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The Social Dimensions of Health and Illness in the Sri Lankan Tamil Diaspora- Implications for Mental Health Service Delivery

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Abstract Immigrant communities are often not well served when it comes to mental health services. A fundamental reason for this may lie in differing cultural concepts of what it means to be healthy. The aim of this paper is to capture how Sri Lankan Tamils with a diagnosis of depression, newly arrived to Toronto, Canada, conceptualize health, and to determine whether this conceptualization is shared by care providers who provide service to this community. The data are derived from a qualitative study based on interviews with 16 Sri Lankan Tamil immigrants who self-report being diagnosed with depression and 8 service providers who work with the community. Findings show that the Sri Lankan Tamil community emphasizes social functioning as the hallmark of health. Study participants see depression as linked to a breakdown in social functioning. The community also holds an integrated notion of health, one that encompasses physical, mental and social components. Responses show little evidence for a belief in the role of the supernatural in causing mental illness. Medication is seen as part and parcel of ill health; it is sought during overt illness but its preventive action is not well understood. Service providers do not fully understand the community's notions of health and illness. It can be surmised that the social dimensions of health and illness are fundamental to this community. Being well means being able to fulfil one's social role. This suggests that the provision of social support services, vocational services for instance, needs to be a key component of mental health services. Acculturation into concepts of preventive health including the role of medication in maintaining health and preventing relapse is also important.

Keywords: *culture, health, immigrant, Sri Lankan Tamil, social functioning, depression, service provider*

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1. Introduction

Cultures conceptualize health and illness in different ways. Culture influences how health is viewed, how symptoms are expressed and how help is sought [1,8,11]. In the past few decades, Canada has witnessed a change of great magnitude in immigration trends, resulting in an increasing number of individuals from various visible minority ethno cultural groups calling Canada home. There is a definitive shift in source countries from European to non-European countries, with rising numbers of immigrants coming from Asia, Africa and the Pacific [23]. It is projected that, if the present immigration trends continue, 20% of the Canadian population will belong to a visible minority by 2017 [24]. Today, Toronto is one of the most diverse cities in the world, with more than 47% of Torontonians belonging to visible minority populations [4].

Immigrants bring with them their own culturally-informed perceptions of health and illness, which, in turn, influences their priorities, their needs, and their help-seeking behaviour. In order to optimally support and promote the health of immigrant populations, Canada's health systems and service providers need to operate in the context of a fuller understanding of cultural differences in conceptualizations of health and illness. Implications for help-seeking and health care need to be appreciated.

Much of the literature pertaining to how health is conceptualized in different populations suggests that non-Western cultures adhere to a holistic understanding of health and lack the concept of a mind/body divide such as exists in Europe and North America [9,18]. An illustrative Canadian study is one of immigrant women in Nova Scotia [25] that used focus groups to explore participants' concepts of health. The investigators found that group members did not define health as an absence of illness - the more common European/American definition [10] – but, rather, as a totality of physical, social, and emotional factors that, together, constituted well-being in their eyes.

Other studies have demonstrated that perceptions of health and illness in non-Western societies rely heavily on social factors. For instance, Ethiopian refugees to the United Kingdom believe that happiness and good social relations are a pre-requisite to and a reflection of good health [19,20]. Hispanics attribute depression to interpersonal and social issues [2]. A recent study looking at what constituted causes of depression for South Asian women in Toronto found the answers to be family relationships, culture migration, and socio economics [5].

Depression and other mental illnesses in ethno-cultural communities are sometimes attributed to supernatural causation [12]. This fatalistic attitude could deter medical help-seeking For example, a Montreal study, using qualitative data from in-depth interviews of 15 West Indian immigrants, attributed the reluctance to use mental health services, at least in part, to a belief in the curative power of non-medical interventions, notably a divine power, and, to a lesser extent, to reliance on traditional folk medicine [26]. Another qualitative study of South Asian women who experienced depression concluded that a belief that mental illness was "God's will" explained why the women did not engage formally with mental health services [7] More recent research points to changes in this belief. The Toronto study of South Asian women with depression, referred to above [5], revealed that not one woman attributed her depression to supernatural or spiritual causes.

