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Depression and Help Seeking in the Sri Lankan-Australian and Anglo-Australian Community: A Qualitative Exploration-Preliminary Findings

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Abstract

This study compared cultural variances in the understanding of depression, help seeking and management strategies between Anglo-Australians and Sri Lankan immigrants with depression, one of the fastest growing immigrant communities in Australia. From 2012-2014 Sri Lankan (n=18) and Anglo-Australians (n=30) participants living with depression took part in semi-structured interviews. Participant eligibility was verified by significant levels of depression on the DSM IV and K10. Sri Lankans and Anglo-Australians expressed overlap in the experience in symptoms, yet differences in beliefs related to the etiology of depression; in general, Sri Lankan migrants attributed depressive symptoms to ongoing social problems whereas Anglos-Australians generally conceptualized depression as a biomedical disorder. These disparities in illness beliefs influenced help seeking trajectories; Sri Lankans favored self-directed behavioral interventions, and in many cases were hesitant to take medication to address mental health issues as this was seen as an admission of “madness.” In contrast early intervention via primary care was common for Anglo-Australians. However, while a significant proportion of Anglo-Australians would use pharmaceutical interventions, many were also prepared to try complementary and alternative therapies. Across both groups stigma still presents a significant barrier to help-seeking, however stigma was particularly noted in the Sri Lankan community. Preliminary analyses suggest important differences in help-seeking strategies that may have implications for improving access to mental health services and the development of culturally salient interventions in the Australian context to cater for the growing Sri Lankan migrant community. The outcomes of this study will provide greater insight into cultural variances of depression and help seeking of Sri Lankan immigrants. These results may further provide valuable information that can be used more broadly in countries receiving Sri Lankan, and possibly other South Asian migrants.

Introduction

Depression is among the most prevalent illnesses on a global scale and is a leading cause of disability, estimated to affect about 350 million people worldwide (World Health Organization, 2012). Yet while depression has been labelled a global health threat, it still goes unrecognized in many non-western settings as well as in migrant and minority communities living in western countries (Morton Beiser, Simich, & Pandalangat, 2006; Tiwari & Wang, 2008). While efforts are being made to improve uptake of mental health services in most western countries, hard-to-reach groups such as migrants and refugees continue to underutilize services and experience greater severity of illness (Morton Beiser, Simich, Pandalangat, Nowakowski, & Tian, 2011).

In the Australian context, this disparity in service use constitutes a major concern as

Australia is one of the most diverse and multicultural societies in the world today (Australian Bureau of Statistics, 2010) (Markus, 2014) receiving immigrants from more than 190 nations annually. Sri Lanka is in the top 10 countries of immigrants into Australia representing a significant minority (Department of Immigration and Citizenship, 2013b). Mental health problems are a concern in this group as many individuals have been exposed to traumatic events related to the civil war (1983-2009) (Silove, Steel, McGorry, & Mohan, 1998), the 2004 Tsunami and the accompanying poverty and hardship as a result of such events. Currently, Sri Lanka has the highest suicide rate in the world (Siva, 2013) and many Sri Lankan migrants bring with them culturally informed health and illness beliefs, which influence their actions and behaviours in relation to mental illness (Pandalangat, Rummens, Williams, & Seeman, 2013).

For example, research in Sri Lanka has shown that depressive symptoms such as low mood may be influenced by the dominant Buddhist culture which holds that life is suffering and sorrow and the transcendence of suffering is the soteriological goal. In this tradition what in a biomedical model is classified as a 'depressive disorder,' may be conceived as natural vicissitudes of life thus not requiring biomedical intervention (Obeyesekere, 1985). These illness beliefs strongly influence help seeking behaviors as highlighted by Wynaden et al. (2005), who found that South Asians living in Australia preferred to address depressive symptomology by seeking help within the sphere of their religion, using mainstream health services as a last resort only, because mental illnesses are not recognized as a medical problem (Lauber & Rössler, 2007).

Closely linked to culturally derived health and illness beliefs is the stigma attached to mental illnesses, which has been identified as "*the single most important barrier to overcome in the community*" by the World Health Organization (2001). In support of this, research in South Asian communities has shown that help seeking from health professionals is inhibited by stigma and concerns about shame and damage to the family reputation amongst other things (Wynaden et al., 2005). Loewenthal and colleagues (2012) found that Sri Lankan Tamil immigrants were concerned about the mental illness stigma, including the concept of madness which leads to feelings of guilt, shame and the urge to conceal psychological distress to avoid being ostracized by the community. In the same vein, Siva (2013) reported that in the Sri Lankan migrant community socio-cultural norms and stigma exacerbate mental illness by imposing significant influence on the experience, expression and behaviour relating to mental illnesses. However, in western societies stigma has been found to modulate health seeking patterns where the perceived stigma and the related shame and embarrassment hampers help seeking for depression (Barney, Griffiths, Jorm, & Christensen, 2006; Wrigley, Jackson, Judd, & Komiti, 2005).

