Central American Immigrant Men and Mental Health

¿Problemas Con Tus Nervios? Qué Puedes Hacer?
Problems with your Nerves? What can you do?

One-Time Research Project
Theme 1: Gaps in Service Delivery
York Community Services

Report prepared for Citizenship and Immigration Canada
Ontario Administration of Settlement and Integration Services (OASIS)

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EXECUTIVE SUMMARY

Background: Central American immigrant and refugee men face language and cultural barriers and are vulnerable to mental health problems including depression, anxiety and alcohol and drug abuse.

Purpose: To understand how Central American immigrant men adjust to living in Toronto and how this process affects their mental health and well-being.

Methods: This qualitative study used participant observation, in-depth interviews with 21 Central American immigrant men, as well as female and male focus groups. The female perspective of men's mental health was explored using two focus groups each composed of 9 Central and South American immigrant women. Member checking involved discussing a “composite narrative” with participants, key informants and a focus group of 8 Central and South American immigrant men. All interviews and groups were audiotaped and transcribed verbatim in Spanish or English and the simultaneous iterative analysis used grounded theory. Particular attention was paid to narratives in the interviews, interpretation process and in member checking.

Findings: The analysis revealed an emotional and often private process of adjustment to life in this metropolitan city. Virtually all of the men had experienced violence in their past leading to loss of family, friends and work. “Losing the way,” or perdiendo el giro, was a central theme in which men described becoming lost within the cultural and social life of their host city. This disruption of identity led to emotional distress that was often manifested as maladaptive coping strategies: alcohol and drug abuse, abusive behaviors toward women and several forms of mental illness, such as depression, anxiety, nostalgia and isolation. Spouses were very aware of the distress, but the men rarely discussed their difficulties due to pride that they often attributed to the cultural practice of machismo. “Finding the way,” or salir adelante, was often associated with accepting new responsibilities and reconstructing or shifting their male identities. Women, although identified as
key support persons, were not effective as a lone agent. Finding the way was often associated with a men's or mixed group of some kind: Alcoholics anonymous, men's support group for abusive behavior, soccer group, or church group. These groups helped them better understand and adjust to roles and responsibilities of the host culture. Health professionals such as family physicians and social workers were helpful when they perceived as trustworthy, understanding and informative and were perceived as an important resource for the family and men as they grew older.

**Conclusion and Recommendations:** Central American immigrant men experience considerable distress and mental illness in adjusting to life in a large metropolitan city. Shifting roles, responsibilities and identities are often facilitated by support groups, spouses, and trusting relationships.

1. There is a need for innovative health services for newcomer men; services that integrate the role of employment, fatherhood, and adjustment stresses and that encourage open discussions on the subject of men and emotional distress.

2. There is a need for the continued development of men's groups, both informal and formal, and these groups should be linked to health promotion campaigns and occupational health initiatives.

3. Policy makers should ensure that health services are available in Spanish, in particular family physicians and psychiatrists.

4. Narratives provide an effective and culturally sensitive way to promote health and should be further explored in developing culturally sensitive health promotion resources.

5. Future quantitative research is needed to investigate ‘who’ (socio-demographically) and when newcomer men access health services in order to better plan for training health professionals. Several culturally sensitive community outreach tools were developed in this study: Resource Card for Spanish Speaking People, composite narrative, and a community newspaper article (all are available in Appendices).
INTRODUCTION

This document reports on the background, methods, findings, and recommendations of the Citizenship and Immigration Canada, Ontario Administration of Settlement and Integration Services (OASIS)-funded project titled, Central American Immigrant Men and Mental Health “¿Problemas Con Tus Nervios? Qué Puedes Hacer? (Problems with your Nerves? What can you do?). This project identifies barriers to emotional support for Central American immigrant men living in Northwest Toronto, explores the process of adjustment in relation to mental health, and discusses the community health outreach tools designed for this population. Based on in-depth interviews, focus groups, ethnographic fieldnotes, and member checking—as well as recent research in medical anthropology, family medicine, gender studies, and other health fields—this study identifies key barriers to formal and informal mental health care for these men and provides tangible solutions to improve access to sources of support. Since many of these men are reluctant to use formal health care (i.e. family physicians, counselors, alternative healers), and avoid talking about emotional problems (such as nervios, loneliness, anxiety, and depression) with friends and family, one of the outcomes of this project—the Resource Card for Spanish Speaking People—seeks to reduce the stigma attached to mental health problems among Latino newcomers (particularly among men) in a culturally sensitive manner. In addition to these practical outcomes this project makes a key contribution to understanding the relationship between gender and health among immigrant and refugee men. In brief, it suggests that attention to underutilization of health care services demands attention to the ways in which men and women construct and act on their identities, and to how these beliefs and actions influence care seeking.
behavior. This study also builds on recent innovations in qualitative/applied methodology by using narrative and community-centred praxis to design and implement outreach tools.