This paper examines perceptions of health and illness in recent Sri Lankan Tamil immigrants to Toronto, whose length of stay in Canada has been 10 years or less, who self-identify as having suffered one or more episodes of depression. Canada is home to the largest Tamil Diaspora in the world, the majority of whom have settled in the Greater Toronto Area [14]. Sri Lankan Tamils are part of the larger South Asian Diaspora in Canada. They share cultural and linguistic commonalities with other populations from South Asia, but form a specific sub-population.

Sri Lankan Tamils constitute a visible minority population with a culture distinct from that of the larger Canadian society. This immigrant population is also distinguished by its exposure to pre-immigration trauma, having experienced civil war prior to emigration and having arrived in Canada as refugees. The mental health of this population has been surveyed in the past [1]. In this paper, the perceptions of health, mental health and mental illness of the Sri Lankan Tamil men and women in Toronto is compared with the views of service providers who work with this population, with the aim of improving service provision. Implications for service delivery are presented throughout the paper.

The findings on perceptions of health and illness presented in this paper are part of a larger exploration into cultural and gender factors influencing mental health, health beliefs, health behaviour, help-seeking and treatment expectations in newcomers to Toronto who are members of this ethno cultural, visible minority population.

2. Method

A large scale study on mental health in the Sri Lankan Tamil community [1] had provided quantitative data about the health of this community. The next step was to obtain insider views, for which qualitative methods were indicated. The study sought and received REB approval from the University of Toronto prior to implementation.

The Long Interview Method [17] was selected as the instrument with which to interview 16 adult Sri Lankan Tamil immigrants in Toronto; 8 men and 8 women whose length of stay in Canada was between 2 and 10 years and who self-identified as having suffered from depression, and 8 service providers, not necessarily of Tamil origin, serving this community.

With respect to sample size, McCracken [17] suggests that data saturation is reached with the Long Interview Method when 8 participants in each category have been interviewed in depth and no new analytic themes appear.

The interview guide was shaped to aid respondents to tell their story in their own language. There was a set of biographical questions, followed by a series of question areas. Interviews consisted of a grand-tour question and floating prompts to be used in each case, plus planned prompts that were banked, to be only used should the need arise [3]. Once developed, the guide was translated into Tamil and back-translated into English to ensure its accuracy.

The respondents were recruited by posting Tamil language flyers in doctors' offices, settlement centres, accident claim centres, community health centres and other community service organizations. On first telephone contact, inclusion criteria were confirmed, the study explained, and consent sought. A time and place for the interview was then arranged. Service providers were recruited through word of mouth in the service community.

Written consent from all participants was obtained prior to the actual interview. The participants understood that their verbatim comments would be anonymously published after editing such that personal identity could not be inferred. Interviews ranged in duration between two and two and a half hours and were conducted in the language of choice of the respondents – Tamil or English - by the first author [N.P.]. The interviews were audio taped and transcribed. In addition, field notes of the interview were written and/or recorded immediately after the interview. The accuracy and reliability of translated transcripts were verified by permitting a certified translator to translate sections of audiotapes from different interviews and comparing them to the original transcription and translation by the first author.

The analysis of interview data involved careful examination of interview transcripts in order to identify common themes and trends and led to the subsequent stage of coding and analysis. Observations were made from verbatim utterances recorded in the transcripts. The connections between observations were scrutinized and analyzed. Both inter-theme consistency and contradictions emerged. Patterns and themes from the totality of the interviews were subjected to a final process of analysis. Throughout this process, the investigator moved from data to observations to meta-observations, finally ending in higher level conclusions. Data triangulation was possible as the design enabled comparison of results from three different data sources [16], namely community respondents and service providers, and men and women among the community respondents. The Long Interview Method allows for the objective positioning of the

researcher's prior knowledge and experience, which adds to the validity of the study. "Deviant case analysis," a process of validation in qualitative research, is also an intrinsic element of the Long Interview Method. This involves discussing findings from the data that do not support explanations and patterns that are merging through data analysis.

3. Results

3.1. The Social Dimensions of Health and Illness

When asked what the term "health" meant to them, the community study respondents, all of whom had suffered from depression, emphasized social functioning as the hallmark of what it means to be healthy. Three aspects of social functioning were especially important to them – family, education, and social relationships. The ability to provide for family and the ability to educate one's children was especially important to Sri Lankan men. The man quoted below was diagnosed with depression following an accident that resulted in the loss of his job, severely compromising his ability to provide for his family. His words indicate that, for him, being healthy means achieving the goal of education for his children.

