From social liminality to cultural negotiation: Transformative processes in immigrant mental wellbeing

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Abstract: The underlying psychosocial processes that produce immigrant mental wellbeing are understudied in anthropology and medicine. This paper provides insights into these processes by describing culturally diverse immigrants’ perceptions of mental health and adaptation strategies. Qualitative data were collected from 21 focus groups as part of a large, multidisciplinary, participatory action research project about mental health with five ethnolinguistic groups (Mandarin-speaking Chinese, Polish, Punjabi Sikh, Somali and Spanish-speaking Latin American) in Ontario, Canada. In framing the analysis, transformative concepts are applied to address dimensions of power and culture--social liminality and cultural negotiation--to the ongoing psychosocial processes of coping with mental distress. ‘Social liminality’ describes how immigrants perceive themselves to be in a psychologically stressful, transitional state, whereas ‘cultural negotiation’ describes how they actively cope with cultural tensions and respond to mental health challenges. Study findings show that while social liminality and cultural negotiation are stressful, they also have the potential to help individuals adapt by producing a positive synthesis of ideas about mental health in new social and cultural contexts. The study contributes to the shift from problem identification using a biomedical model of mental illness to a more psychosocial and ecological approach that reveals the potential for resolving some mental health problems experienced in immigrant communities. Describing active psychosocial process of adaptation also reinforces the therapeutic and educational value of partnerships between practitioners and clients and immigrant communities and mental health systems.

Keywords: Immigrants; mental health; Canada; psychosocial processes; community-based research
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Migration involves altering mental landscapes as well as crossing physical borders, a complex process that creates both opportunity and risks to mental health. Immigrant settlement and adaptation trajectories are often stressful and characterized by interactions of personal and social factors in pre- and post-migration contexts (Beiser, 1999, 2005; Bhugra and Jones, 2001). “Adaptation” is not a straightforward course, but rather a dynamic psychosocial process in which immigrant individuals and communities play active roles in coping with cultural differences, navigating new systems and attempting to overcome barriers to social integration. Immigrants who need help coping with mental distress associated with the transition are currently underserved by existing mental health care systems, which face increasing challenges serving culturally diverse populations (Ingleby and Watters, 2005; James and Prilleltensky, 2003; de Jong and van Ommeren, 2005; Kirmayer et al., 2003; Standing Senate Committee 2006; Takeuchi and Kim, 2000; US Department of Human Services, 2002).

Understanding how to transform mental distress into mental wellbeing is part of the personal adaptation process for immigrants, just as understanding immigrant’s diverse perceptions and mental health needs is part of the social adaptation process for health care providers and institutions. Little available research provides insights into transformative social processes underlying immigrant mental health and adaptation, however, as most research focuses instead on measurable risk factors. Currently, immigrant mental health research tends to be concentrated in epidemiology, public health and nursing, which often aim to understand the distribution of illness and service-related challenges among immigrants, but seldom to discover qualitative immigrant “illness experiences” (Littlewood, 1991), perceptions of mental health or subjective responses to mental distress.

For its part, medical anthropology has not focused sufficiently on immigrant mental health to have significant impact on theory or practice. This lack of attention is surprising in the
climate of “accelerating social processes of migration, urbanization, and more frequent cross-cultural professional interactions” that necessitate interdisciplinarity and culturally responsive health policies (Weiss, 2001:6). A long tradition of studies in culture, emotion and psychiatry (Jenkins, 1996), investigations of “social suffering” (Kleinman et al., 1997) and refugee mental health (Marsella et al., 1998) and efforts to integrate culture and epidemiology (Hahn, 1995; Weiss, 2001) have made contributions in the globalized context, but have had less impact on understanding immigrant mental health in the localized contexts of ‘receiving’ societies.

