivistic cultural traits and ideals. These values are deeply engrained in Asian Indians and get passed down through generations. This pattern of acculturation may provide a distinctive framework for understanding how perceptions of mental health and illness vary in this community (Kumar & Nevid, 2010). Kumar and Nevid (2010) indicated that it is necessary to continue researching mental illness within the Indian community. This research may help determine community wide interventions that utilize cultural beliefs to promote acceptance of prevention and treatment of mental disorders.

In a Canadian study, the researchers found that Caucasians were more likely to use mental health services than those from a South Asian background (Tiwarii & Wang, 2008). Over 12 months, a study was done to observe the use of mental health service by different ethnicities with major depression. Data was collected from the Canadian Community Health Survey (CCHS-1.1). Participants included in this analysis were those who were born in Canada, white immigrants, Chinese and South Asians, and South East Asian immigrants. The participants were randomly selected from 10 provinces and were to be household residents aged 12 years old and older. The result was that Caucasians were more likely to have used mental health services than by any other ethnic group. They found that due to the increasing diagnosis of major depression in immigrants, it is important to understand how different the Asian immigrants are from Caucasians in the prevalence of mental health problems and mental health service use (Tiwarii & Wang,

2008). This information is critical to understanding the impact of social process on mental health. More investigations about the barriers that Asian immigrants face accessing health services are needed to develop strategies to promote mental health service for those who are in need of help (Tiwarii & Wang, 2008).

As mentioned earlier in the discussion of a study done by Mathur (2009), depression can occur at any age during a woman's life, irrespective of educational, economic and ethnic groups. The consequences can include an increased risk of suicide, medical illness, poor self care, and even morbidity (Mathur, 2009). A report released by the World Health Organization, (2012) states that depression threatens to be the world's most common illness by the end of the century, especially in women. The reason seems to be increasing stress levels, demands of work, and nuclear families, along with disappointment with the old world values and systems that make a person an easy target for depression (Mathur, 2009). It is much harder for each family member to have their own role in India where men work and women generally manage the children and the home. In North America, women are doing the traditional chores that women tend to do in addition to working in a career. The demands are greater on women who are more susceptible to depression; it is more difficult to cope with virtually no support system. The change in family patterns and the variation in social and economic status between generations are additional reasons for stress. Older people tend to suffer from isolation because they cannot always look to their grown children for emotional support (Mathur, 2009). Family life is very different in Canada due to how busy everyone in the household is trying to work, manage the house, and raise children. Older people are accustomed to having more time to interact with their grown children and have more

input into their children's life but due to life's growing demands, the grown children have less time to support and look after their elders. It has been observed that a higher rate of depression in women is not due to greater vulnerability, but due to the particular stresses that many women face; these stressors include major responsibilities at home and work, caring for children and looking after aging parents (Mathur, 2009).

In a study completed by Ekanayake, Ahmad, and McKenzie (2012), it was found that three main factors emerged as the causes of depression in the female participants account: family and relationships, culture and migration, and socioeconomic status. Their study was done through cross sectional in depth qualitative interviews that lasted 45-60 minutes in an outpatient service in Toronto, Ontario. There were 10 women with symptoms of depression from ages 22 to 65. Seven were from India, two from Sri Lanka, and one from Pakistan. Two of the participants had university degrees, one a high school diploma and seven had completed less than a grade eight school education. Out of the 10 women, eight were married; one was single and one a widow. None of the women were employed. A topic guide was used to direct the flow of the interviews. Interviews were taped, transcribed, and analyzed; data collection and coding were completed as an interrelated process. (Ekanayake, et al., 2012).

Ekanayake, et al., (2012) found that in family and relationships there is the possibility of domestic abuse, lack of social supports or family available, ageing, and isolation. For culture and migration there are stressors such as divorce or separation, taboos around a second marriage, and children and parents having a difference of western society values verses collectivistic values. Lastly, with regards to socioeconomic status, it can be difficult for immigrants to get jobs and keep them as they tend to face unfair

treatment and experience racist acts of hatred and discrimination for jobs (Ekanayake, et al., 2012). Once again, these problems could be the target for prevention and health promotion because depression is one of the most under recognized and under treated mental illnesses in primary care globally; it has also become a common and costly mental health problem in Canada (Ekanayake et. al., 2012).

Hussain and Cochrane (2004) reviewed research on South Asian women living in the United Kingdom (UK). The research has shown that South Asian people in the UK under-utilize health services compared with Caucasians; it highlighted the need for services for women in the UK (Hussain & Cochrane, 2004). As mentioned previously, it is widely accepted and known that the rates of depression are much higher in women than in men (Roseth et al., 2013). This has been attributed to gender differences in life events and biological factors (Palazidou, 2000). In addition, there is the added burden of child care responsibilities, experience of abuse, lack of employment, social isolation, and social roles and values (Hussain et al., 2004).

The researchers also looked at racism and the effect it has on depression (Fenton & Sadiq, 1990). There are two levels of racism; direct racism such as abuse, discrimination, and social rejection and indirect racism, which involves economic disadvantage, a perceived lack of opportunity, and low self esteem (Fenton & Sadiq, 1990). They found that all 16 of their respondents had experienced racism and hostility which increased their anxiety when added to other problems in their lives. They noted that often times, the emphasis on cultural differences can serve as a smoke screen for the impact of racism experienced by minority groups (Fenton & Sadiq, 1990).

Asian communities are known to attach greater stigma to mental illness than do white communities, which inhibits individuals and families from seeking professional help for psychiatric problems (Cartwright & Anderson, 1981). This may in part explain why mental health services are under utilized by South Asians. Culturally there is shame attached to mental illness and depression within South Asian communities. One reason why the stigma of mental illness is over emphasized in Asian cultures is that arranged marriage prospects are reduced (Qureshi, 1998). The responsibility of caring for a person with a mental illness, especially if it was unknown to the partner prior to marriage, is considered an inappropriate expectation, particularly when the choice of potential partner is made by a parent on behalf of their child (Qureshi, 1998). Future research in this area needs greater sensitivity to the underlying problems of cross cultural research (Hussain et al, 2004).

Bullying and Racism and its Relation to Low Self Esteem and Depression

Bullying consists of three components: 1) the bully commits negative actions intended to harm 2) the bully's actions are repeated over time 3) there is a power differential between the bully and the victim (Olweus, 2001). When individuals of equal power or status argue, it is not considered bullying; when the bullied victim is unable to defend or stand up for herself, it is now considered bullying. Olweus (2001) suggests that this is when a victim of bullying may experience an interruption of emotionally healthy adolescent development. This imbalance of power implies that individuals that have power within their social group are desperate to keep it and, adolescent girls in particular, are looking to be part of a group; sustaining a sense of belonging is important to them (Olweus, 2001).

Verbal bullying is defined as using "words, statements, and name-calling to gain power and control over a target. "Generally, verbal bullies will use relentless insults to belittle, demean, and hurt another person." (Gordon, 2014, p. 2) Gordon asserts that most verbal bullying is meant to target victims for the way they behave, look, or act.