This report outlines both the theoretical and applied contributions of the project. First, it provides a brief review of relevant literature in immigrant and refugee health; the ethnography of emotional distress; gender and health; and culturally sensitive health care. Second, it discusses the methodological approaches used to recruit participants, collect data, gather community feedback, and design outreach tools. Third, accompanied by quotations from participants, it illustrates the findings from interview and focus group data. This section examines the health experiences of Central American immigrant men since moving to Canada, their shifting sense of personhood and identity, their experiences with formal health care services, and the socio-economic contexts in which they become healthy or ill. Fourth, we analyze these narratives in relation to current efforts to provide culturally sensitive health care in Canada. Finally, we outline conclusions from the project, describe the tools designed to address the problems gathered from the data, and provide recommendations for future research on immigrant health.
LITERATURE REVIEW

Immigrant and Refugee Health

Research in a wide range of social science and health research fields suggests that although the experience of migration itself does not produce mental illness (Beiser 1999; Hyman et al. 1996), the multiple processes of dislocation, movement, and resettlement may together put immigrants and refugees at risk for emotional problems (Losaria-Barwick 1992; Jenkins 1991; Desjarlais et al. 1995). For refugees in particular, experiences of war, state endorsed terror, political persecution can result not only in physical health problems (due to torture, for example) but also may cause anxiety, stress, depression, and other emotional difficulties. For most newcomers, the process of adjusting to a new economic, social, and cultural climate in the host society can be painful (Beiser 1999; Meredith 1992). In particular, previous studies have demonstrated a strong relationship between employment and health (Beiser 1999; Freire 1995). Newcomers may have difficulties finding satisfactory or fulfilling jobs in resettlement countries, and thus many suffer from a loss of status that in turn can produce emotional difficulties such as “nerves”, isolation, and loss of hope. Social researchers have argued, therefore, that health problems are intrinsically linked to—and cannot be understood apart from—social problems (Kleinman et al. 1997).

Several researchers have called for increased attention to the health and resettlement of Latin American refugees (Meredith 1992; Losaria-Barwick 1992; Jenkins 1991; Freire 1995). War, poverty, unequal land distribution, and political persecution in most Latin American countries have caused the killing, disappearance, and displacement of millions
in the post-war era (Desjarlais et al. 1995; Suárez-Orozco 1990). Recent estimates suggest that 37,350 Latin American immigrants have settled in Ontario, 90% of whom have arrived as refugees (Vidal 1999:3). Most of these individuals live in Metropolitan Toronto (26,410) as well as in other larger cities of Ontario, such as Ottawa, Hamilton, London, Kitchener/Waterloo and Windsor. Most of these immigrants came from Central American countries, particularly El Salvador, Guatemala, and Nicaragua (Vidal 1999:4). Furthermore, the Latin American community is one of the largest and fastest growing immigrant groups (most arriving as refugees) in Ontario in the last decade. Since many of these individuals have been exposed to violence and political persecution in their home countries—as well as unemployment and underemployment in the country of resettlement—the mental health of Central American refugees is a research and service priority in Canada.

**Idioms of Distress**

There is a wealth of research reporting on the mental health difficulties faced by immigrants and refugees in host societies. Research with Latin Americans in the United States and Canada suggests that newcomers may experience a wide range of emotional difficulties, including confusion, anxiety, tension, and depression (Freire 1995; Meredith 1992). Particular attention has been paid to a cluster of emotional difficulties identified as “nerves” or *nervios*. According to medical anthropologist Janis Jenkins, *nervios* is “an indigenous cultural category widely used in Latin America for a variety of forms of distress and disease…and may refer to a variety of bodily and affective complaints (1991:146). While social theorists have argued that *nervios* is a metaphor for political
oppression and poor socio-economic status (Lock 1989:85; Low 1989a:40; Guarnaccia and Farias 1988) or a somatization or embodiment of terror (Low 1994:140; Taylor 1998:154), it is also a source of distress which not only affects individual well-being but also the family and social relations of the sufferer.

Studies within medical anthropology and cultural psychiatry have illustrated the various ways in which nervios is manifested in individuals, and how nervios sufferers explain their illness. Nervios may be expressed somatically as headaches, dizziness, and difficulty sleeping (Lock 1990:241), or as emotional problems such as loneliness, isolation, nostalgia, and boredom (Guarnaccia and Farias 1988:1224; Farias 1991:179-184). Importantly, researchers have suggested that embodied complaints of nervios call into question Western/biomedical distinctions between the mind/body and mental/physical, by demonstrating that nervios is an idiom of distress for social problems or other health conditions (Jenkins and Valiente 1994:166). Efforts to categorize suffering as a clinical or culture bound syndrome risk dehumanizing and dehistoricizing the lived experiences of refugees (Green 1998:5).

Individuals with nerves in a variety of cultural and social settings may consider the condition “normal” to the extent that “having nerves” or “being nervous” is a part of everyday life (Lock 1990:249; Davis and Low 1989). Individuals tend not to seek care until nerves are perceived as serious or chronic in nature. These findings have implications for clinical practice, as nervios may be a metaphor for the everyday struggles of newcomers, but may also signal the onset of more serious mental illness. It
has also been suggested that *nervios* among refugees may take different meanings and levels of severity in the country of resettlement. Our project is based on the belief that health researchers and practitioners need to be aware of these spatial and temporal dynamics of *nervios*.

**Gender Theory**

Studies of gender identities among Latino men and women have provided important groundwork for the study of the relationship between gender and health. Until recently, however, few investigations have viewed men *as men* (Sabo 1998). Based on the notion that gender is a fluid, contingent process—rather than a fixed, bounded category—researchers have come to view Latino men’s identities as shifting, contradictory, and ambivalent (Ong and Peletz 1995; Allen 1996; Kimmel and Messner 1998). As such, Latino men may have many sides to their masculinities; stereotypes of the *macho* Latino male, therefore, are insufficient to understand the multiple ways in which Latino men construct and act on notions of manhood in their everyday lives (Gutmann 1996; Gutmann 1997). Working class men in Mexico City, for example, may be irresponsible drinkers, caring fathers, violent partners, or hard workers. In short, a unitary description of the *macho* Latino male does not hold (Gutmann 1996).