Anthropological interest in migration has seldom focused specifically on mental health, but instead has explored social and cultural determinants of mental health, such as identity and citizenship (Ong, 1996), political experiences of conflict and trauma among refugees (Malkii, 1995; Muecke, 1992) and transnational (primarily economic) functions of social networks (Brettell, 2000). The growth of research on transnationalism has enhanced appreciation for the “double consciousness” and the contradictory, often alienating, processes through which migrants cope with changing social environments and identities (Daniel, 1997; Foxen, 2007, p.18), but the psychological processes underlying immigrant adaptation are relatively unexplored. Exceptions to this rule are recent in-depth studies with immigrant women, who struggle actively with changing meanings of self, mental health and illness that are grounded in multiple contexts and which point to the complexity of creating a sense of wellbeing (Dossa 2002; Bäärnhielm 2004).

Traditional anthropological research methods may also have limited the discipline’s influence in studies of immigrant mental health. Ethnographies of single cultural groups, while often rich in depth and detail, do not examine shared adaptation experiences across diverse ethnolinguistic communities, nor can they readily inform policy and programs in health care systems that are required to serve multicultural client populations. Collaborative, multidisciplinary studies informed by anthropological theory and methods can help overcome these limitations by examining cultural assumptions, everyday experiences and adaptive social processes in multicultural contexts.

This paper describes such a study and uses two anthropological concepts -- social liminality and cultural negotiation -- to analyze perceptions and transformative processes that affect mental health among immigrants in Canada. ‘Social liminality’ describes how immigrants perceive themselves to be in a psychologically stressful, transitional state, whereas ‘cultural
negotiation’ describes how they actively cope with cultural tensions and respond to mental health challenges. By describing such experiences and adaptive strategies, our analysis attempts to go beyond problem identification to conceptualizing the transformative potential of individual and professional solutions to mental distress in immigrant community mental health.

Study background

This paper reports selected research findings from a large-scale participatory action research (PAR) project, Taking Culture Seriously in Community Mental Health. Participatory action research can be characterized as “research with,” not “research on” people, as providing training opportunities for members of the community being studied, as offering opportunities to effect community change, as producing data for advocacy, and as placing a high value on experiential knowledge (Ochocka, Nelson and Janzen, 2002). The purpose of the Taking Culture Seriously study is to explore, develop, pilot and evaluate how best to provide community-based mental health services and supports that are effective for people from culturally diverse backgrounds. This initiative has brought together over 40 research partners in the two study sites, including academics, members of cultural-linguistic communities, and umbrella organizations. The two main study sites are Toronto and Waterloo Region in southern Ontario. Toronto is a large city (population 2.5 million), while Waterloo is a mid-size urban and rural region (population .5 million); the foreign-born populations in each are nearly one-half and one-quarter, respectively (Statistics Canada, 2003). The study has three phases. In the first phase (2005-2006), academic and community researchers used multiple data collection methods (literature review, key informant interviews, a service provider survey, community focus groups and individual case studies) to explore conceptualizations of mental health problems and practice. In phase two (2007-2008), study partners are developing demonstration projects, which are being piloted and evaluated in phase three (2009-2010). In this paper, data are presented from 21 focus groups with the five participating ethnolinguistic communities: Mandarin-speaking Chinese, Polish, Punjabi Sikh, Somali and Spanish-speaking Latin American.

The research team developed its theoretical approach from a literature review and collaborative discussion of an analytic framework including both culture and power dimensions, (Westhues et. al., 2008). Drawing primarily from research literature in anthropology,
community psychology, psychiatry and social work, the research team found that studies of cultural diversity and mental health have emphasized dimensions of culture or power—for example, cultural competence (e.g. Walker, 2005) or anti-oppression themes (e.g. Sakamoto & Pitner, 2005)—but less often integrate the two dimensions or examine their interrelationship.