According to Gordon (2014), the long term effects of verbal bullying are difficult to ignore and can result in maladaptive psychological responses well into adulthood, even if the adolescent child has outgrown middle or high school where the bullying took place. One could ask what makes bullying so difficult for the victim. Humans have an innate need to belong to a group, and although attachment forms in early infancy, there is a constant need to form emotional bonds with others that exists throughout our life time (Bowlby, 1969). For some individuals, the need for a sense of belonging can be so strong that even being rejected by a group that is not well regarded can be hurtful. One of the most damaging aspects of bullying to the victim is the helplessness it can create (Gordon, 2014).

South Asians have historically experienced discrimination but their successes in certain areas such as education and economics have overshadowed their experiences as a marginalized minority (Inman, 2006). Kaduvettoor-Davidson and Inman (2013) suggested that discriminatory experiences and the stress that results from these experiences can be harmful for individuals. The psychological impact of discrimination and stress on minority groups can lead to depression and anxiety and can also create negative consequences for one's sense of well-being and physical health.

Essentially, stress from discriminatory experiences can significantly influence one's self-esteem and satisfaction with one's life (Kaduvettoor-Davidson & Inman,

2013). It is important to look at the relationship between perceived discrimination and psychological well-being (Kaduvettoor-Davidson & Inman, 2013). There has been little research on the harmful psychological effects of racism against South Asians. Recent studies on the effects of racism among ethnic groups indicate that racism related stress impacts racial identity, sense of self such as self esteem, and the ability to cope with such stress. There is clearly a strong association between racial/ethnic discrimination and clinical symptomology such as depression (Inman, 2006).

Inman, Ettigi, and Tummala-Narra, (2011) focused on whether socialization varies across generations and whether generational status and racism have an effect on racism related stress and self esteem. They defined first generation as those born and raised in India and migrated to the US *after* age 18 and second generation as those either born or raised in the USA *by* the age of 18. Their definition between first and second generations is based on literature which illustrates that there is a different relationship for those who have been in the USA longer and the identification with mainstream culture or culture of origin (Deaux, 2004). In particular, second generation South Asians are socialized within a racialized society that is immeasurably different from the Indian society. On the other hand, first generation South Asians may internalize experiences related to the caste system and or colonization and therefore have a differing perception of race, ethnicity and racism (Inman et al., 2011).

In the study, a total of 102 participants of which 75% were women and 25% men, 42% were first generation and 58% second generation. The mean age was 37.1 and the range of residents living in the USA was 1-35 years. Ninety eight per cent of the participants completed a bachelor's degree and 78% completed a graduate degree. When

asked about their cultural identifications, 28% identified as more Asian Indian than American, 54% identified as being bicultural, and 11% identified as more American than Indian. The rest of the participants identified as either very Asian at 6% or very American at 1% (Inman et al., 2011).

Multiple tests were used to measure information about the participants such as the Identity Salience Measure (IDM), Racial and Life Experiences Scale (RALES), the People of Color Racial Identity Attitudes Scale (PCRIAS), Asian American Racism-Related Stress Inventory (AARRSI), the Collectivistic Coping Scale (CCS), the Rosenberg Self Esteem Scale. The results revealed that when participants experienced discriminatory incidents, race became significant due to feelings of alienation and a threat to participants' sense of safety and personal rights. Race was also important when participants identified as a racial minority in work place or educational settings, as a function of the participants experiencing feelings of alienation in both situations (Inman, et al., 2011).

Generational differences revealed that for first generation, race was important in situations involving discriminatory incidents and the experience of immersion within the Indian community, whereas for second generation, race was important when they identified as a racial minority (Inman, et al., 2011). It is important to note that a reason for this importance was the same when a sense of safety and security of one's personal rights were threatened and when longing for a connection with their Indian heritage (Inman et al., 2011). For first generation, experiencing racism seemed to make race prominent. For second generation, race was relevant in work place and educational settings when one identifies as a racial minority. The findings indicated that second

generation South Asians raised in the USA may have a stronger internal self as "American." Being seen as the 'other' may further their feelings of being internalized as a minority (Inman et al., 2011). On the other hand, first generation South Asian's exposure to postcolonial India and their identification as ethnic immigrants may be reflected in their expectations and perceptions of discrimination from mainstream society (Inman, et al., 2011).

Inman et al., (2011) discussed that the lack of discussions around racism may contribute to further difficulties in coping with racism, particularly among second generation participants who reported more exposure to mainstream racial cultural contexts and higher levels of racism related stress. This lack of being prepared for the realities of racism through family socialization processes may impede coping with racism related stress. This may be especially important to second generation groups who are engaged with creating a multicultural identity through interactions within Indian communities (Inman et al., 2011). Their study illustrates the fundamental role that race and ethnicity play in navigating relationships with first and second generation South Asians and that both groups may deal with racism, and the stressors that go with it, in very different ways (Inman et al., 2011).

It can be argued that special attention is warranted for culture specific ways of coping with racism related stress, and for seeking professional help in coping with this psychological distress (Inman et al., 2006). This is of particular concern due to the relatively low mental health service utilization rates among first generation and second generation South Asians (Abe-Kim et al., 2007). In looking at the almost invisible nature of South Asians' experiences of racism in the mainstream culture, there is a hope that

these findings lay a foundation for continued exploration of race, ethnicity and racism with South Asians in the USA (Inman et al., 2006).

Interventions for Depression among Middle Aged Women

Obesity is associated with clinical depression among women (Linde, Simon, Ludman, Ichikawa, Operskalski, Arterbern, Rohde, Finch, & Jeffery, (2011). In a study that was done by Linde et al., (2011), it was concluded that depressed, obese women lost weight and demonstrated improved mood in two different treatment programs - randomized behavioural weight loss or behavioural weight loss combined with cognitive-behavioural depression management. Two hundred and three (203) women were randomly chosen to participate in a behavioural weight loss program or behaviour weight loss combined with cognitive behavioural depression management. The average patient was 52 years old and the Mean Patient Health Questionnaire and Hopkins Symptom Checklist was used (Linde et al., 2011). They explained that obesity is associated with clinically significant depressive symptoms; especially among women, and found that women are more likely to seek weight loss treatment than men. Additionally, adults who seek weight loss treatment present with higher rates of depression than those seeking other medical treatment Linde et al., 20110).

Depression and anxiety are disorders that are common in primary care, especially among women (Cramer, Salisbury, Conrad, Eldred, & Araya, 2011). Health authorities encourage general practitioners to recognize patients with depression but they often find themselves with little to offer patients with depression. Brief individual psychological interventions are the preferred method but the availability of a one to one therapist is limited (Cramer et al., 2011). Group based approaches may offer advantages over

individual therapy. Group based Cognitive Behavioural Therapy (CBT) is more cost effective than individual CBT at reaching more people and would have additional advantages such as providing mutual support and encouraging good imitative behaviour (Cramer, et al., 2011).