Marlinda Freire, in one of the few studies on gender identities among Latino newcomers, indicates that work is an important “core identity” among Latino men (1995:23). Most Latin American immigrant men in Toronto, according to Freire, arrive with a professional, technical, or semi-technical degree (1995:23). Since many of these men
have difficulties finding employment in their field of expertise—due to unavailability of jobs or lack of recognized credentials—they are unable to provide financially for their families, and thus suffer from feelings of inadequacy and loss of socio-economic status (Freire 1995:23). Whereas the women in Freire’s study were able to seek help or assistance for financial or health problems in Canada, men—for reasons which Freire does not explore—were unable to respond to these challenges in a positive way. Freire argues for a “gender differentiated pattern of response” between newcomer Latino men and women (1995:20). Our study not only provides a glimpse at the multiple ways in which Central American immigrant men construct and act on their own identities, but also discusses how their shifting identities influence health and use of informal and formal health care services. In sum, our project aims to build upon the work of Freire and other researchers studying the relationship between gender, resettlement, and emotional well-being and support.

**Gender and Nerves**

Relatively little applied or theoretical research has addressed the intersection between gender and nerves among Latin American populations. While some studies have suggested that nervios is largely confined to women (Bourgois 1985:300; Guarnaccia et al. 1989), other investigations have argued for increased attention to the influence of gender on the levels and expression of nervios (Low 1989a). In one review article on the cross-cultural meanings of nerves, the authors ask the important question: “to what degree is nerves a gender-related illness?” (Davis and Low 1989:xiii). In response, they
argue that “although gender plays a role in modeling the expression of nerves, the experience of nerves is not necessarily gender specific” (Davis and Low 1989:xiii).

Our study builds on previous work that calls attention to how nervios and other emotional problems are expressed—or not expressed—by Central American immigrant men. Research with El Salvadoran refugee men and women in the United States has demonstrated that nervios among men was expressed in a variety of ways, most commonly as loneliness, isolation, and anxiety (Farias 1991:173). Nervios was also seen as an infringement on being “able bodied” (Farias 1991:179). Although there were also similarities in the ways men and women embodied nervios, women typically expressed it as headaches, crying uncontrollably, and loss of breath (Farias 1991:186-7). Based on these and other findings, several researchers have concluded that nervios is an idiom of emotional distress for both Latin American men and women (Farias 1991; Guarnaccia and Farias 1988; Low 1989a; Lock 1990).

**Gender and Health Care**

An important difference exists between men and women's pattern of care seeking in relation to nervios and other idioms of emotional distress. Several studies have reported on the reluctance of immigrant Latino men to use formal health services or to discuss emotional problems with friends or family (Freire 1995; Meredith 1992). Marlinda Freire notes that men typically “resist seeking professional services, [they] do not attempt to create or use existing support systems, and even reliance on friends tends to be minimal or nonexistent” (1995:24). Freire further shows that Latin American men have difficulty
verbalizing their emotions—particularly negative ones, such as fear, anxiety and anger—because of feelings of inadequacy resulting from a decline in occupational status (1995:23). Diane Meredith (1992), in a study of Guatemalan refugees in Toronto, also demonstrated that men tend to be resistant to reporting and discussing intimate problems. Other studies of immigrant and refugee health suggest that men tend to avoid discussing or dealing with health problems (Lock 1990; Koss and Chioino 1989; Low 1989a), but fail to analyze the gender and cultural dynamics of care seeking. In anthropologist Setha Low’s review of a series of articles in *Medical Anthropology* on the cross-cultural meanings of nerves, she notes that:

*Most of these papers discuss nerves as a woman’s disease but can we fully support the argument when analyzed in a clinical setting in a culture where men are actively discouraged from going to the clinic for anything but the most life threatening diseases?* (1989b:93)

Despite this evidence, few studies provide tangible solutions to the problem of under-utilization of informal and formal mental health care by Latino immigrant men.

**Health Care Accessibility**

An important aim of this project is to design and implement culturally appropriate tools to improve community awareness of—and access to—informal and formal sources of emotional support for Central American immigrant men in Toronto. Under the rubric of “multicultural health,” health researchers have proposed ways to reduce barriers to health
care for newcomers. Although findings are not conclusive as to whether newcomers underutilize health services because of cultural barriers or because immigrants are healthier than Canadian-born individuals (Beiser 1999; Kinnon 1998), it has been argued that health care is not accessible to refugees who suffer from emotional problems (Losaria-Barwick 1992), and that health professionals in Canada lack knowledge of the broader social, economic, and health experiences of newcomers (Lock 1989; Masi et al. 1993).

Since the passing of the Multicultural Act in 1988, there has been increasing interest among health professionals and health researchers in Canada to design and implement health care services and programs that are accessible and sensitive to people from a wide range of social, cultural, and religious backgrounds (Dunn 2000). Since the late 1980’s, a wealth of academic literature, training manuals, and committee reports has emerged on access to health care by immigrants and refugees and the cultural competence of mainstream health practitioners (Juliá 1996; Masi et al. 1993; Waxler-Morrison et al. 1990; Majumdar 1995). By employing the concept of “multicultural health”—defined as “health care that is culturally appropriate, sensitive, and responsive” (Masi et al. 1993)—health planners and practitioners aim to ameliorate the low levels of client satisfaction and poor adherence to treatment regimes among newcomers. Within this framework, it is argued, the individual must be understood as shaped by a cultural context, which includes shared norms, values, beliefs, and practices among a particular group of people (e.g. Somali refugees, homeless, White middle class) (Dyck 1992; Waxler-Morrison et al. 1990). It is also argued that physicians need to have a better
knowledge of the cultural and socioeconomic issues affecting the lives of individuals seeking care (Juliá 1996). Without attitudinal changes towards people from diverse backgrounds, interactions between newcomers and physicians may be fraught with conflict, resulting in low patient satisfaction, physician frustration, and poor health outcomes (Masi et al. 1993).
METHODS