"*[Health]* ***Oh, right, I think of children. We should bring up our children well, make them study well. I didn't study - now we need to know what they are interested in and channel them. We have suffered*** *[because of the war in Sri Lanka]* ***– now if we get them in the right path, that is enough. That is my desire – but this*** *[the accident]* ***happened***."

Not being able to accomplish this social role equalled a loss of health. Worrying about this further aggravated his problems.

"Initially I thought I would be like this – I will work well, taking care of them. Then, I didn't expect the accident. So thinking about all this, I worry and I have developed a lot of problems."

Another man explains:

"Health means that one should be happy. There should be progress in life through education, through living; mental health means dreams and relationships should thrive."

For women, health was more closely connected to the maintenance of intimate relationships. The women respondents reported significant stresses in their relationship with their spouses; several were estranged from their spouses.

"For mental health you should get a good husband. I think that is what life is about. Otherwise whatever happens, there won't be happiness in the heart."

"When you say health - it encompasses everything – troubles and diseases. I feel healthy when people care for me and come and visit me."

One male respondent was estranged from his wife and did not have a steady source of income:

"When I think of health, I feel that you should be peaceful in your mind and happy with your wife and children. Other than that, be happy with the income you receive. I think that is the basis of health."

The factors that were seen as crucial to staying healthy all had a significant social functioning dimension. Respondents spoke about friendships, healthy marital relationships, ensuring good education for children and a job through which to support the family. These were the most important factors in keeping a person healthy.

"I thought I needed to be relieved completely of the depression. I knew why I had become depressed - now I am taking medication for depression and I am staying home. But that alone is not enough. You have to make other things available."

[Such as?]

"***I need a job – I need to go to a job, but I am unable to work*** *[where I previously worked]* ***because of my pains. However if I am able to work in some job that is compatible, then I think that I will feel better.***"

This need to have a job was very closely linked with this man's need to play the role of primary provider.

"After coming here, I was working well, for my house, others, I have helped many others as well.....But now everything has stopped, I cant do anything. Wife is not working.....I could not support my daughter and her husband who are in India. This threw my life completely on the other side and I was severely depressed"

3.1.1. The Service Providers' Perspective

By contrast, the social dimension that underlay the community's conceptualization of health and illness was not specifically articulated by service providers, yet does appear to inform their understanding of when and how the Tamil community engages in help-seeking.

"I don't think they see themselves as needing more help for themselves, for their depression; it's more like ' help me get a job so that I can get money so I can provide for the family.'"

"The major concern is not to feel better…… because the woman mostly wants to keep the family together and most of the time, whatever happens, ...and at that time they might be very angry, they want some help, they want to get some housing and something like that……."

In summary, all respondents concurred that a return to social function is fundamental to recovery. Culturally competent care would, thus, need to put this understanding into action by, for example, the provision of, not only direct counselling around depression [grief, loss, anger, self-esteem], but also marital counselling, supportive employment, and instrumental help to re-enter the workforce.

3.2. The Relationship between Mental and Physical Health

Many study respondents spoke about health as encompassing both physical and mental health.

"….Real health is when the mind ["manam"] is good. If the mind is good, then automatically the body will be good… that's what I am thinking of. Now after I got cancer, my mind has been affected. I have depression…."

This first quote indicates that body ill health can lead to psychological ill health.

"Health is….., I feel that it is both physical and mental well-being. Only if there is mental health, there

will be physical health. What I mean is, you can achieve anything - even if you don't have a hand or a leg - if you have a healthy mind. So I think mentally – I think 90% is mental health when you talk of health."

This quote endorses the oneness of mental and physical health, with the psychological aspect taking precedence.

"Mental health, thinking positive things, have a good eating habit, sleeping habit, sleeping is very important for your health, I know, those are the things very important. Because mentally when you think healthy stuff you tend to do healthy things…"

This quote speaks of another aspect of the connection between mental and physical health. Here, mental well-being leads to a healthy life style which, in turn, promotes physical health.

3.2.1. The Service Providers' Perspective

For the most part, the interviews with service providers did not reflect the understanding that the community viewed mental health and physical health as one. Some service providers did speak about a movement towards better understanding of mental health issues in the community, but they were referring to the community's adoption of Western Medicine's tenets rather than to a cultural understanding of an inseparable body/mind concept of health.