Study methods

This paper presents selected findings from the focus groups, the research method that best captures community perceptions. Focus groups are generally useful for examining what people think, how they think and why (Kitzinger, 1995). The method privileges lay knowledge of everyday situations and interactive dialogue among participants, involving them in the co-creation of knowledge (Kemmis and McTaggart, 2000; Kitzinger, 1995). The purpose of our focus groups was three-fold: to understand culturally diverse conceptualizations of mental health problems; to understand perceptions of mental health interventions; and to obtain community perspectives about necessary services. In addition to receiving institutional ethics approvals at the various universities and hospitals with which investigators are affiliated, the research team emphasized an ethic of reciprocity in our collaboration with communities (Maiter et. al. 2008). An example of this participatory approach was the hiring and 5-month training of community researchers, who, as enthusiastic agents of change and ‘ambassadors’ of the study, met bi-monthly for mutual support, organized and conducted the focus groups and contributed to data interpretation and to the validity of findings (Ochocka & Janzen, 2007). A total of 10 people were hired, one from each of the five cultural linguistic communities in both study sites.

Focus group participants were recruited through snowball sampling by community researchers and selected with the criterion of maximum variation and the following attributes: cultural identity, gender, education, age, regional representation, and interest in mental health. Eligibility criteria included being born outside of Canada and living in Canada for at least five years to ensure some familiarity with the society and health care system. In total 21 focus groups (including one pilot focus group) were held with 185 participants (two focus groups in each ethnolinguistic community in each study site). Community researchers conducted all focus groups in native languages with the exception of Somali participants, who chose to speak English. Some focus groups were divided by gender on the advice of community steering
committee members. Among the participants, 64% were women and 36% were men. The majority (60%) was 31 to 50 years old; 23% were 50 to 65 years old and 11% of participants (mostly Somali) were 30 or under. Year of arrival in Canada ranged from 1950 to 2004, with 60% arriving between 1990 and 2004.

Focus group discussions were designed to elicit participants’ understandings of mental health and illness and what is done to help people struggling with mental health in each community, and perceptions and experiences of the formal mental health system. Specific questions were as follows: “Think of someone in your culture who you think has good mental health. What makes them mentally healthy? What does it mean to have a mental health problem? To whom, if anyone, does a member of your community or their family turn when they experience mental health problems? What is your experience with, or impression of, mental health supports in Canada? What types of services and supports would be most effective in helping members of your community to have good mental health?

After community researchers transcribed and translated the data, a subcommittee of the larger research team read and discussed the transcripts. Data analysis occurred at three levels: data reduction, data display, and verification (Miles and Huberman, 1994). At the first level (data reduction), investigators performed directed content analysis, which relied on predetermined research questions. At the second level (data display), a five-part analytic framework attentive to issues of both culture and power highlighted a) contextual factors in Canada underlying perceptions of mental health and illness, b) problem identification, or how participants talk about mental health and illness, causes and consequences c) proposed solutions on community and health systems levels, d) strategies to achieve these solutions, and e) desired outcomes. Reflexive analysis, data source and investigator triangulation helped ensure analytic rigor (Krefting, 1991; Mays and Pope, 1995). Team members, including community researchers, discussed and received feedback on initial study findings from participants at a conference attended by over 150 participants held for this purpose in December 2006.

Focus Group Findings

Focus group participants situated ongoing experiences of mental distress in the social context of immigrant settlement and social integration in Canada. An overview of the focus
group findings describing how participants defined and mental health and illness and their recommendations is published elsewhere (Simich et al., 2009). In everyday life, this was expressed as a feeling of exclusion and expressed by the need for continual coping with cultural differences in the workplace, social and religious life. For example, participants stated,

The stress in China came from how to associate with coworkers in tasks and financial affairs mainly internally in a company. The main stress in Canada comes from the effort to merge into new circumstances in mainstream society and its view of values. We face the stress of how to be accepted by society, which means getting our professional skills approved.
--a Chinese participant

The culture of Whites is entirely different. For example, they have the concept of dating and late night parties, but in our culture it is not acceptable. …A majority is against it and these are contributory factors [for mental distress].