Research in Australia has also emphasized that the underutilization of mental health care by migrant communities is a concern. Despite evidence suggesting that the impact

of depression in Sri Lankan diaspora is similar with the mainstream Australian population, there is paucity in the literature relating to Sri Lankan immigrant communities mental health rates, factors that shape their help seeking behaviors and experiences of mental illness. This dearth of research can impede the development of relevant and responsive policy and mental health care services for this growing minority in Australia.

The present study

This study aimed to address this gap in the literature by exploring help seeking behaviors for depression in the Sri Lankan diaspora living in Australia and compared and contrasted culturally patterned illness conceptualization, experiences and help seeking strategies with an Anglo-Australian cohort using a qualitative methodology.

Method

The findings presented in this paper are part of early preliminary results drawn from a large qualitative study that examined the perspectives of Australian Sri Lankans and Anglo-Australians on depression and help-seeking. Data were collected in Melbourne, Australia. Sri Lankan participants were either first or second generation migrants from Sri Lanka residing in Australia; Anglo-Australians were defined as individuals of Anglo-Saxon and Celtic heritage born and raised in Australia. The Sri Lankan community was chosen as it represents one of the fastest growing immigrant groups in Australia and the Anglo-Australian community as it represents the majority population in Australia (Department of Immigration and Citizenship, 2013a).

For the overall study multiple data collection methods were employed: 48 semi-structured interviews were undertaken with individuals with depression and 10 focus group discussions were held with community members from the Sri Lankan and Anglo-Australian communities. For the purpose of this paper, only the preliminary findings from interviews with people with depression are presented. The qualitative paradigm selected for this study allowed for the exploration of the meanings and complexities of individuals' experiences as well as the underpinning motivation and logic of behaviors which in turn will allow for a greater understanding of the meanings attributed to particular phenomena and practices in context (Denzin & Lincoln, 2011).

Recruitment

Participants were recruited by means of purposive sampling followed by snowball sampling methods where appropriate. All participants were over the age of 18, self-identified as either being from an Anglo-Australian or Sri Lankan background and were able to communicate in English. In addition, participants had to have a clinical diagnosis of depression or self-identify as being depressed which was verified by in-take screening which included the Kessler Psychological Distress Scale (K10) and DSM IV-TR depression checklist (Kessler et al., 2002; The American Psychiatric Association, 2000). By including individuals with and without a formal diagnosis we captured diverse data ranging from individuals who had mild depressive symptoms as a result of ongoing treatment

and/or recovery to those individuals with high scores either as a result of severe illness, non-treatment and/or other factors.

Procedure

Data were collected between May 2012 and May 2014. Interviews were conducted by the first and second author. Each interview lasted between 45 and 60 minutes. All participants received a \$40 gift voucher for their time. Interview questions were designed based on a review of the literature on culture, migration and mental help-seeking; participants were asked questions including how they were feeling, their experience with depression and both formal and informal care, barriers to help-seeking, use and attitudes towards biomedical, psychological and complementary and alternative treatments, the effects of these treatments, sources of medicine procurement and experiences of stigma.

Data analysis

Interviews were audio recorded and transcribed verbatim and subsequently de-identified. Preliminary thematic analysis has been conducted which involves an exploration of the data through an iterative process of finding meaning within and across data to identify core themes. This process involved constant comparison of codes and themes within and across the data set as well as an analysis of how themes may be related to each other. At this stage a preliminary thematic analysis has been conducted by the first author using NVivo Version 10 for data management.

Results

Participants across the two groups were well matched in terms of age and gender but there were differences in terms of work type with Sri Lankan participants disproportionately being employed in manual labor type of work. Further, Anglo-Australians were found to earn higher wages relative to their Sri Lankan counterparts (Table 1).