Recruitment and Data Collection

This study used a wide range of methods to gather qualitative data on the health and health care experiences of Central American immigrant men in Toronto. The project coordinator interviewed twenty-one men in the language of choice of the participant, Spanish (12) English (9). All interviews were conducted in Toronto with the majority being conducted at York Community Services (YCS). The project team collaboratively facilitated three focus groups in Spanish. Two groups consisted of members of a Spanish-speaking mother’s group at YCS (18 participants in total), and one group was with eight Spanish-speaking men who were seeking help for abusive behaviors toward women (co-coordinated by Counterpoint Counseling Services).

Participants were recruited through the assistance of several sources. Many of the men (or their partners and children) were patients of Dr. Kevin Pottie or clients of the project assistant, Magnolia Mazzeo from York Community Services. Other participants were contacted through key informants and their community agencies. An attempt was made to recruit participants who had not established connections to formal health care services.

Semi-structured interviews were designed to collect data from Central American immigrant men on their personal backgrounds, experiences with migration and adjustment in Canada, health problems, and experiences with health care services (see Appendix A). Although specific personal data was collected from all participants, the semi-structured interview provided a degree of flexibility for participants to share stories
about illness and learning to live in Canadian society. Participants were also asked to provide critical feedback on proposed community outreach tools, and to share their views on broader issues, particularly community cohesion and health care awareness among Central American immigrant men in Toronto.

The focus groups sought to elicit feedback on interview findings—such as the degree to which men and women suffer from *nervios* and the ways in which men and women express this idiom of distress—and to actively involve participants in the design of community outreach tools. Each focus group lasted one to one and a half hours and was facilitated by the principle investigator while the coordinator observed and recorded field notes. The focus groups also clarified questions the researchers had about the role of women as sources of support for men with emotional difficulties, as well as the degree to which men discuss problems with friends and family members.

Qualitative data collection also involved ongoing reflection on fieldnotes between team members. These notes were shared and discussed to address methodological and theoretical issues as they arose during the course of data gathering.

Several key informants played important roles during the course of the project. These informants were Spanish-speaking professionals working in areas of social and health services. They were a valuable source of knowledge about utilization of health care services within the community, and provided team members with constructive feedback on the Resource Card for Spanish Speaking People and the composite narrative. Key
informants were affiliated with the following agencies in the Toronto area: Binks-Hillcrest Centre, Madison Avenue Housing Services, Counterpoint Counseling Services, and the Mennonite New Life Centre. Several key informants also played an essential role in co-coordinating and facilitating focus groups, providing contacts and helping with translation during these sessions.

The methodology for this study was informed by some key concerns and contributions in the fields of medical anthropology and family medicine. Addressing questions of gender and health care, the researchers approached the issue of underutilization of health care services by Central American immigrant men with attention to recent methodological debates among ethnographers and health care professionals on culture, access to health care, gender, narrative theory, and migration and health.

First, recent studies of Latino men and masculinities suggest that men’s identities cannot be understood without attention to women’s changing identities and roles in political, economic, and social struggles (Gutmann 1996; Gutmann 1997). In a study of working class men and women in Mexico City, anthropologist Matthew Gutmann argues that “male ethnographers working exclusively with male informants on questions of masculinity primarily constitute a methodological manifestation of a conceptual error” (1997:841). In our project, we found that discussions with Spanish-speaking women about Latino men and their health and health care experiences were critical to developing a more holistic perspective on the ways in which men deal—or do not deal—with health problems, and the ways these behaviors affect the lives of friends and loved ones.
Second, recent developments in culture and gender theory also influenced the research methodology. The encouragement of subjects to share stories on health and illness in Canada represents an acknowledgement that the identities of Central American immigrant men are not fixed or static, but rather shifting and contingent on particular historical and cultural contexts (Ong and Peletz 1995; Sabo 1998). Rather than impose popular gender stereotypes of Latino men (such as *machismo*) on participants, the researchers believed a more productive approach would be to allow these men to describe their own sense of personhood and identity, regardless of whether these stories resonated with images of the *macho* Latino man.

Third, in an effort to elicit data that would inform the design of culturally appropriate community outreach tools, the researchers also avoided attempts to identify or define the “culture” of Central American immigrant men. Rather, by understanding culture as a process shaped by power dynamics and the discursive acts of individuals (Ahmad 1996; Lambert and Sevak 1996), and not as a set of beliefs which *determines* behavior and practice, the researchers were better equipped to understand how many men are actively struggling to *unlearn* behaviors associated with being a man—such as drinking—which may become health risks. In order to produce outreach tools that would effectively *speak to* and attract the attention of Central American immigrant men, we felt, methodologically, that trying to identify the particular beliefs of “their culture” was a less fruitful approach than encouraging these men to reflect on their own health experiences and gendered practices.
Outreach

The outreach component of this project’s methodology incorporated recent key developments in the design of culturally sensitive materials. Recent research in applied anthropology with refugees and immigrants suggests that successful research outcomes depend on the involvement of participants in the design and implementation of outreach tools (Krulfeld and Macdonald 1998). In this project, for example, participants were asked how health professionals and institutions could improve access to health care for Central American immigrant men suffering from various health problems. Participants were also asked for their views on a pilot version of the Resource Card for Spanish Speaking People, and were encouraged to provide other suggestions for community outreach. In addition, key informants contributed comments to the “composite narrative” (English and Spanish versions) and suggested changes to the resource card. These efforts represent an attempt to incorporate a community-centred praxis into the research methodology. Community involvement, therefore, was a condition for project success rather than an ad hoc research component.