--a Punjabi Sikh participant

I am just saying that growing up in a Western world and practicing a religion that preaches the total opposite of what the Western world practices can create mental health problems…..
--A Somali participant

Often study participants highlighted the recurring nature of the associated psychological challenges. As one participant said,

The whole process of going through culture shock, which has no time limits, is as if you have to forget who you were and create yourself all over again. And once you think you’ve got your feet on the ground, there comes a new “out of this earth” experience that will shake your reality. Going through a culture shock is a never-ending story. It is a source of enormous stress. The damaging part of it is that it is prolonged. It is destructive to our
health and our families.

--A Polish participant

Intergroup differences emerged in the varying emphases given to different cultural values and perceived sources of tension. For example, Somali refugees tended to emphasize the importance of religious faith and identity; Chinese immigrants, the importance of professional employment; Punjabi Sikhs, the value of family cohesion; and Latin Americans, the deleterious effects of family separation. However, all focus group participants described common experiences of social liminality and cultural negotiation in relation to mental health.

In the analysis of study findings in the following sections, both power and culture are considered. The two dimensions may be linked conceptually by the psychosocial processes of social liminality and cultural negotiation, respectively. First, social liminality refers to a relatively powerless, transitional social status experienced by many immigrants; second, arising from the liminal experience, cultural negotiation refers to a transformative process of resolving cultural contradictions, which, our data suggest, may help resolve psychological stress and promote mental well being.

Social liminality

Focus group participants identified as a significant challenge a pervasive sense of powerlessness and marginality related to the long, slow social integration process in Canada. The concept of liminality captures the stress of being on the margins or “on the threshold” of society. For many immigrants, social exclusion, which produces multiple disadvantages and hinders social integration and mental wellbeing, is a pervasive experience (Galabuzi, 2004). Social liminality, however, is a more dynamic concept than social exclusion for describing the active psychosocial process underlying immigrant adaptation and the struggle to maintain mental health, because it carries within it the potential for transformation. Liminality is experienced as a psychologically powerful state when moving from one status or role in life to another in rites de passages (Turner, 1967). Full of risk and potential, liminality often involves a state of heightened awareness and self-realization. The concept of liminality has been used analogously in studies of illegal
immigrants in the United States to describe how lack of legal status produces a feeling of being “stuck” on the margins of society, unable to move forward toward full social incorporation (Chavez, 1998).

Social liminality may be experienced as marginalization from mainstream culture and society and the inability to exercise power and control, but also as marginalization from the mental health system. For example one focus group participant said,

I have a very long experience in getting treatment for mental health. I got treatment under an EAP (Employee Assistance Plan). When I requested help from a [Punjabi] counselor, they said he is not on our list. …The system says that Western university professionals are more competent than others to provide good services in the mental health sector. But if someone does not understand your culture or the problem, how he is going to treat you? I have five years experience with white professionals but I was not satisfied. …Until you get proper help, help of your own culture, you are nowhere.

--A Punjabi Sikh participant

Another participant drew a parallel with the way people may be treated in the mental health system today using an infamous historical reference,

A long time ago when people had mental health issues, they used to put them all in a boat, take them down to Australia and drop them off [nervous laughter in group] ….Anybody who was handicapped, mentally disabled, anything…This is what we do here. We do not put them in a boat, we do it in a different way. …Now chains are replaced with medicine. It is the same thing.

--a Punjabi Sikh participant

Other focus group participants described one reason why there is a tendency among Somalis to express deep mistrust of the mental health system. One said,
Another reason Somalis look at mental health institutions and anything to do with mental health [in this way] is … that, when they first migrated to Canada, the kids were put in special education just because they couldn’t speak English. Instead of putting them in ESL or bettering their reading skills, they were nullified … And now these students are trying to get into university and what does it say on their records? ‘Special education, disabled.’ The student was never disabled to start.