One exception to this was a family physician**,** whose experiences with clients from the general Tamil community were reflected in his understanding of what his patients regarded as health. As a primary care physician, patients talked to him about aches and pains and mental stresses and social distress.

"People are very open to open up about their family problems and their underlying stress, depression, family problem, relationship issues, financial problem, work stress and their other stress, which was affecting their physical health and, thereby, their mental health too. So sometimes they come and talk to us openly."

It is a possibility that as the is mind/body divide is not pertinent in this culture, the community is more open to talking to family physicians [whom they identify as being a general health provider] about physical, social and mental health issues rather than with service providers that are identified as providing specific/specialist services. This also speaks to the possibility that, for best results, mental health services for this community need to be organized around primary health care.

3.3. Medication and its Association with "Being Sick"

Discussion of good and bad health invariably led to the topic of prescriptions and medications. Many respondents drew the parallel between taking medication and "being sick," hence the expressed desire to reduce medication, as that would indicate a return to health. Medication being equated with ill-health, there was a tendency to stop medication as soon as possible. This translated into a long history of non-adherence to medication for many respondents in their struggle with depression.

The Tamil culture places an emphasis on health as freedom from medication, and this emphasis clearly influences health behaviour. Many accounts highlight not visiting doctors and not taking medication as positive attributes**.** Medication was associated in the minds of respondents with acute symptoms. Recovery meant no more pills. The notion of medication as prevention or medication as a rehabilitative strategy did not exist for this community. This has obvious implication for incomplete recovery from depression. Only after long experience with depression did some respondents choose to stay with ongoing medication.

Seeking medical help of any sort is avoided whenever possible. This is evident in the health care avoidance behaviour of the following male respondent:

[Why did you not go to the specialist?]

"I did not think it was necessary. I don't like taking medication. I was in Europe for 13 years. Even there I will not go to the doctor or take medication."

"Only now I have started going to doctors after this. Before that I did not like to go to doctors."

[Why is that?]

"I don't like to take medication. In the 10 years *[that I have been in Canada]****, it is only now that I am going to a doctor. If I am really very unwell, then only will I take a Tylenol. If it does not get better with that….as I remember, I have gone to a doctor only 3 or 4 times."***

[So the yearly check ups?]

"I have done it only three times – full medical check ups. But for blood donation – I go every six months."

A second example, from a female respondent, further illustrates the connection between not-seeing a doctor or not-taking medication, and being healthy:

"When I landed in Canada with my five children I had no ailments or complaints *[health wise]* ***whatsoever. When I came here and saw the doctor, she checked me and said 'since you need a family doctor in Canada, you should register with some family doctor'. I said that I don't need a family doctor as I was keeping my body and health under good control. I don't need a doctor. But then I was advised that I definitely need a doctor, because if I was going somewhere for something, they would require a report from the family doctor. Only because of that, I registered myself and my children with the family doctor. When my doctor saw me she asked me, 'did you use any medication in Sri Lanka, did you have any ailments?', I said ' only when I was pregnant did I take tablets. Otherwise I have not taken any medicines. Till 46 years, I have had such good control over my body and health.' I had kept my body disease-free. Sometimes for cold or fever, I would just take a Panadol. She then tested me and said 'you are a smart woman,' she said, 'here, even young people get ill, but you are good – so maintain your health as such'. Apart from that, I wouldn't come to her, but she advised me to come and get a check up done intermittently. But I wouldn't since I had no issues…."***

Though suffering from depression, this female respondent did not take the prescribed medication; she felt she would become 'lazy' if she took medication.

"….So when I went to the clinic the next time, I told the doctor and they gave ECT treatment [in Sri Lanka].. I felt better, but the mistake is with me – discontinuing medication…..Now I take medication, but I would like lesser medication."

For most of the respondents, access to services, referrals, or reminders to take part in regular check-ups were not sufficient to ensure visits to the doctor or the regular taking of prescribed medication, even when needed. While most of the respondents were nominally attached to a primary care physician, the data suggest that

visits generally occurred only in response to an acute illness, and not in the context of prevention.

3.3.1. The Service Providers' Perspective

Service providers come at the medication issue from a different perspective. Many contrast medication to counseling and complain that their clients prefer the former. Counseling and psychotherapy are largely alien concepts to Sri Lankan Tamils, and are usually not considered stand-alone treatment.