Following a recent innovative qualitative study on diabetes among Bangladeshis in London, England (Greenhalgh et al. 1998), our project team along with feedback from participants produced a vignette or composite narrative that aimed to represent the health experiences of Central American immigrant men. This composite narrative will be published along with background on the study in a local Spanish-speaking newspaper to increase public awareness of mental health issues in the community, and provide a narrative resource for people suffering from emotional difficulties. By telling the story of
one man, “Miguel”, we hope to provide a story that captures the emotions and diversity of health experiences among (and beyond) this population, while at the same time offering information and encouragement to men and women to seek help for health problems (Appendix B).
RESULTS

Socio-Demographic Profile

The following table outlines the socio-demographic characteristics of the 21 participants in the in-depth interviews, 2 women's focus groups, and men's focus group.

<table>
<thead>
<tr>
<th>Country of origin:</th>
<th>Men: In-Depth Interview N=21</th>
<th>Women's Focus Groups n = 18</th>
<th>Men's Focus Groups n = 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Salvador</td>
<td>13</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Guatemala</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Peru</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Ecuador</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Mexico</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Uruguay</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Chile</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Argentina</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Bolivia</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td><strong>Status of Arrival:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refugee</td>
<td>13</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Immigrant</td>
<td>9</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td><strong>Year of arrival:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After 1990</td>
<td>10</td>
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<td>8</td>
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<tr>
<td><strong>Marital Status:</strong></td>
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</tr>
<tr>
<td>Married</td>
<td>12</td>
<td>14</td>
<td>4</td>
</tr>
</tbody>
</table>
Composite Narrative

Miguel's story was constructed in Spanish from the quotations and themes identified during the interviews and revised based on suggestions from participants and key informants. It was a tool to present a summary of the findings for participants in an emotionally engaging fashion in order to stimulate debate and awareness. (See Appendix B for original version in Spanish).

Miguel's Story

Miguel had always had friends, family and a job; that is, until the war. The war brought changes he could never have anticipated, like his immigration to Canada. Even after 3 years in Toronto he still felt like a stranger. At some point in the turmoil of adjusting to a new country, a new language, a new culture, he had lost the way. He looked for work but his English was poor, and anyway, there were no jobs. His wife had left him, and he was
unhappy with his treatment of her, unhappy with his drinking and frustrated with his lack of motivation.

_He wondered how could he cope with his nervous problems? He would say to himself, “I don’t want to be a bother, I can handle things on my own.” Then he would try to forget about everything. He knew his drinking problem was getting worse and he felt more and more alone. “I am disappearing like the people in my country and I can’t talk with anybody.”_

_Miguel knew he did not come to Canada to disappear. He tried to think of what he could do to improve things. He thought, “If I was back home I might try to talk with my friend, my wife or maybe the priest. I might even go to the doctor. But in Canada what is there?_

_One day a friend said to him that to move ahead in life you have consider ways to integrate into the community like, for example, using men's support groups, participating in church activities, or taking advantage of various services at community health centres. Well, thought Miguel, there are possibilities to explore._

**Personal Histories**

*Background*

Most of the participants in this study—both men and women—have survived experiences of war and conflict. Although most of the men interviewed had not been physically harmed during the many armed conflicts in Central America in recent decades, most had
been affected emotionally or economically by violence in their home country. Many also had family who were either killed or “disappeared” as a result of the counter-insurgency campaigns of government-backed armies in the region.

Reflecting on his experiences in Guatemala in the 1970’s during that country’s 36 year civil war, Nery described what it was like to lose his brother and to live in a constant state of fear:

The situation in Guatemala when I came to this country was bad too, you know. I lost a brother, you know. They accused him that he was a collaborator in the Movement and I lost him, he was twenty-four and he was just you know, to become like a refugee…. A lot of people died in nineteen-seventy--it started in 1966 and from there on it was terrible.

If you talked, the guerrillas killed you. If you didn't talk, the army killed you, you know, so we were between the wall and the arrow, you know what I mean?

Paulo, a 21 year-old man from El Salvador who came to Canada in 1997, had suffered injuries as a result of the army trying to kidnap his sister. When asked why he had come to Canada, he gave a lengthy description in broken English of one particularly terrifying experience:
Around two years and a half ago the people came from the army. I have a sister, a sister that is older than me. One guy from that group, they started to bother her when she went to school. And later they try to take her....

And after that I went with her to the school. And one black car with dark glass came, then a guy from that car asked her to stop. Then another guy got out of the car and pushed my sister with a gun. And I tell him, “Hey, why do you do that?” And he put us in the car, and then one guy pushed me out of the car onto the street and I broke my leg.

And later we were afraid because we wanna go to the police. But [the people from the army] give one note to my sister, if we going to the police they know a lot about us, they know where we live, they know where I work, and if we go, they gonna kill us. Because you know what, in my country the people who have money, the police protect them. When you don't have money the government or the police don't care.