--A Somali participant

Liminality also captures many immigrants’ feelings of living in a hybrid cultural reality, existing between two social worlds, but belonging to neither. For some, a sense of disillusionment about their powerlessness with respect to cultural identity and social integration grows stronger as time passes. For example, one study participant described the long-term costs to mental health and family wellbeing,

Many people feel that the quality of life they live here was not worth the price they had to pay. It cost them their health, often conflict and bad relations with their children and so much more. It is very sad. Some people lost their identity. They do not know who they are anymore. …. We are “stuck,” because in Canada we still have not learned new, Canadian ways of life and when we visit Poland, “the old ways” of life that we knew have changed as well, or do not exist anymore.

--A Polish participant

Many participants also talked about intergenerational strains. For example, one commented,

We are stuck in two cultures. We keep our old culture alive and the kids go into Canadian culture. When they need something, they adopt Indian culture. When they are not in need, then they adopt Canadian culture. The result of this is mental problems. Our family is fine, but we hear stories like that. … Sometimes the situation reaches the point of using alcohol, then it goes on to drugs and it could also lead to suicide.
If the immigrant experience is inherently liminal and full of potential, adaptation is a non-linear process of reconciling the values and practices of two social worlds (Portes and Rumbaut 1996). A possible adaptive response to the experience of social liminality, expressed by study participants as feeling "stuck," is to try to negotiate contradictory aspects of original and host cultures. Cultural negotiation is a psychosocial process that many scholars and lay people recognize, but few have explicitly defined. Social scientists often describe immigrants and others as having to ‘negotiate’ situations and ways of thinking and living; in fact, Strauss (1978) described virtually all social and institutional relations as processes of negotiation. The idea is implicit in studies of the psychology of migration and describes the 'give and take' of old and new ideas and practices using a "dual frame of reference" (Suarez-Orozco 1997). The negotiation process allows critique or appreciation of aspects of each culture to arrive at a new synthesis of cultural values and identities. For example, Ong (1996) states that negotiating citizenship and identity is about deciding "lines of difference" and calls this a process of "subject-making" or constructing the self within society (p. 737).

Explicit analytical uses of the concept of cultural negotiation are rare; however, Yeh et al. (2005) operationalized ‘negotiation’ in a study of Korean immigrant youth who struggled to find a cultural balance within themselves and to "negotiate across, or find a way to deal simultaneously with, both Korean and American cultures" (p.178). They negotiated in three ways: shifting themselves to meet the demands of both cultures; feeling caught between the two cultural groups; and perceiving differences between how they see themselves and how others see them. Similarly, in a study of marriage among Japanese living in the U.S., cultural negotiation may be defined as "the way in which individuals encounter, understand, construct, reconstruct, negotiate, and reevaluate the multiple cultural contexts of their everyday lives" (Sakamoto, 2005, p. 352), a definition that captures a sense of agency and decision-making missing from many acculturation studies. According to Sakamoto, several possibilities occur in the process, including encountering the host culture, accommodating differences, resistance, or reevaluating
or gaining perspective on the original and host cultures. The term 'negotiation' suggests dialectical change, or a process of shifting between two identities or value systems, sometimes involving cultural resistance, and sometimes adopting new ideas from an expanded cultural repertoire. For example, immigrants’ continual efforts to meet cultural expectations reflect changing evaluations:

We are pushed and molded by Chinese culture in China. We are educated to be a top person, to pass others. This is about life values… Here in Canada, our next generation wants to be normal instead of being better than others. In my view, China’s education is unhealthy. Parents in Canada feel happy if their children are healthy and happy. Family influences people’s mental health. Not only our parents, but also our society pushes us.

--A Chinese participant.

In this study, many participants described processes of negotiation and synthesis as a necessary and psychologically healthy process. For example, one focus group participant said,

I believe adaptability is a change in mental attitude, processing information in a different way. We bring a certain bias from our countries and we pretend that people adapt to us instead of the other way around. That’s where the problem resides. This is a multicultural country…What can we do to integrate? If we all cooperate and are open-minded we can learn from each other. I think that passion fills us with the desire to live, to adapt, and to have inspiration and new ideas to confront life with a different attitude from the one we had before, which used to be useful in our countries. But here everything is different. The rules are different, so the process should be different as well.