Depression is a common presenting problem in primary care, however, 30-40% of depressed patients do not seek treatment due to perceived stigma, and difficulties regarding access and the symptoms of depression themselves such as low levels of motivation (Coote and MacLeod, 2012). Coote and McLeod (2012) tested the effectiveness of a self-help, well being intervention (Goal-setting and Planning, GAP) in both increasing well being and reducing depression within a sample from a registered charity. There were 55 participants in Coote and McLeod's (2010) study; there were 26 in the intervention group of eight men and 18 women, with a mean age of 53 years in age, and 29 participants in the waiting list group that consisted of eight men and 21 women with a mean age of 52.

Coote and MacLeod (2012) used a cross-over design with half of the participants allocated to GAP and half to a wait list control group. After five weeks, the wait list also received GAP. Compared with wait list controls, those allocated to GAP showed overall positive change, with individual decreases in negative affect satisfaction after the intervention. Then the wait list controls also received the GAP. In the entire sample that received the GAP, there were significant increases in positive affect and life satisfaction, and significant decreases in negative affect and depression. These findings support the use of self- help interventions for depression (Coote & MacLeod, 2012). There are clear advantages to self-help. For example, self-help is useful for people who prefer to take an

autonomous approach to their treatment, and treatment gains are often maintained at follow-up which might be due to the ability to refer back to treatment materials (Coote & McLeod, 2012). This makes it advantageous for people who experience fluctuations in depressive symptoms and need some guidance to get 'back on track' (Coote & MacLeod, 2012).

This recent research has found that guided self help has high acceptability and is an empowering treatment. The evidence for self help is among the best in terms of effectiveness for treating mild to moderate depression (Coote and MacLeod, 2012).

Self-help interventions are an accessible, first step treatment for depression. Well being interventions focus on increasing peoples resources and bringing about positive feelings and behaviours and could enhance self-help interventions for depression by increasing well being as well as reducing depression. As mentioned previously, it was found that GAP appears to be a feasible approach to enhancing well-being and reducing depression symptoms (Coote and MacLeod, 2012). This seems to fit well with the drive to promote well-being and provide accessible, cost effective interventions for people with depression. Overall, the results strengthen the application of GAP with a range of populations and suggest that people with depression can benefit from a self help manual that emphasizes goal setting and planning skills (Coote and MacLeod, 2012).

In Closing

In summary, some studies have shown that the prevalence of depression is significantly greater in women. During their lifetime, women endure various physiological changes and reproductive events such as pregnancy, post partum, perimenopause and menopause. These biological factors combined with psychosocial

influences contribute to their higher vulnerability to major depression. The bio-psychosocial origins of depression in women may require a multidimensional approach to treatment. By providing education about this illness, referring individuals with signs and symptoms of depression for evaluation, and encouraging appropriate use of antidepressants, pharmacists and physicians can improve the detection and treatment for major depression. If recognized, major depression can be successfully treated, resulting in significant improvements in patients' productivity, their participation in society, and the quality of life for women and their families.

CHAPTER 3 METHODOLOGY

In this thesis, I chose to use the qualitative method of auto-ethnography to share my experience of how much my depression has been affected by bullying, racism, discrimination, and low self-esteem during my younger years. My intention in sharing these painful experiences as a personal narrative is to inspire learning, reflection and to bring greater awareness in others by inviting them to have a glimpse of this difficult time during my life. In the words of Carolyn Ellis, the goal of auto ethnographies is "to write meaningfully and evocatively about topics that matter and may make a difference, to include sensory and emotional experience, and to write from an ethic of care and concern" (2004, p.46). From this deeply personal and reflective writing, a reader can be provoked to a "feeling level about the events being described" thereby stimulating them "to use what they learn there to reflect on, understand, and cope with their own lives" (Ellis, 2004, p. 46).

Ellis (2004) offers four goals for auto-ethnographic writing. One goal is to evoke "emotional experience in readers" (Ellis, 2004, p. 30) Auto-ethnography gives "voices to stories and groups of people traditionally left out of social scientific enquiry," (Ellis, 2004, p. 30). "Ultimately, it is my personal goal to improve readers' and any participants' lives, as well as my own" (Ellis, 2004 p. 31).

It is vital that readers "keep in their minds and feel in their bodies the complexities of concrete moments of lived experience" (Ellis, 2004, p. 30). It is also important that "reader becomes an active participant in the meaning making" (Glesne, 1998, p. 41). Auto-ethnography stems from an ethnographic philosophy that believed borrowing "the eyes of others to enhance our perspectives" was necessary; "at the same

time, we should go on valuing our own (Glesne, 1998, p. 43). An essential aspect of auto-ethnography writing is the ability to "see and feel the world in a complicated manner and then reflexively turn that lens on ourselves" (Ellis, 2004, p. 98).

When writing auto-ethnography, this type of self reflection can be a traumatic process but it is also one which leads to identification and learning from experience (Scholten, 2007). Rather than concealing one's personal experience, ideas are articulated through one's experience, leading to a form of communication that is viewed as being heartfelt, honest and authentic (Scholten, 2007).

When reading a published study, one often is told very little about the context in which it took place, or the personalities, backgrounds and biases of those who embarked upon it. Silverman, (2004) states that it very important to provide a complete context in which a study is conducted. Silverman, (2004) suggests that this should consist of a detailed explanation of the background, history, personalities, cultures and circumstances impacting the study of those who take on this study. This is especially important when complex social phenomena are being investigated in naturalistic settings, or where prior knowledge, skills, and expertise of those engaged in its conduct are likely to impact upon its outcomes (Silverman, 2004).

Auto-ethnography is a form of autobiographical narrative which looks at the researcher's subjective experience. Ethnographic participant observation has been characterized as the 'art and science of describing a group or culture' (Fetterman, 1998, p. 473).

Data Collection and Presentation

My one and only source of data collection is memory recall. The stories I wrote about are etched in my mind as if they happened yesterday. Once I started writing them, all the memories and feelings came flooding back to me. I did not write in a journal or keep a diary; most of these stories have not ever been discussed with anyone until I started writing them down for this thesis.

Ethical Considerations

As Ellis (2004) explains in *The Ethnographic I*, because all ethnography is interpretive, it is also fiction. Ellis' comparison of the writing process of ethnographers with novelists illustrates that there is a blurry distinction between the two:

> Ethnographers select and omit, often creating composites and typical representations that may describe behavioral means rather than specific actions. Sometimes, they camouflage participants' identities and events. Readers may have trouble finding a truth that resonates with their own experiences. Novelists seek a truth of experience, often basing their scenes and characters on real life events and real lives. Readers of novels often find profound insights and moral lessons about how to live. The stories we write as ethnographers do not have to be factual to be true. Novels and ethnographies coexist on a continuous plane of truth seeking; they are not oppositional forms of truth telling. (2004, p. 332).

Ellis (2004) uses the term auto ethnographic observation with novelistic and fictional writing. My main goal was to accurately communicate the essence of my experience to readers, wanting to examine, understand, and gain a greater awareness of such experiences. At the same time, it was also important to address ethical

considerations such as confidentiality and privacy rights. I tried to tell my story in such a way that maintains ethical integrity as well faithfulness in the sensory and emotional description of my experience. Specifically in this case, I did not use any real names in order to protect people's identities. In addition, while being mindful of telling the truth, I had to be creative in the form of omissions and fictional additions for the purpose of preserving anonymity and to accommodate the literary demands required of succinct thesis writing.