These descriptions of state-sponsored terror indicate the dangerous contexts from which most of these men and women arrived. Referred to as “la situación” by several respondents, war has touched the lives of all Central Americans, especially those who have been forcibly displaced because of violence. As the next section will illustrate, the emotional well-being of the men in this study cannot be understood apart from these past experiences.
Resettlement

The emotional health or illness of immigrants and refugees is not the result of the process of displacement alone. Several factors impinge upon the well-being of individuals, particularly social factors such as employment, family unity, sense of community, and access to care. This study of Central American immigrant men offers an opportunity to weigh the influences of pre- and post-migration stressors on individual health and illness. Since roughly half of the participants in this study have arrived in Canada within the last ten years, this project can contribute to current debate on how—and to what degree—changes in health reflect pre- and post-migration experiences.

This section introduces several key themes that will thread throughout the entire report. It brings into focus the many barriers newcomers face in accessing health care, as well as the structures of Canadian society that influence individual well-being—such as employment, schooling, and social services. Similar to cultural psychiatrist Marlinda Freire’s investigation of gender and health among Latin Americans in Toronto (1995), our study suggests that there is a deep interrelationship between work and health for Latino men. Although most of the men in our project were forced to leave their countries of origin for fear of their lives, several came to Canada to improve their own employment opportunities or those of their children.

Upon his arrival in Canada from Guatemala in 1989, Francisco had several expectations about life in a new society:
Well, I just came to Canada, I thought that the second day, the next day I want to start working. It didn’t happen. The real thing was that I had to learn English and I didn’t know anything about English language, so I went to some classes and I was sitting in the chair after being in university, sitting in these classes and not knowing anything about English, it was so sad. Those are my experiences.

Like several other participants in this study, Francisco had studied at university in his home country and suffered from feelings of disappointment and inadequacy upon arrival in Canada. Similarly, Marcelo carried a sense of hope with his migration to Canada:

Pensé que iba a ser fácil empezar una nueva vida. Tenía mucho optimismo. Conseguir un empleo, tener un empleo, tener una compañera, ayudar a alguien. No pude ver en ese tiempo que la barrera más fuerte era la del idioma. Es lo peor.

(I thought it would be easy to start a new life. I was very optimistic. To find a job, hold a job, to have a girlfriend, help someone else out. I could not see at that time that the biggest barrier would be language. That is the worst thing.)

Clearly, language barriers can create a range of anxieties for newcomers, especially in attempts to find employment. This is well documented in the literature on immigrants and refugees to Canada. Language and work are challenges faced by most newcomers—both men and women—from many parts of the world. A key finding of
this study, however, is that gender seems to shape the differential impacts of these changes in the lives of Latino men and women. The following discussion of the ways in which Central American immigrant men construct and act on their identities is necessary to better understand the negative consequences that language and employment barriers can have for this population. How these men see themselves as men is the focus of the next section.

**Personhood**

*Diverse Identities*

Our discussions with Latino men and women about men’s health frequently centred on the influence that men’s behaviour had on health and resettlement experiences. Our questions about problems with *nervios* or depression would repeatedly elicit stories on how “hard it was to be a man” or how “people don’t understand how much responsibility a man has.” Conversations about alcoholism or domestic abuse were so deeply entangled with the meanings of manhood (*ser hombre*) that these constructions of gender became a key focus of the research. Narratives began to emerge on how being a man shapes individual health or response to illness.

First, many men emphasised the importance of being responsible for the family. Since most of the participants are married and have children, meanings of manhood tended to intertwine with fatherhood and being a husband. Subjects not only felt a sense of obligation toward their families, but also viewed the family as a source of pride.
Yo siempre fui un hombre que trabajé para mi familia y mis hijos. Me ha gustado ser responsable en muchas cosas..., en todo. Cuando uno es responsable es bastante bueno. Porque la responsabilidad del hombre tiene que ser muy efectiva, positiva... para sembrar la semilla para el ser que viene, al hijo que viene. Para que los hijos se desenvuelvan con una buena experiencia, con un padre que le ha dado una buena orientación que les pueda servir en el futuro. (Ricardo)

(I was always a man to work for his family and children. I have enjoyed being responsible for many things..., in everything. When one is responsible it is a very good thing. Because a man's responsibility has to be very effective, positive...to sow the seed for the being that is coming, for the son that is about to come. For children to grow up with a good experience, with a father that has given them good guidance that will serve them in the future.)

In our meeting with a counselling group for Spanish-speaking men who had committed domestic abuse, several participants insisted that being a responsible man was “part of their culture” and that men and women had certain roles to fulfil in their daily lives.
El hombre es el que trae el pan y organiza la casa y la mujer es donde gira alrededor lo que es la organización interna del hogar: la mujer. Entonces, nosotros nacemos con esta responsabilidad. Desde que supimos que nacimos hombres. Ya nos criaron con esa mentalidad. Entonces eso es difícil venir acá y...cambiar de un día a otro. (Men’s Focus Group participant)

(The man is the one that brings home the bread and organizes the house and the internal organization of the home revolves around the woman. The woman. So we are born with this responsibility. Since we learned that we were born men. We were brought up with that mentality. So it is difficult to come here and...change overnight.)

Clearly, migrating to Canada may cause shifts in the meanings of manhood and womanhood. As we discuss below, the meanings attached to personhood among Central American immigrant men are forged and re-forged in relation to changes in women’s lives in Canada. With respect to health, the ways in which men are responsible or irresponsible can have implications for individual and family well-being.

Second, the meanings of being a man were also associated with friendship and belonging to social groups. Although the importance of social connections varied from respondent to respondent, as did the ability of different men to meet friends and maintain friendships, having social ties was considered important in everyday life. After struggling for several
years to learn English and find a job, Imanuel was able to make connections with fellow Spanish-speaking people in Toronto which in turn had a profound impact on his emotional well-being.