--A Latin American participant

Negotiation may describe an active, empowering process of personal reflection and recovery from mental distress in a given social context (Ochocka et al., 2005). On a personal level, the resulting psychological compromises may be beneficial, if not entirely satisfactory on a social level. As an example, one focus group participant recalled,
My first job in Canada was cleaning up the mall. It was a shock when I saw that all that food was being thrown out. Everyone ordered a pizza, ate half, and the rest was left on the table. No one cleaned up after himself. In contrast in Poland, people as a rule cleaned up after themselves. I was initially shocked, almost depressed. At a certain point I realized that if people cleaned up after themselves, they wouldn’t need me. So thanks to the fact that they didn’t clean up, I got the job. --A Polish participant

When cultural negotiation fails and liminality becomes an enduring state of mind, mental distress increases. As suggested, however, the transformative process of cultural negotiation can be psychologically adaptive. The participant's comments below illustrate this process, beginning with a feeling of isolation caused by family separation:

In our Latin American community family is very important…when you come to a country like this and the family is left behind, you have to learn to face the situation without the family, without advice, not being surrounded by the extended family or people that you love. You have to learn to be alone. You have to fight in a different world.

The participant’s tone then changes, appearing more empowered as the idea of creating new ‘family’ beyond one’s own community is explored:

… We Latinos tend, if there is not a mother or father, to look for somebody similar, so I end up with friends becoming "cousins, uncles and aunts" … This is possible when you have good mental health, having strong relationships that replace the family that has been left behind.

The participant next compares and considers various solutions for mental distress, concluding with a statement about the cultural exchange of mental health strategies:

… You may have the idea that [Canadians] are not attached to their families, but they share with us [Latinos] the same depression problems. Probably they have different ways
to confront the problem. Maybe we can learn from them and they from us [and] probably share the learning experiences that enable you to find solutions. We in our countries look for social support and maybe they don’t, but they could have good strategies.

--A Latin American participant

Discussion

Findings from this multicultural study provide insights into various adaptive strategies that many immigrants actively undertake in their long-term efforts to move in from the margins of society, to reconcile cultural differences and to achieve mental wellbeing. This article has sought to explain underlying psychosocial processes of immigrant adaptation using anthropological concepts of ‘social liminality’ and ‘cultural negotiation, which may be somewhat unfamiliar in immigrant mental health research, to contribute to a broader and more grounded understanding of how psychological adaptations and transformations occur. Study participants report a sense of social liminality and powerlessness, the strain of having to cope continually with two cultural worlds and recurrent “culture shock.” However, they also report that these challenges can be potentially transformed into new awareness and understanding of mental health through a process of cultural negotiation. As in Sakamoto’s study (2005), individuals reflect, evaluate and reconstruct their perspectives using both the culture of origin and host culture. Study data illustrate, for example, how immigrants’ critical perceptions of causes of distress and perceptions of mental health care may differ from that of the existing, Western biomedical system. Moreover, they show that this awareness of different values and ideas related to mental health may contribute to problem solving and adaptation.

This study contributes an experiential perspective on immigrant mental health to the growing body of research on immigrant and minority ethnocultural health, which demonstrates that many external factors contribute to experiences of social marginalization, including lack of language proficiency, isolation, racial discrimination and structural barriers in host societies, and which affect mental health adversely. The qualitative approach helps illustrate immigrants’ subjective sense of liminality, social exclusion or powerlessness with respect to the larger society and the mental health system in particular, and in this aspect agrees with findings of other studies.
of factors affecting immigrant and ethnic minority health. Study participants also report a sense of continual strain from continual coping with cultural differences, which are also often recognized in acculturation research as being sources of risks to mental health. Rather than focus on the mental health impact of risk factors, however, this analysis highlights underlying psychosocial processes that seem protective and potentially positive in the social context of settlement in host societies. Study participants describe how the sense of liminality and cultural tensions produce critical reflection on the self and culture and active attempts to negotiate a balance and move forward. While some participants described feeling “stuck” on the margins of, or between, two societies, others reported striving to come to terms with cultural differences in order to resolve the tension of living between two realities. The findings show that this dialectical cultural negotiation process holds potential for addressing mental distress on the individual level and mental health promotion on the community level.