Researcher Bias

Researcher bias occurs when the group performing the study influences the results so that a desired outcome arises (Shuttleworth, 2009). In qualitative research, bias is an inevitable factor as the work is dependent upon experience and judgment (Shuttleworth, 2009). It is important to understand that researcher bias will inevitably occur; it is unavoidable and important to understand that it is impossible and indeed undesirable for this kind of study to avoid (Shuttleworth, 2009). Additionally, when people partake in research, it is much easier to become emotionally involved to a certain view point, thereby jeopardizing objectivity (Shuttleworth, 2009). According to Shuttleworth (2009), it is up to the researcher to show that they understand that bias is to be expected and that they have done everything possible to lessen the impact.

A practical way to think about the issue of validity is to look at error and bias. Qualitative or quantitative research is a human activity that is subject to the same kinds of failings as other human activities (Norris, 1997). Researchers are fallible. They make mistakes and get things wrong. Research requires scepticism, commitment and detachment (Norris, 1997). Research also encourages detachment from oneself, a

motivation to look at the self and the way it influences the quality of data and reports. In particular, research demands a capacity to accept and use criticism, and to be self critical in a constructive manner (Norris, 1997).

I have been aware that while writing this thesis I personally have certain expectations of the outcomes and findings of the study. There is a possibility that the findings may not match my expectations in which case I would still have to present these findings; not to do so would be unscholarly. As a South Asian woman who grew up in a small town on Vancouver Island, I suffered from prejudice, bullying and marginalization. It is imperative that I remain open minded during my work even if there are studies with findings that are contradictory to my hypothesis.

In Closing

In writing this auto-ethnography for a qualitative study, I have adhered to the guidelines written in *the Publication Manual of the American Psychological Association*. The privacy and confidentiality of the characters in my auto-ethnography have been protected and ethical considerations have been made considering researcher bias.

CHAPTER 4 AUTO-ETHNOGRAPHY

Earlier in my thesis I talked about discussing my experiences encountering racism, bullying, low self-esteem, and depression. These experiences are revealed for the purpose of illustrating how they have affected me as a South Asian woman (second generation), living in Canada.

In this chapter I will provide anecdotal vignettes of events that happened to me during my childhood and teen years up to grade seven. After that first year in my new school when Grade 8 started, I made new friends as I became adjusted to being in a school where there were more Indo Canadians attending; my school life improved significantly. I connected with three other South Asian girls and I felt like I had found my 'tribe' which made my life easier and happier from Grade 8 to 12.

These are not very pleasant stories but they are a part of my journey to self-discovery and the realization that I had been suffering from depression. I have written a section at the end of this chapter about the long term effects of these events in my life. These lived experiences are shared with the intention to illustrate how they shaped my life today and created the person that I have become.

The Dreaded Walk Home from School

Like most kids, I walked to and from school every day. I also walked with one of my siblings. As mentioned earlier, our family was one of the few, if not the only, visible minority in the neighbourhood. My family had limited financial resources and we got our haircut at home and didn't wear the most fashionable clothes. We sort of stuck out like hillbillies at a debutante ball. Like clockwork, there were always two teenagers waiting for us at the bottom of the hill, ready to harass us. Every day, these boys would

call us racist names such as "Paki," "Punjab," turban twisters," or "Hindu." Ironically, no one in my family wore a turban but we were still called names such as "rag head." Eventually the name-calling turned to physical harassment and boys grabbed our school bags and ran around with them, laughing at us as we scrambled to get them back. Over time, this progressed to watching them beat up my younger sibling on a daily basis. I was only seven years old at the time and was powerless to do anything; I would stand there weeping silently as they beat up my sibling. I felt like a failure as I couldn't protect him out of fear of getting beat up myself. Those feelings of powerlessness have stayed with me to this day. I am hyper vigilant about my surroundings and get especially triggered when I am in a park where I see teenagers. I get the same feelings I had when I was a little kid and it reminds me of those awful feelings I had as a young and helpless child.

Legal Name Change

I was in Grade 2 when a white boy started calling me a name that attached a label of a very smelly verb onto my name. It was a catchy phrase that caught on very quickly. This boy who we'll call "Kelly" was big, tall, and very mean. He was the class bully and always found someone to pick on; I was to be his next victim. The name he called me was very embarrassing and the sound of it was very traumatic for me as a small child. I still cannot say it without cringing as it continues to affect me today as an adult; I will not disclose this name due to the shame I feel when I say it or hear it. I was the only South Asian kid in this particular class and one of few in the whole school. I could not get away from this name, it lasted throughout the whole school year with no end in sight. Everyone laughed when they heard the name, and even the teachers couldn't help

themselves when they heard it. I was so ashamed and couldn't tell anyone about it. I don't recall having any friends during that school year. It was a very lonely and humiliating time.

I tried to figure out why I was being called this name; was I malodorous, I wondered? Did I not wear clean clothes, have a bath everyday and brush my teeth like all the other kids? Maybe it was the Indian food my mother cooked. I was so convinced that I smelled bad that I started taking two baths a day, washing my clothes by hand in our bathroom sink, and wearing baby powder to help me smell better. I was only in grade two. I look back on it now and realize that there was nothing wrong with the way I smelled, it was the mean boy Kelly who decided to pick on me. I don't know if it was because I was of a different skin color from the other kids who were almost all white skinned, or if it was because I was just 'different'. The impact of this name on me as a teen and now even as an adult has been very difficult to live with. It has also been very challenging for my loved ones who have lived with me both in the past and currently. These difficulties and challenges will be discussed later in this thesis.

By the end of Grade 2, I had successfully argued to legally change my name to a different one; so that this name that Kelly had chosen for me wouldn't stick, and would be forgotten once a new name was announced. I was then called 'Barinder' and all the teachers and students had to learn my new name and address me by it. We actually had it legally changed to remove the old name from my new identification. Grade three was a much better year for me as I met my new South Asian best friend that had moved from another school and she only knew me as 'Barinder'. It also helped that Kelly was not in

my class again that year. In hindsight, this may have been pre arranged by the adults to make the transition to my new name easier.

Halloween Night

As a young child I lived in a house that was situated on the corner of a street right beside a very big park that spread out over on a hill above my house. It was October 31, Halloween nigh,t and I was getting ready to go trick or treating in my usual homemade costume, a 'gypsy' outfit. Being a young family, new to Canada, it was frowned upon to spend money on an outfit that I'll only use once a year, so I made my own. It was about 5:00 pm and getting dark. I heard a crack on the side of the house and ran to my room that faced the park on the left side of the house. There were raw broken eggs all over my window and egg shells everywhere. I could hear the kids as they laughed and yelled out "stupid Hindus" as they quickly ran up the park. My heart sank as I recognized one of the boys who was running away and laughing; it was a boy from my class. The police were called but it took a very long time due to it being a busy Halloween night; an egged house was not on their list of priorities. I recall hearing the officer apologizing and heard him mention the word 'racist.' I didn't really know what that meant at the time and felt confused about it. I used to watch the news with my family and had heard of the term, but wasn't able to see the connection and what it had to do with my family and this incident. I always thought racism was directed towards black people on television and in the news. It hadn't really occurred to me that this was a phenomenon that was affecting me. Regardless, there was nothing that could be done as the kids ran away and were now long gone. I didn't tell anyone that I knew the identity of one of the kids that egged my house, for fear of being treated badly at school and being pitted as a 'tattle tale'. I

was also afraid of what my family would do and was worried about what the consequences of that would mean - more harassment and more problems. Deep down, I knew it would make things worse for me.