Canada was really bad in the beginning. Why it was really bad is because all the time I was inside the house with my nerves, because the problem I had was that I didn’t speak English, and I didn’t know nothing. So I wanna go out, I wanna have some time outside or I wanna go to walk or to use a bike or to see a friend but I don't have NOTHING when I come here.

But after a while I go by bicycle two blocks and I find a park, High Park, and there’s a lot of Spanish people there, so I have friends, and then I see Canada differently.

The point is my life changed in December of 1990. From 1990 I see that it's different because I see a friend, and he brings me to a church, I start to read the bible, now I'm Christian, and I have a lot of friends, so it's different.

Participants in the women’s focus group also identified the importance for men to belong to social groups to alleviate or prevent serious problems with nerves.

Yo creo en los grupos de apoyo muchísimo. Y creo en la recuperación del hombre también. Creo que si al hombre se le da una oportunidad, de pertenecer a un
grupo, socializar, de tener un lugar seguro. Donde se sientan protegidos y aceptados y no criticados. (Second Women’s Focus Group participant)

(I believe very much in support groups. I also believe in the recovery of men. I think that if a man is given an opportunity, to belong to a group, to socialize, to have a safe place. Where they can feel protected and accepted and not criticized.)

This important statement indicates that women identify the gendered nature of men’s and women’s adaptation to Canadian society. These women recognise the role of social networks and ties for newcomer Central American men. This feeling of “belonging”—although articulated in a variety of ways—stems from shared experiences of exercise and spirituality with other Spanish-speaking men and women. As the following paragraphs will demonstrate, these practices are also informed by meanings attached to machismo, a popular construction of Latino male identity.

Machismo has received a lot of attention in both scholarly and popular works on Latin American culture. Our conversations with Central American immigrant men frequently included debate over the meanings of machismo, and the relationship between the beliefs and actions associated with machismo and health. On a popular level, machismo is associated with risky behaviour, drinking, violence, and sexual prowess (Gutmann 1996). The meanings of machismo, however, are not fixed or static, but rather contested, contradictory, and ambiguous. This became evident especially in our focus group sessions with both men and women. Interestingly, many men agreed that “they were less
“machista” since migrating to Canada because they “were not in their culture anymore” and because women had more protection and rights in Canada than in their home country.

Usaba mucho machismo yo allá. Pero aquí llegué y mi machismo se bajó abajo. ¿Por qué?. Por las leyes. Por las leyes que existen en este país. Y me cuesta mucho cambiar mi machismo ahora. Pero estoy tratando…. (Men’s Focus Group participant)

(I used a lot of machismo over there. But I arrived here and my machismo went down. Why? Because of the law. Because of the laws that exist in this country. And now it is hard for me to change my machismo. But I am trying....)

This statement produced considerable debate among focus group participants. While some men viewed machismo as fulfilling particular family and household responsibilities, others felt that to be machista was to be in control of “your woman” and to use force with her if necessary.

Pero cuando se habla del machismo, no entendemos que el hombre es el que provee todo para el hogar. Eso no es machismo. Machismo es querer dominar a la mujer. Querer tenerla encerrada a la mujer. Querer golpear a la mujer. Querer insultar a la mujer. Eso es machismo. Es mantener la santidad del hogar, eso no es machismo. (Men’s Focus Group participant)
(But when we talk about machismo, we do not understand that it is the man that provides everything for the home. That is not machismo. Machismo is the desire to dominate the woman. Wanting to keep the woman locked up. Wanting to hit the woman. Wanting to insult the woman. That is machismo. Maintaining a holy home, that is not machismo.)

We raise these debates over the meanings of being macho to foreground the relationship between gender identity and health care seeking. Machismo was also associated with reluctance of men to seek help for health problems. Not talking about emotional difficulties—“keeping it in”—was viewed as a characteristic of being a man. Being assertive, proving oneself to others, not showing weakness, and not bothering friends or family about personal problems were frequent themes in our interviews and focus groups. Before addressing these health-related behaviours, however, it is necessary to document the various forms of emotional distress from which many of these men suffer.

**Idioms of Distress**

*“Losing the Way”*

Problems with nerves, alcohol, depression, loneliness, violent behaviour, and other forms of distress were often described in terms of losing direction in life, losing a sense of selfhood, or “being lost” or “disappearing.” “Losing the way” (*perdiendo el giro*) was often associated with the of lack of language skills, financial resources, friends or sexual relationships, as well as being unable to fulfil goals and aspirations. One man, Roy, felt
he had “lost the way” since he had arrived in Canada in 1994 as an immigrant from El Salvador:

When we just came to Canada...we have a big barriers here; for example, language, culture, money, everything is new for us. They are taking us from what you call the Third World into a First World country. The culture is very totally different the way that they both behave and act. And so it is a very great impact. And they just bring us, I can say just like animals. Also what I can say, we are coming from conflicted countries, that there was war. We are coming from war, from seeing chopping, killing, torture, and some of us has been tortured, you know. So we are coming with very high emotional and psychological problems.