Table 1*Descriptive statistics of sample*

Demographic		Anglo-Australian	Sri Lankan
	<i>N</i>	30	18
	<i>M_{Age}</i>	40.93 yrs	40.28 yrs
	<i>Age range</i>	19- 74 yrs	18-78 yrs
	<i>Males</i>	33.3%	44.4%
Diagnosis	<i>no</i>	4%	22.2%
	<i>yes</i>	96%	77.8%
CAM*	<i>no</i>	33.3%	66.7%
	<i>yes</i>	66.7%	33.3%
Employment	<i>Full-time</i>	23.3%	33.3%
	<i>Part-time</i>	26.7%	16.7%
	<i>Casual</i>	16.7%	22.2%
	<i>Unemployed</i>	33.3%	27.8%
Work type	<i>Not applicable</i>	33.3%	38.9%
	<i>Doing manual labour</i>	16.7%	33.3%
	<i>Sitting in front of a computer</i>	46.7%	27.8%
	<i>less than \$300</i>	23.3%	38.9%
Weekly income	<i>\$300-\$600</i>	33.3%	22.2%
	<i>\$600-\$900</i>	16.7%	16.7%
	<i>\$900-\$1500</i>	16.7%	16.7%
	<i>More than \$1500</i>	10.0%	5.6%
	<i>Christian</i>	33.3%	27.8%
Religion	<i>Hindu</i>	0.0%	22.2%
	<i>Buddhist</i>	3.3%	22.2%
	<i>Atheist/Agnostic</i>	60.0%	16.7%
	<i>Other</i>	3.3%	5.6%
	Years Spent in Australia	<i>Mean(SD)</i>	NA
<i>Range(years)</i>			1.5-40
English spoken at home		NA	72.2 %

*CAM: complementary and alternative therapies

The reason for discrepancies in sample sizes is due to recruitment difficulties in the Sri Lankan community, possibly due to a reluctance to speak about mental illness(Siva, 2013).

In the preliminary thematic analysis three main themes emerged; concepts, etiology and chronicity of depression, disparities in help seeking and management, and stigma alive and well. These themes will be discussed in the following section

Preliminary thematic analysis

Concept, etiology and chronicity of depression

The analysis of the interview data suggests a significant overlap in the experience of depression across both community groups; depression was commonly described in terms of extreme loneliness and darkness;

“...it is a completely different world, I get plunged into this complete darkness ... the best way to describe it is like having your soul sucked out of you...that is the best way that I can describe it..”

Sri Lankan f, 22

“Supreme sadness like this weight. I mean I’m not a religious person at all but it kind of felt if I was brought up with a religious vocabulary, I would have said like, you know, demonic possession or something.”

Anglo-Australian, f, 36

Yet while the subjective experience of depression was described in similar terms, there were distinct differences in the perceived etiology of depression. Anglo-Australians predominantly perceived depression to have biological causes:

“Now Prozac puts me on the level playing field. I get up in the morning with the same chances of good days as you do. You know because I’m not battling against some imbalance of chemistry in my brain. You know I can have a great day or I can have a shit day depending on how I’ve handled myself.”

Anglo-Australian, f, 55

However, while the majority of Anglo-Australians indicated that depression did in fact have a biomedical cause, social attributes for depression were frequently noted as well within this group and at times in parallel with the biomedical model of depression. Usually the social causes noted were distinct life events such as illness, deaths, or relationship break downs:

“...Ex-girlfriends would be another major factor. I repeated year 8. That would be another major factor. I never should’ve repeated. And I sort of – that was a really bad decision, you know, that really affected my life badly because of that.”

Anglo-Australian, m, 37

Those Sri Lankans who had resided in Australia for many years appeared to align their explanatory models to a greater extent to that of their Anglo-Australian counterparts. More recent arrivals, i.e., those who had been in Australia for less than 10 years

were much more likely to contribute depression to psychosocial causes such as familial disharmony, financial concerns, loss of status due to migration, uncertain legal status in Australia, employment difficulties and yearning for home (Sri Lanka):

“...uuhhmm lack of status I can say, lack of English, lack of finances...that’s it..that’s the major things..”

Sri Lankan,m, 52

The subscription to a psychosocial explanatory model was in particular pronounced in recently arrived Sri Lankans, and male participants generally attributed depression to the difficulties obtaining satisfactory work:

“...I finished my studies in March and graduated in September, but I started applying since March and I couldn’t get a single interview at least, uuhhh I’m feeling really depressed about the situation at the moment...”

Sri Lankan,m, 25

Interesting disparities in the understanding of the chronicity of depression also emerged; a proportion of the Anglo-Australians, while reluctant in acknowledging this, conceded that their depression might be an enduring part of their life similar to other chronic illnesses such as diabetes:

“Interviewee: Now, I think of it as illness, but it isn’t illness that can be treated.

Interviewer: Yeah.

Interviewee: Like diabetes.”