I was very sad but also ashamed that this happened to my house. I kept thinking to myself; "What have I done wrong? Why me? Do I look funny? Why didn't the other houses get egged?" I knew it was because we were the only Indian people. There wasn't a darn thing I could do about it. I was so ashamed that I couldn't bring myself to go to school the next day as I didn't want to see that boy in my class. I was afraid he would laugh at me and tell the other kids what had happened. Even though a wrong had been done to me, I felt humiliated and didn't want anyone to know that people didn't like me and had egged my house. I tried my best to keep a low profile, but no matter what I did, a new incident always seemed to arise. At this point I knew that I was *not* popular in school, that boys didn't like me, that people called me repugnant, racist names, and that I was different from the other kids. I was starting to realize that I was being subjected to all sorts of racism in many ways; my heart helplessly swelled with a sea of tears as I didn't know what I was doing wrong or how to stop it. At an early age, I started to hate being Indian and did everything I could to blend into Canadian culture. I would get embarrassed if someone heard me speaking my native language of Punjabi and only took western food to school in my lunch. After a while I even stopped taking my lunch to school altogether and just went home to avoid being bothered by the other kids. I felt worthless and unlikeable; I started to become a very angry kid but only expressed my anger at home, never at school or in public. I looked like a very happy kid on the outside, but on the inside, I started to develop a very low sense of self worth.

Isolation and Rejection

This incident happened in grade two around the same time I was being called that repugnant name I mentioned earlier before I legally changed my name. I lived in an area where there were mainly Caucasians, hence I had more Caucasian friends during my younger years. I used to walk to school every morning like most kids and meet up with a dear friend of mine who lived closer to our school than I did. She would wait for me at the corner until I walked up the hill to join her and we would make our way to school. My ethnicity never seemed to bother her-she was white. Although we weren't in the same class, we occasionally hung out after school; her parents were really nice to me. Then another girl our age moved into the neighbourhood and became friends with my friend as they lived only two houses away from each other. Initially, the three of us walked to school together, but after a few weeks I started to notice that the new girl was acting kind of strange towards me and started to walk ahead of me with my friend. Sometimes, the new girl would be plugging her nose while walking away from me. I knew right away that it was due to the name calling at school that the bully Kelly had started. My friend didn't plug her nose, but didn't defend me, either. She just kept walking to school in front of me with her new friend. After that, I stopped walking home with those two girls. They started to deliberately leave for school earlier than me so that I couldn't meet up with them. I took the hint and started walking alone. My friend would occasionally wave to me when her new friend was not looking but I kept my head down so that she would think that I couldn't see her. I was ashamed and felt alone. I knew my friend felt embarrassed by the cruel names the kids called me and didn't want anyone to know that we were friends. I didn't blame her for feeling that way as I understood that

she didn't want to be picked on by the other kids. I felt like a loser. My self-esteem just got worse after that as I continued to walk home alone, with no friends.

One day during spring break, that same friend asked me to hang out with her at her house during the break. I was both surprised and very happy that we were still friends as I assumed she didn't like me anymore, especially since she had a new friend in the neighbourhood. We played at her house with all the toys her parents bought her and had a great day. I loved going there as I didn't have as many toys as she did. As usual, her mom was super nice and brought us a great snack to eat while we were playing. When it was time for me to walk home, my friend asked me to take the long way home by walking the other way; at first I didn't understand. Then I realized it was because she did not want her new friend to see me walking on their street past her house in case she looked outside. My friend was afraid that her friend would find out we had played together that day. I was very hurt but didn't say a word to my friend or to anyone else. We continued with this 'secret' friendship so that the other friend wouldn't find out. The only time I was invited to walk home with my friend was if the other friend was absent from school. Sadly, those were good days for me. It was very lonely not having any friends in school so I took whatever I could get. It was very desperate of me to allow this to happen but I didn't care as I loved going to her house and spending time with her; being so desolate, I was like a hungry dog, starving for food and willing to take any scraps that I could. After all, it wasn't like I had a lot of other friends waiting to play with me. I didn't tell anyone that this was going on as I was worried about losing my one and only friend.

School Play

In grade school we were involved in a school play. Since I had been taking private French lessons, I had a pretty good French accent to try out for the French character in the play; lucky for me, I got the part. All the popular and pretty girls got the best parts so I was feeling pretty pleased with myself. On the day of the play, our teacher brought make up to school. She was doing the girl's entire make up and putting on eye shadow, blush, lipstick, and the works. I was the last character to have my make up put on. She put the blush and eye make-up on my face and stopped. I reminded her that I didn't have any lipstick on; she replied, "Barinder, your lips are so naturally rosy and red already, that we don't *need* to put any lipstick on you." That sinking feeling crept up in my stomach again and I knew she looked at me differently than she did all of the other girls. I naturally assumed she must have thought I was ugly, gross, dirty, or that I had some sort of disease. I laughed it off but my feelings were very hurt. I acted like I didn't care but in reality, I was very insulted. Once again I felt like an ugly loser who is not worthy enough to share lipstick with the other girls, and that even the teacher felt that way.

Merry Go Round

Growing up on Vancouver Island in the sixties and seventies was a tough time for visible minorities. It was a lot different than from living in a major city like Vancouver where there is a strong ethnic presence. There were very few of us South Asians on the Island. We used to visit some relatives a few hours away from our town on the weekends. I looked forward to these times as I had lots of family on the Island. In that small Vancouver Island town, we were allowed to go to the park to play on our own as

long as we stayed together. There were five of us as we played on all the swings and teeter totters, just like the other kids did. Eventually some teenagers came walking by the park while we were on the merry go round, which we were pushing ourselves with our own feet. All five of us were on the merry go round when the teenagers came by and deliberately decided to pick on our group out of all of the other kids that were in the park. We were the only people of colour there. They started pushing the merry go round really fast; and while doing it, they laughed at us and called us racist names such as "Paki's" and told us to go back to our own country. I was too afraid to tell them that this is my country too and that we too were born in Canada. We had some very small kids with us and I was pretty young myself and didn't know how to respond. We became very anxious as the boys kept pushing the merry go round faster and faster. Soon we were screaming and one of the kids in our group threw up on the merry go round while it was being pushed so rapidly. I was really frightened and my stomach was in tight knots; I didn't know what to do even though I was one of the older kids in the group. We were all sobbing out loud. The other patrons started to leave the park and left us alone with the teenagers. Then we heard a sundeck door open and a man yelled out, "Leave those kids alone, you punks!" The boys ran off once they realized an adult saw what they were doing. We couldn't run home fast enough and never went to that park *ever* again. Even when we were asked to go to the park, we refused to go but we didn't tell any adults why we wouldn't go. All of us were too scared. I was afraid that if we told anyone that I would get blamed for always having these types of incidents happen to me. It was a daily and dark part of my existence to be picked on. I felt like I could not do anything right

and could not find peace or safety in my life; even in a different town where no one even knew me.