Theoretical implications of this analysis touch upon the core distinction between subjective illness experiences as defined by study participants in the social context of immigrant adaptation, and objective medical disorders that are often defined clinically with little regard for social and cultural factors. Not finding common ground for these opposing views impedes the accessibility of mental health services and the quality of care for immigrant populations. It is necessary to understand immigrants’ perceptions of the causes and appropriate responses to mental distress in order to bridge the gap. In fact, from the study participants’ descriptions of liminality and cultural negotiation emerges the sense of agency and active participation in problem-solving that makes therapeutic relationships possible. Another theoretical implication is related to the view of culture in medicine. The description of the cultural negotiation process offered here is more fluid and dynamic than tends to be understood in encounters with medical practitioners in psychiatry, where a person’s nominal culture is still often considered a static characteristic or a barrier, rather than a resource for resiliency and recovery.

Limitations of this participatory action research include the fact that only five of many ethnocultural groups in Ontario could be sampled and involved in the study in great depth. However, that the investigation was, in fact, participatory and multicultural lends weight to the validity of the concepts used in analysis and to the application of the evidence collected from the diverse perspectives to the mental health system in Canada, which must today serve large multicultural populations. This study also does not intend to address links between mental
health, social adversity and health inequities, although it did allow participants to speak about feelings of powerlessness from their everyday life experiences in the social context of immigration and settlement. It is possible that immigrants’ perceptions of problems and marginalization from formal mental health care would differ in another study context, country of settlement, or health system where social exclusion and access to mental health services might take different forms. Finally, this study did not attempt to measure the level of mental illness in any of the participating ethnocultural communities, but rather focused on participants’ perceptions and experiences of mental health issues in general. Study participants’ expressions of mental distress are, however, likely to be shared by larger proportions many more immigrants than the smaller proportion who suffer from specific mental illnesses.

The participatory study methodology has had clear benefits. The analysis of psychosocial transformation that emerges from this study was enabled by the participatory action research approach, which was for many participants the beginning of the transformative process. Focus group participants described the problems they encountered as immigrants and how these affected mental wellbeing, but they went beyond identifying the problems to revealing how the process of cultural negotiation led to new insights into mental health. In many immigrant communities, mental health is seldom openly discussed. As the researchers discovered in this study, opportunities in focus groups for meaningful discussion about mental health issues were welcome and empowering for study participants (Simich et al., 2008). Participants opened up, learned from one another and generated ideas for actions in their communities. Such discussions begin the process of moving beyond a state of disabling social liminality to increased personal and community empowerment, negotiating new understandings of mental health and new relationships to the culture of the formal mental health system. The study thus demonstrates the value added of participatory inquiry that not only employs community-based researchers in data collection, but also uses the research process to create innovation and interventions. One implication of methods and findings of this study for mental health systems and practitioners is that inclusion of immigrants in research and services can foster greater understanding and trust, which is fundamental to achieving mental health and quality health care.

In sum, the value of understanding cultural adaptation as a transformative process is that it acknowledges and advances the active search for solutions to mental distress that can be tapped to prevent mental distress and promote immigrant community mental health. The data
presented in this paper illustrate the underlying processes and point to the capacity for resiliency during immigrant adaptation. They also suggest that health and social service providers need to do more health promotion for, and with, immigrant communities, because cultural negotiation and achieving mental wellbeing are more complex and longer-term processes than generally acknowledged. In theory and practice, health and social service providers tend to problematize mental distress among immigrants. It may be helpful to reconceptualize the tensions arising from experiences of social liminality as opportunities for negotiating creative cultural syntheses that have the potential to enhance mental health.

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