Anglo-Australian, m, 36

Conversely, given that Sri Lankans tended to use a psychosocial explanatory model, depression was often described as a transitory issue which would be resolved once the underpinning cause had been addressed:

“Interviewer: So would it be viewed as a medical problem, like an illness?

Interviewee: No, it is, I think it is just a general, just a normal thing you get like if you.... Mainly because of the job search”

Sri Lankan, m, 25

In the Sri Lankan community it was further noted that the actual existence of depression as an actual problem, psychosocial or biomedical, was at times questioned:

“At the beginning it was quite hard, my parents were like; hey you know..there is no such thing as depression...no-one is depressed in Sri Lanka! and what not, so it was quite hard to communicate with them as to what I was feeling and what I was going through...”

Sri Lankan, f, 22

Disparities in help seeking and management

Given the difference in beliefs relating to the aetiology of depression, it is not surprising that we found significant disparities in help seeking strategies and management preferences. Sri Lankans were generally found to be reluctant to seek professional help and expressed a preference towards informal help seeking strategies, such as support from close family members, and for some even informal support was challenging:

“I don’t discuss my mental health problem with the children...and uhhh...and very rarely with my wife also”

Sri Lankan, m, 72

In some cases help seeking from informal channels such as religious leaders were described as preferable to medical intervention. Moreover, religion and spirituality arose as an important part of the Sri Lankan participants’ coping strategy regardless of reluctance or acceptance of other forms of treatment modalities. Of note, participants who self-identified as Buddhist would often seek help from a spiritual leader as the first step:

“...I am a Buddhist and there are like certain ways of getting rid of the depression feelings through religious activities...like if you meditate, if you go through meditation you can get rid of the depression feelings...”

Sri Lankan, m, 25

Moreover, Sri Lankans were found to favor self-directed behavioral interventions, and in many cases were hesitant to take psychotropic drugs to address even severe mental health issues as it was seen as an admission of “madness” to require drug intervention, thus alluding to the strong influence of community stigma on help seeking:

“There is stuff around stigma, if you take anti-depressants you are mad, you are insane”

Sri Lankan, m, 33

“...because I think I am now come to stage where I have got to take some pills because I am not proper in my mind or something.”

Sri Lankan, f, 79

In contrast, while Anglo-Australian participants also expressed reluctance to seek help for depression, they were more likely to obtain early intervention via primary care and only a few reported seeking help only via informal channels such as religious leaders.

Despite the fact that a significant proportion of Anglos-Australians reported using pharmaceutical interventions, interestingly, they were also likely to embrace alternative therapies, including traditional medicinal systems such as Ayurveda, complementary therapies such as homeopathy and mind-body practices including meditation to an equal

or greater extent relative to Sri Lankans.

Stigma...alive and well

While the degree and intensity of stigma noted in the Anglo-Australian community was somewhat subdued relative to the Sri Lankan community, stigma was still present in both communities. Discernable differences emerged in terms of the description and experience of stigma by participants across the two groups. In interviews with Sri Lankans it was clear that depression was a highly stigmatized condition within the community and being diagnosed with depression, or any other mental health problem, was seen in some cases as an admittance of madness:

“Interviewer: How is depression generally perceived within the community?”

Interviewee: It is not taken lightly, they take it serious that is...mad or something”

Sri Lankan, m, 72

Not surprisingly, this perceived stigma presented a significant barrier to seeking help for depression in a timely manner as some participants were trying to avoid being labelled as mentally ill:

“...so just the stigma of, I don't know uuhmm, of not wanting to be labelled as mentally ill if you know what I mean , like, so because of that there is reluctance to see a doctor, because you just don't wanna take those antidepressants you know, uuhhmm, be labelled as mentally ill.”

Sri Lankan, m, 34

A number of Sri Lankan participants further expressed that it was an abnormal state of being suggesting that the perceived community stigma had been internalized, in turn further reducing the individual's self-esteem amongst other things(Ciftci, Jones, & Corrigan, 2013):

“I feel this is not normal, normal person who got this sort of problem, and how can I get a job and this sort of thing...going into my record”

Sri Lankan, m, 51

While depression did not appear to be as highly stigmatized in the Anglo-Australian community, stigma or the experience of stigma was described in different terms; for example, a number of participants noted that depression was seen as a way to avoid responsibility, weakness and or laziness rather than an admission of insanity reported by Sri Lankan participants:

“I think that, yeah, some people might think that depression is just a ‘cop out’ sometimes, or something like that”

Anglo-Australian, f, 29

Whereas Sri Lankan participants described strong feelings of shame associated with

the diagnosis of depression, Anglo-Australian participants reported feeling uncomfortable in incorporating the concept of depression in their identity as it resulted in a gap in their ideal identity relative to the actual identity which highlighted personal flaws:

“... I’ve done a lot of thinking about it over the years and I think because of my intellectual arrogance, I did not want to believe it because I thought depression happens to people that don’t have coping skills in life, that don’t know how to think their way out of the negative situation and I thought I’m a doctoral candidate. I’ve been awarded for my intelligence, et cetera, et cetera. I can think my way out of this.”