On the drive back to our home town after the weekend ended, I was sitting in the back seat of the car and thinking that even while away from my own home town and school, I was unable to escape from racists and bullies. It was a very depressing revelation. I kept thinking, "Everywhere I go, people just don't like me." I started to believe that people hated me and I felt rejected.

Square Dancing

After Grade 6 in elementary school, all of us kids had to register in a middle school a little further away from home that had kids from different areas attending this school from Grades 7-9. When I was in Grade7, our class had physical education (PE) classes a few times per week. These were my favourite times as the boys had PE separately from the girls. I think I liked not having any boys in the class as I had experienced more bullying and racism from boys than I ever did from girls up to that time in my life.

I was pretty good in sports and really enjoyed this time of physical activity; but then along came square dancing classes. I had never done this before nor had I ever danced with a boy so it seemed like a great thing at the time. I quickly started to hate square dancing. There were a few mean boys who would refuse to dance with me when it was their turn and wouldn't touch my hands when it was time to swing and move; it was so humiliating for me as the other kids in my group could see what was happening. I recall one boy who used to cross his fingers together as if it would fend away any germs or fleas I may have. He called me a "Pun" all the time. His friends imitated him and

laughed when he made these remarks and gestures. The teachers were too far away to notice and the group was far too big for them to see it anyways. I felt ugly and unworthy. I was ashamed that they openly did this to me and hated the negative attention it drew to me; it was very humiliating. Their mean words and actions were like bullets shooting at my heart. I would pretend I had to go to the bathroom and then not come back. I conveniently found an explanation and got a note to be excused from PE class during that week of square dancing classes. I was again very ashamed about why I wouldn't attend square dancing so I made up excuses, even to tell friends. It was too embarrassing to admit the real reason. That was another very bad year for my self esteem as more bullying followed, shortly after that.

"I'm going to beat the Crap Out of You after School Today"

In the same school year as the square dancing incident, I met some very mean girls who did not like me at all. No matter what I did, it was the wrong thing and I was always accused of making the wrong facial expression, regardless of how hard I tried to remain neutral. They would say such things as, "I don't like the way you're looking at me." I had always played team sports such as soccer, field hockey, volleyball, and basketball and I was skilled at playing in PE. During a PE basketball game, I had the ball and was dribbling it towards the net, when one of the girls physically picked me up with the ball in my hand and threw me down. Luckily I wasn't hurt. She said "No! You can't have that ball!" Again, no teacher witnessed it and she got away with it. I think I finally had had enough and told one of the school counsellors about the bullying. That only made things worse; once the bullying girls found out I had talked to a counsellor, they started threatening me and giving me dirty looks whenever they saw me. They got their

friends to join them and soon started telling me that they would beat the crap out of me after school for telling; this happened on a daily basis. I was so scared and I didn't know what to do, so I started riding my bike to school and rode it home for dear life before any of them could find me. I found a way of leaving class early each day or getting my friend to get my bike from the bike rack area for me so that I could leave right away. Their class was near the bike racks and I didn't want them to see me or run into me when I quickly tried to make my escape. Ironically, it was my childhood friend from grade two that used to walk to and from school with me that came to my aid, the one who was too embarrassed to tell her new friend that we were still friends. That year in grade seven was a tough adjustment to middle school and my self confidence had really plummeted. After that tough year of Grade 7 ended, school life became easier as I eventually made new friends of South Asian origin and had a group of people that made me feel like I belonged somewhere. Since there were a lot more South Asians in this school, I was less of a target and felt like I blended in with everyone; I started to feel like I belonged. Although my school life had significantly improved, the damage had been done to my self esteem; this sense of low self worth still exists today for me, even as an adult.

Long Term Effects of These Experiences

I mentioned earlier that I would talk about how these negative experiences have affected me in my life during my teen years and beyond. The long term effects of these experiences are apparent in many ways but I did not realize it when I was younger. I always thought I was a very intense person or even, a 'freak.' The obsessive compulsive traits I was exhibiting started at a very young age, shortly after the 'nick name' that Kelly the bully started calling me. After that experience, I began to get up early before school

to have a bath before leaving for class. I started to have a preoccupation with scent and nice smelling things. Since I was only in Grade 2, I didn't have any perfume so I started using baby powder to mask any possible scent in case I smelled bad; after all this *was* what I was being teased about. This preoccupation kept going into my teens and now even into adulthood. As mentioned earlier, we lived on a limited income; I didn't have a lot of clothes so I wore the same few outfits frequently and kept hand washing them in the bathroom sink every day to ensure that I would smell fresh. As an adult, I am still very particular about scent and cannot leave the house without putting on deodorant and perfume. I am known in my circle of family and friends for always smelling fresh, I love hearing people tell me this as it reassures me that I *don't* smell bad. Even though I am an adult and know better, I wash multiple piles of laundry as a result, ensuring that I don't wear the same clothes two days in a row so that no one ever thinks I smell bad. It has improved over the years, especially once I realized why I had this preoccupation with smell and scent.

This brings me to the next area of obsessive traits that I have - ensuring that any area I am in, is neat and tidy, and especially clean. This is another revelation I only figured out as an adult. As a young child, I started cleaning the house and took over the job of doing this chore. If someone messed up the bathroom or any area of the house, I would yell or get angry at them, especially at my siblings. It got to the point where I stopped being a 'kid' and would come inside to clean up instead of playing outside with my cousins and siblings. I would sweep the entry of dirt, dust the house and make sure we had the cleanest bathrooms ever. I scrubbed the stove and washed cupboards unnecessarily as it became a soothing activity for me to engage in. I was oblivious as to

why I was doing this and everyone that knew me thought I was just a 'clean freak.' Before I even became a teenager, I washed all the laundry, scrubbed the decks, washed the outsides of the house in the summer, cleaned sidewalks, our driveway, etc. Through counselling, I now realize that I was doing all of these things to have some sort of control in my life. I didn't have any control on my walk to and from school, I couldn't stop kids from teasing me or calling me names, nor could I stop the racism and bullying that was directed at me. What I *could* do was have control in my own surroundings, and I became a control freak. Sometimes, it is really hard to be *me*; this comment is not meant to be a compliment directed to myself or a form of boasting. If I have to go in an area where there is dirt or filth, it is very difficult for me to be there. I will not go swimming at a public pool due to the dirty floors and other people's hair all over the place. If I am ever in such a situation, I have to keep my eyes up and not look at the ground to stop myself from 'freaking out.' These obsessive compulsive traits have affected the people I live with both in the past and present time. I became tired of always being angry at my loved ones for 'leaving a mess.' This obsessive compulsive behaviour was affecting me at work, at home, and anywhere else I would go. I would ruminate over the mess and dirt, and not be able to get over it. It caused a lot of negativity and unnecessary arguments. It was exhausting for me, and very difficult for anyone that was in my life. I finally realized I had a problem in my early forties and saw my family doctor. She prescribed an anti depressant to help me with my angry outbursts and obsessive traits. She told me I have depression and that obsessive compulsive behaviours and anxiety are things that go along with depression. I was very surprised to hear it but once I started to think about, it

made perfect sense. Ironically, I have been working in the mental health field for almost 20 years and did not realize I was suffering from depression.