"….yeah, and they do want a prescription or medication – very few of them would like to engage in ONLY psychotherapy, without medication"

Noteworthy is service providers' experience that the Sri Lankan community offers less resistance to the idea of using medication to treat depression than other [Western] clients:

"…. of using medication as against psychotherapy to deal with the issues, it is ' give me the medicine, I will sleep better'. There does not seem to be the resistance, that I am seeing with the general population, it is … ' I don't want medicine…' so they are very different things…

Non-medical service providers in this study felt that their skills with respect to dealing with depression were devalued in this community.

... the kind of respect and belief in the family doctor and psychiatrist is very high *[in the Tamil community]**, very different from what you would see with the general population. That seems to be the pathway, through the doctor and the psychiatrist, and then counseling."***

While the perspectives of Sri Lankan Tamil clients and their health care providers might at first seem contradictory, they can, in fact, be reconciled. When there is acute illness, one goes to the doctor for medication. The expectation is that the illness will be cured by the medication. As soon as the medication runs out, the need for it is considered over. If, as in the case of depression, social role functioning is not regained when the prescription ends, the "go to" people for further help would be friends and relatives, not mental health workers. This is how Tamils have traditionally resorted to help-seeking in their home country.

Hence, it is important for primary care physicians [and psychiatrists] to stress the social factors behind depression and to explain what social services can do. They need to actively refer Sri Lankan Tamils to social service supports because, left to itself, this community would not know how to avail itself of these services.

3.4. Illness Causation and the Diminishing Significance of the Supernatural

An interesting finding of this study was that supernatural causation was not cited by any of the respondents as a reason for depression. Most respondents cited social factors.

"Only after the accident did I start staying at home. After the accident I couldn't go to work."

[Where were you working prior to your accident?]

"I was working in a restaurant and a laundry, I sometimes used to do three jobs in a day. I would go wherever – whatever job was given to me, I am okay. If they ask me to clean it, okay, if they ask me to write it – okay. My mentality is like that – I have been habituated like that. After coming here I was working well, for my house, others, I have helped many others as well. Before the accident I have sent so much money – to orphanages etc. But now everything has stopped, I can't do anything. Wife is not working. She has problems in the leg because of the cold weather. So she does not work. Children are at home. I could not support my daughter and her husband who are in India. This threw my life completely on the other side and I was severely depressed."

This female respondent talks about marital problems as causing her depression.

"We got registered there. It was okay, then. Then after I came here it was okay. Then after marriage in a short while, there were problems and I became unwell"

However, some women whose illness started in their home country cited community members back home as suggesting that their condition could be the result of 'being punished by the Gods because of inappropriate behavior , or 'possession by spirits' or a result of 'black magic' ['sei vinai' in Tamil], though they themselves were unsure of this.

"…Well, they thought that this was happening due to some wrong doing [kurai], when I went to my mother's place in *[name of village]**, I became unwell, when I went to attend my cousin brother's wedding - they said that since I was wandering during my periods*** *[menstrual cycle]**, and there was the Vairava temple, they said that the spirits had caught me."***

However, supernatural causation was never cited as the exclusive reason for developing depression. At most, it was a factor contributing to a multiple causation theory of illness. The instances quoted referred to events in the home country where community members may still hold supernatural beliefs about illness causation.

3.4.1. The Service Providers' Perspective

Service providers seemed to understand that cultural beliefs and beliefs around supernatural causation of mental illness, while they do exist, no longer dominate the Tamil psyche within the diaspora community. Service providers believe that psycho education and acculturation are responsible for the currently more medical and less supernatural view of the causes of mental illness.