Anglo-Australian, f, 38

While there were differences in the experience and perception of stigma across the two communities, it is clear that the stigma associated with depression was an influential factor creating real and perceived injustices and possibly interfering with the help seeking process.

Discussion

This preliminary analysis highlights how experience, illness beliefs and help seeking behaviors related to depression are modulated by the individual’s cultural background. Findings also suggest that there are aspects of depression that are common across both cultures. For example, the psychological phenomenon of depression was described by most participants in similar terms; loneliness, darkness and sadness, suggesting that the subjective experience and recognition of symptoms is reasonably similar across the groups sampled in this study. Analogous to findings of European-Americans and South-Asians (Karasz, 2005), our findings suggest that while there are similarities in the concept “depression-as-feeling” there appears to be cultural differences in conceptualizing depression as a disease; the majority of Sri Lankans attributed depressive symptoms to emotionally challenging situations, whereas Anglo-Australians tended to alternate or merge psychosocial and biomedical explanatory models to explain their depression, with the more serious cases of depression being seen as having a biological basis.

These differences in the beliefs about the etiology of depression had a flow on effect on the sense of the legitimacy of depression, chronicity, and subsequent help seeking strategies. When depression was attributed to social or situational challenges, as it was for many Sri Lankan participants, it was not necessarily viewed as an on-going problem requiring medical intervention, but rather requiring non-medical help such as family support and spiritual guidance. This is not surprising given the Buddhist teachings which emphasize that suffering is part of life and the transcendence of suffering is the soteriological goal of life and hence is not medicalized per se as highlighted in prior research (Obeyesekere, 1985).

On the other hand, Anglo-Australian participants tended to employ a biomedical

explanatory model for depression and hence were reasonably comfortable seeking help to address their depressive symptoms. Nevertheless many expressed reluctance to take pharmaceutical drugs based on fears of side effects, rather than a denial of depression as a disease. It was in addition interesting that Anglo-Australian participants were engaging in more complementary and alternative treatments, including interventions traditionally originating from South East Asia compared to Sri Lankan participants. This observation suggests that a transculturation of medical knowledge is occurring in which for example traditional Eastern medicines are being incorporated into mainstream Western healing practices (Napolitano & Flores, 2003).

Interestingly, while some Sri Lankans also shared the belief that depression has biological underpinnings, most expressed extreme concern about engaging in pharmacological interventions based on account of the community associating anti-depressant medication and madness.

In line with prior research, our findings suggest that stigma associated with mental health problems persists. Stigma negatively impacts on the affected individual and represents major barrier to engaging in help seeking from both formal and informal channels (Loya, Reddy, & Hinshaw, 2010). Stigma was noted to have much greater prominence in the Sri Lankan community both in relation to having depression as well as medication use compared to the Anglo-Australian participants. While stigma remains an issue for Anglo-Australians the negative connotations associated with the diagnosis of depression related to personal weakness and incongruence between the ideal self versus the actual self was more prominent in the SL community. Despite noticeable variances in the perception and experience of stigma across cultural spheres, stigma in all its forms was present in both communities and has serious implications for the individual living with depression.

Conclusion

Preliminary results from this study suggest cultural variations in illness beliefs which in turn impact on the mental health care trajectories of the Sri Lankan migrants as well as Anglo-Australians living with depression. To develop effective and culturally-salient services and programs to improve uptake and effectiveness of interventions, it is essential that policy makers as well as health professionals have an understanding of ethnocultural illness beliefs, an important factor that has been noted in previous research (Pandalangat et al., 2013). The current study further highlights that more work is required to reduce mental health stigma in the Sri Lankan as well as Anglo-Australian community, however different approaches might be required to effectively target the culturally derived stigma within the various communities. With further analysis we anticipate that more subtle nuances of cultural variations will emerge providing the substrate for addressing under-utilization of mental health services in the Sri Lankan community. This in turn may potentially be expanded to incorporate other South Asian minority groups

in the Australian context.

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