As a child, I had a lot of insecurities, and for good reason, everywhere I seemed to go, there would be someone waiting to beat me or my sibling up, threatening me, scaring me in a public place or causing damage to my home. I felt like I always had to look around me to make sure that nothing bad will happen. It seems like I was always in a state of paranoia, this feeling of dread or fear and not knowing when the next bad thing is going to happen. I didn't feel like I was ever safe and always felt tense and uneasy. I am over cautious in my daily life and fear for the safety of all that are important to me. This insecurity still exists today but I have learned to manage it by finding ways to reassure myself that everything will be fine. It is still a constant struggle but now that I know where these insecurities stem from, I can deal with them better.

During those early days in Grade 2 when everyone called me names and refused to play with me or walk with me, I learned a lot about what it feels like to be rejected. Again, even though these experiences happened to me as a child, I cannot seem to put them behind me. I am hyper sensitive to rejection, or what I perceive as rejection. I have had a tendency to assume that when someone cancels plans with me, it is because they don't want to see me, that I am not important enough to them, that they have something better to do, or that there is someone more fun than me that they would rather see. This paranoia has been difficult to live with, I would constantly feel that no one likes me and make negative assumptions that aren't true. I struggle to rid myself of this perseveration that no one likes me; that they think I'm ugly, or too fat.

I was very hard on myself and never felt smart or pretty, or cool enough. I played sports in school and was an average player; I was an honour student all through school and had a good group of friends. But still, I always compared myself to other people, often wishing I could be more like them and be funnier or smarter, or more athletic. I was never happy with myself and always self doubted any accomplishments I ever made. Most people would not have guessed that I was this way as I superficially always presented as being a 'happy go lucky' person who was funny and all smiles on the outside, even though I was very unhappy on the inside.

There was a certain desperateness in me that I now recognize; I struggled and fought to hold onto relationships even when they were not beneficial to me out of a fear of being abandoned or being alone, this was the case in both friendships and romantic relationships. I attribute this to my low self-esteem and confidence that was shattered at a very young age when I had no friends. As I became older, I recall always having a need to be liked or be viewed as popular and to have a tendency to surround myself with lots of friends. It seems as if I was trying to fool myself into thinking that everything is fine as long as I have lots of people around me, even if those relationships are superficial.

Added to always needing to have friends, I started to show signs of what I call the "please disease" where I would go out of my way to 'make' others like me by doing special things for them or doing what they want instead of what I want. I have spent most of my life trying to please others to fulfill my need to be liked and accepted. I am still guilty of doing this but I am trying to make changes and not care so much about what others think, such as if they like me or not. Going to counselling over the past few years

has helped me realize that I am fine the way I am and that it's okay if not everyone likes me.

In Closing

Although these aforementioned incidents happened a long time ago, they have affected me in many ways that began in my childhood and went on into my teen years and adulthood. Racism, bullying, name calling, feeling like I'm not good enough, rejection, and having low self esteem are all things I have faced from a very young age. For better or worse, these experiences have shaped my life and the way I live it today.

CHAPTER 5 SUMMARY OF FINDINGS

In this final chapter I will be comparing and contrasting the findings from the literature review with my auto-ethnography. I will discuss where there is a need for future research as well as implications for future counsellors with regards to working with minority and marginalized populations. Finally, I will write about my experience in doing this qualitative study and talk about the research process.

Main Findings

Women and Depression

In a study by Sowislo and Orth (2013) it was found that there is a strong parallel between depression and self esteem. During my experience as a youth, I went through times in which my self-esteem was destroyed and these negative experiences led to eventual depression. As a child, I witnessed a sibling being beat up daily, I went through a legal name change to stop kids from calling me insulting names, endured all sorts of racist acts, felt discriminated against (even by the teaching staff), had difficulty fitting in when I was one of the very few South Asian kids in my school, and could not make any friends that didn't face the repercussions of being Caucasian and becoming friends with a South Asian kid.

This low self esteem, sense of helplessness, self blame, social isolation and low morale causes women to feel exhausted, worthless and sometimes to develop the feelings to give up. As was mentioned previously in a study by Mather (2009), women then suppress their need for autonomy, neglect their health and fail to acquire the skills to feel competence and self confident. I can personally attest to the fact that this happened to me as a result of all of my negative experiences that were discussed earlier. I did not know

how to help myself and didn't realize what was happening; I was full of self doubt and low confidence and believed that I was inferior to everyone else. It seems like a natural conclusion that Sowislo and Orth (2013) discovered that there is a strong correlation between depression and low self esteem.

Implications of Depression in Women of a South Asian Background

Growing up as a second generation South Asian female, I did not hear any conversations about depression, medication, counselling or talking to someone about these issues. I rarely ever heard about anyone having depression, it was not discussed in our household or in my community. The few times that I did hear about someone feeling depressed, my experience was that the South Asian community would suggest that the person was faking illness to get out of working or attending post secondary school. No one seemed to believe that a person can genuinely suffer from being depressed and that it could, in fact, be an authentic illness. As mentioned earlier, there is a degree of shame attached to mental illness and depression within South Asian communities which hinders families from seeking professional help for psychiatric problems (Cartwright & Anderson, 1981). This stigma *may* have prevented me from accessing mental health services earlier in my life. I didn't even consider that I could have been suffering from depression until I spoke to my family physician in my forties about how I was feeling. It took me a long time to fully comprehend that I was depressed and learn how to adjust to this revelation.

Mathur (2009) mentioned that depression can occur at any age during a woman's life irrespective of educational or economic groups. I completed my undergraduate degree 25 years ago and have had a successful career in the mental health and addictions

field with certain economic advantages, yet I still experience bouts of depression, anxiety and feelings of insecurity on a regular basis. This fully illustrates Mathur's point (2009) that wealth and education don't matter, anyone can experience depression.

Bullying and Racism and its Relation to Low Self Esteem and Depression

In writing my auto-ethnography, I made reference to the fact that bullying and racism affected my self-esteem on a number of occasions. If a child hears someone constantly calling her names, has people being mean to her, deliberately excluding her, and is constantly being picked on, it is inevitable that there will be long term effects of this bullying behaviour that will be difficult to ignore. As in my case, these acts resulted in maladaptive psychological responses that went well into my adulthood (Gordon, 2014). I am hyper sensitive about feeling left out or excluded, I make assumptions that people don't like me based on actions that have nothing to do with me, and I am very critical and conscious of how I smell, never wearing the same clothes two days in a row. These feelings are congruent with what Olweus (2001) suggested a victim of bullying may experience an interruption of healthy adolescent development. Logically, I know that I don't smell bad and that I have excellent personal hygiene, but the long term effects of the bullying and racism that I experienced around being told I smell bad and being a person of colour have not left me. The psychologically harmful effects of these experiences still resonate with me in my current life as an adult, even now in my late forties.