"…..now *[as compared to earlier]* ***99.9% of my patients are Sri Lankan Tamil. That shows their shift about their views about illness, about psychiatry as such. I'm not saying that the Tamils accept psychiatric illness as a normal condition like Canadian White ... still we have taboos and beliefs and all that. In spite of that, most Tamils do understand the concept of depression. Change occurred over a period of time, by many of us who have been involved in the community, educating them…."***

"That kind of beliefs mainly, in paranoid illnesses, some of them – it has lessened now. Like they have done something 'sooniyam' *[black magic]* ***exactly - so they go to the poojari, the temple, and do all these things - that is still there, but I don't see them as often, because one person might believe it, but the spouse might say 'no, no no, this is something, this is an illness, we have to take treatment."***

While data from service providers indicate that some clients still believe in supernatural causation, the emphasis

on this is definitely diminishing. As supernatural explanations become rarer in the Diaspora community, service providers should be alert to the fact that such beliefs may still influence new arrivals from Sri Lanka, which might put them at odds with older immigrants and, therefore, increase their isolation

4. Discussion

The findings from this study indicate that the relatively recent Sri Lankan Tamil community in Toronto subscribes to a perspective of health that focuses on meaningful social functioning and sees a role for medication only in the acute stage of illness. This conclusion aligns with the prominence of the social dimensions of health and illness derived from studies in other ethno-cultural populations [2,19,22]. Precisely what characteristic of social function is 'meaningful' depends on specific cultural and also on gender perspectives. In the Tamil population, both genders consider family-centrism and achievement in education to be important markers of health. For men, this means the ability to provide for their families and ensure the education of their children by being gainfully employed. For women, health means happy families and a good relationship between spouses. This supports evidence in the literature that familial factors predict distress in women [6,15]. This study adds to the literature on the social aspects of health and illness in Tamil men by underscoring that family factors are important for men as well as for women. The difference is that, for men, 'good health' means the ability to meet internalized gender role expectations as instrumental providers in a family-centric context, a role that is often challenging for new immigrants within the resettlement context.

The Tamil community members interviewed for this study view health as encompassing social, physical, and mental health, and they underscore the interrelatedness of physical and mental health. This, again, reflects the thinking in many non-Western cultures [9,18,25] where health is perceived as holistic, with no division between mind and body. This stands in contrast to some [though not all] of the underlying premises of Western-based medicine, and may help to explain why the formal health care system of the West may not always optimally serve this population.

The analyses of the interview transcripts of Sri Lankan Tamil clients with a diagnosis of depression revealed that visiting the doctor and taking medication are both equated with ill health. The services of a doctor are sought when there is an acute breakdown –but not for preventive or rehabilitative reasons - and medication may be stopped as soon as there is a relief of acute symptoms. The findings of this study also show that the concepts of counseling and psychotherapy are not readily utilized within the Tamil community, probably because they were not part of the health care system into which Tamils have been socialized. This does not mean that Tamils do not value disease prevention; rather, it means that prevention is seen as operating outside of the traditional health care system. Health-promoting interventions are conceptualized as occurring along the social dimensions of well-being and include employment, income support, the successful education of children, and enhancement of positive communication in relationships, particularly within the family unit.

Our findings show that service providers socialized in the Western tradition, even when originally from non-Western cultures, tend to judge a community's view of health and illness by the parameters of Western medicine.

An important finding of this study, important because it contradicts the majority of the literature in the field [7,26], although it confirms a recent study in Toronto [5], is the movement away from a belief in the supernatural causation of ill health and the efficacy of supernatural intervention. When supernatural causation was brought up by respondents, it was, at most, stated in a speculative way, and was restricted to respondents whose illness experience originated in Sri Lanka. This is a good example of the dynamism of culture. Sri Lankan culture, its beliefs and traditions, has evolved and continues to evolve. Beliefs are not static [27], which necessitates a heightened sensitivity to cultural shifts in order to keep therapeutic interventions in line with changing realities.

5. Conclusion

This paper reaffirms the fact that it is important to ascertain patients' own perceptions of health as distinct from external views based solely on the observations, expectations, or views of providers [13]. Public health decisions need to be responsive to patients' own understanding of suffering and healing Understanding differences amongst individuals, populations and groups will assist policy and program leaders to develop need based programs and services [21] This study makes clear that notions of health and illness in the immigrant Sri Lankan Tamil community who have suffered depression emphasize the social dimensions of mental health. This suggests that the provision of social and support services, needs to be a key component of mental health services. Primary care physicians and psychiatrists need to play a crucial role in directing people to these services. Acculturation into concepts of preventive health including the role of medication in maintaining health and preventing relapse is also important. Future research should look at evaluating programs and models of care which take into account the social dimensions of health and illness in ethno cultural communities. Also research into culturally informed perceptions of other mental health issues such as PTSD, schizophrenia and anxiety are warranted.

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Statement of Competing Interests

The authors have no competing interests

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