As a second generation South Asian, I feel that my socialization within a racialized society is quite different from that of my parents who are first generation South Asians. Their identity was already established when they came to Canada as adults as

they had experienced colonization and the caste system in India. As a second generation South Asian, I have a stronger internal self that identifies with being "Canadian." As Inman et al. (2011) suggested, being seen as the 'other' would further internalize my feelings of being a minority. The generation that I am from seemingly reports more exposure to racial cultural contexts and higher levels of racism related stress (Inman et al., 2011). The first generation of South Asians from India experienced exposure to post colonial India. As a result, their identification as ethnic immigrants may be reflected in their expectations and perceptions of discrimination from mainstream society (Inman, et al., 2011).

Isolation and Rejection

Those first few years of my school life were very tough for a young child. The humiliation of my friend in grade two being too embarrassed to allow the other kids to know that we were secretly friends, the boys who refused to dance with me in PE during square dancing class, and the shame I felt about the things that were happening to me, collectively had a huge impact on my self esteem and level of confidence. Not only was I isolated, but I was rejected every which way I turned. These feelings of rejection left me feeling ugly, unwanted, and worthless.

Kaduvettoor-Davidson and Inman (2013) suggested that discriminatory experiences and the stress that results from those experiences can be harmful for individuals. The psychological impact of the stress of being isolated and rejected by my peers simply because of the color of my skin has had a huge impact on me. In the vignette about the two school friends that stopped walking to school with me, it wasn't beneficial for my personal sense of self worth to allow my friend to only play with me

when her friend didn't know about it or was away from school. I learned that being desperate for friendships and allowing people to treat me poorly is acceptable. I allowed these school kids to take away my dignity and self respect; I allowed these girls to psychologically harm me due to my desperate vulnerability to fit in somewhere and belong.

Humans have an innate need to belong to a group and, although attachment forms in early infancy, there is a constant need to form bonds with others that exists throughout our lifetime (Bowlby, 1969). In my case, this need to belong was so strong that even though I knew I should not have played with my 'secret' friend because of the social stigma that she would face if others found out that she plays with me, I still wasn't able to stop myself from secretly playing with her. It felt good to have a friend to play with, even if it is in secret and only occasionally. I was desperate to have *someone* to be my friend, even if it was at the price of my dignity and self respect.

Future Research

It seems apparent that future research in this area needs greater sensitivity to the underlying problems of cross cultural research. There has been research done in Canada that illustrates that Caucasians are more likely to utilize mental health services than those from a South Asian background (Tiwarii and Wang, 2008). More investigations about the barriers that Asian immigrants face to access health services are needed to help develop strategies to promote mental health service for those who need it.

As Western society becomes increasingly multicultural, those accessing mental health services, including family therapy, will become more culturally diverse. There is a lot of evidence that shows that the therapeutic alliance is one of the most important

aspects of psychological therapy, and a significant predictor of successful outcome (Panda and Herlihy, 2009). Unfortunately, most of this research is focused on white populations. Little research explores whether culture or ethnicity affect the quality of the alliance. If it does, those in ethnic minority groups may be at a disadvantage as their needs are less likely to be met or understood.

With regards to South Asians, the little literature *that is* available highlights the following: collectivism, power and authority, trust and engagement are all important features to this group (Laungani, 2004). McGoldrick et al. (2005) argue that therapy is a Western concept and those from a South Asian background may be sceptical about the use of therapy, and possibly distrustful of services. Traditional Asian cultures are more hierarchical, there is a person of perceived authority and expertise such as a therapist. South Asian clients may prefer a therapist who adopts an 'expert' approach. For South Asian families the therapeutic approach may be similar to seeing a medical doctor. The family may then expect instruction rather than collaboration (McGoldrick et al, 2005).

There is a gap in knowledge about therapy and South Asians and clearly a need for research that could be done by interviewing South Asian families themselves rather than therapists. If future research can support the correlation that relates low self esteem and depression, then there may be more interventions aimed at increasing self esteem to reduce the risk of depression which could result in a long lasting, positive influence. As a South Asian woman, I didn't get a diagnosis of depression until I was in my forties. Had this research and awareness been around when I was growing up, maybe there could have been a different outcome for me and many others who may have gone through similar experiences.

Implications for Counsellors

Throughout this thesis, I have discussed my self-esteem and how bullying and racism affected it. I feel that this would be an ideal counselling intervention to help boost self esteem. These problems that I experienced are not unique to just me, other children have faced similar problems. Providing more education, outreach, and communication about these issues would be helpful in the school system where all of these issues originally started. There are many diverse cultures in each community and they would all benefit from having counsellors or youth workers present in the school system to fill these 'gaps' that affect our children.

Research in the area of discrimination may influence psychological practice; practicing therapists may be able to integrate the findings of such research into their work with South Asian clients and others for whom this research may be relevant (Kaduvettoor-Davidson and Inman, 2013). Practioners can be mindful about this and enquire about these types of experiences with clients. In terms of assessment, therapists can assess the level of discrimination related stress a client experiences and explore relationships between discrimination and psychological well being (Kaduvettoor-Davidson, 2013). In addition, counsellors can focus on ways to reduce this stress in order to alleviate some of the negative consequences of discrimination. Professionals can then provide resources and support for South Asian groups that might be impacted by racism in their communities.

Contrasting Findings

Ekanayake et al. (2012) talked about domestic abuse, lack of social supports or family being available, ageing and isolation and how these stressors have an impact on

the mental health of women. There was also mention of how it can be difficult to get jobs due to unfair treatment and discrimination of women of colour. This was not the case for my situation. I was born and raised in Canada and believe that because I have a Canadian education and speak fluent English, I was fortunate to *not* experience discrimination when seeking employment. Further, I was also very fortunate to have a family that is very supportive of me even when I married a second time out of my own culture. I had excellent social supports and did not experience any domestic abuse. In the case of collectivistic vs. western values, my family was very supportive about my divorce and my remarrying. Cartwright and Anderson (1981) stated that one of the reasons stigmas attached to mental illness and depression is emphasized, is due to the fact that arranged marriage prospects are reduced. I did not have an arranged marriage for either of my weddings; this is contrary to my experience.

In Closing

My hope in writing this thesis was to look at how the role of exposing 'my story' has transformed me and maybe even others who may or may not have moved past depression. Although self-reflection is a worthy endeavour, and one which is certainly fundamental to this writing process, it can also be an unpleasant one. It can bring up many uncomfortable and unexpected emotions such as regret, humiliation, self-denigration, and embarrassment. In order for this exercise to be worth doing, I knew that I could not write this thesis without a sufficient amount of self-awareness and self-disclosure. I turned to many people in my life for support such as my immediate and extended family, close friends, colleagues, instructors, and my therapist. Self care was a critical component of being able to finish this project.

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