Given that most of the men in this study migrated to Canada during their twenties or thirties goals, many had aspirations of achieving particular work or family. Migration for political or economic reasons caused disruptions in their lives. Of course, both immigrant men and women share these experiences, but our study suggests that compared to the women we spoke with, Central American immigrant men have particular difficulty “moving on” (salir adelante) after these disruptions. The ways in which disruption is influenced by gender, therefore, provides an important context for an analysis of the emotional problems faced by these men.
Emotional Distress

The men in this study have suffered—and some continue to suffer—from a wide range of emotional problems, including stress, depression, loneliness, nerves, isolation, and frustration. As mentioned earlier, these problems have stemmed from difficulties in learning English and finding work, as well as not being able to pursue or fulfil dreams in Canada. When asked about how their health had been since moving to Canada, many men shared their struggles with emotional problems:

Pues, hace más o menos como cuatro años, estuve muy enfermo, con los nervios, depresión, ataques de pánico, y me estuvieron viendo unos psiquiatras. (Matias)

(Well, about four years ago, I was very sick, with nervous problems, depression, panic attacks and psychiatrists were seeing me.)

Ahm, maybe by the second year after coming to Canada I feel so depressed because I didn’t...didn’t--couldn’t find a job, you know. So and ah, and ah, sort of ah, I start drinking a little bit. So, that's the only time I feel depressed. (Edgar)

Yo tengo nervios desde hace mucho tiempo, desde que era pequeño tuve nervios. People looked at me and they said...cuando una persona te ve, te pone nervioso. I took pills, tranquilizer. No more, no more. They made me sick. (Marcelo)
(I have had nervous problems for a long time, since I was very little I had them. People looked at me and they said...when a person sees you, they make you nervous.)

Although these men have clearly suffered from a variety of emotional difficulties since coming to Canada, some problems—nervios in particular—may also be viewed as a normal part of everyday life. Only when “nervousness” or stress is perceived as chronic or unresolved do men and women consider these conditions to be serious. Further, distinctions were made between “nervous episodes” and being a “nervous person.” While many of the men in this study had bouts with nervousness few considered themselves to be nervous people who required help. Although there is stigma attached to being a “nervous person” for Central American immigrant men, most men accept that some degree of nervousness or stress is a part of everyday life. As we will discuss further below, this health belief may have important clinical implications.

Bodily Damage

In addition to problems that in biomedical terms would be considered “mental” or “psychological,” many men have struggled with alcoholism, drug addiction, weight gain, abusive behaviours, and suicide ideation. Like nervios, these illnesses may be understood as embodied responses to the social and economic struggles in their lives. Mario’s problems with drugs and alcohol, for example, intensified after his migration to Canada from El Salvador in 1989:
Cuando llegué a Canadá ese problema, o esa enfermedad se intensificó. Fue mayor que en mi país. Me imagino-- estoy seguro que fue una clase de frustración al encontrarme con una nueva cultura, un nuevo mundo. Y sobre todo con una barrera muy grande que era la del idioma. Al llegar a Canadá, bueno yo ya fumaba marihuana todos los días y varias veces al día durante muchos años. Y tomé alcohol desde la edad de 13 años hasta que llegué acá, casi todos los días también. Pero luego acá en Canadá llegué a darle a la cocaína. Entonces mi enfermedad de adicción a las drogas era mayor aquí en Canadá que en mi país.

(When I arrived in Canada this problem, or this illness was intensified. It was worse than in my country. I imagine --I am sure that it was a kind of frustration in finding myself in a new culture, a new world. And above all with a very large barrier which was language. Upon arrival in Canada, well I already smoked marihuana every day and several times a day for many years. I drank alcohol from the age of 13 until I arrived here, almost every day too. But then here in Canada I started getting into cocaine. Then my illness in addiction to drugs was bigger here in Canada than in my country.)

For many men, drinking is a way to forget about problems in their lives, both past and present. “Forgetting” through drinking was a common—though harmful—strategy employed by men to deal with unemployment, family conflicts, boredom, and loneliness. Drinking with other men may be a source of camaraderie in both home and host countries.
After describing his divorce from his wife and his efforts to curb his violent behaviour towards her, Francisco talked about his poor mental health and his attempt to take his own life:

My physical health was okay, but my mental health was not good because when I went through the separation with my wife, I was kind under restraint with Immigration.... In Guatemala you would say didn't have this kind of situation. But here I was under restraint and I tried to kill myself. I was in the bath when I tried get out by the window and run and run, and because I couldn't deal with my family problems like I did in Guatemala. So I said everybody is against me, everybody wants me to be nothing, everyone wants me to be quiet and don't say anything.

Francisco’s ability to talk openly about his problems has taken time. He was able to find a counselling group for his problems, and, in fact, now leads a Spanish-speaking group for men who have abused their partners. However, few men in this study have been able to “find the way” (salir adelante) like Francisco. Most are unable to overcome barriers to informal and formal sources of support in Toronto.
Barriers to Informal Support

“Keeping It In”

One the main goals of this study is to identify the relationship between gender and health care seeking behaviour. A key finding of this study is that the underutilization of informal and formal sources of emotional support among Central American immigrant is linked to constructions of what it means to be a man. These men may not seek help for the problems illustrated above for a number of reasons: men hide or conceal health problems because of pride; they lack trust in the people around them; they consider it “unmanly” to discuss their emotions; they don’t want to worry others about their health status; or they blame others for their bad health.

Although Orlando considered his health to be “normal” for a 24 year-old man (“Nothing major, just ah, colds….”), he admitted that he doesn’t ask for help when he needs it:

But when I really need the help I don't talk about it…. I think people are just selfish in a way that, you know, if you tell your problem to someone, I think they'll just hear you but to them it won't really matter because they don't really feel what you feel, you know. And so it's hard to find someone you can trust really like, to have an interest in helping you out.

Some men attributed their reluctance to deal with health problems as an aspect of machismo:
El hombre latino, tenemos un problema. En el machismo: no creerse menos que la mujer. Creerse superior a la mujer…. El hombre latino nos gusta aparentar. Ser fuerte, somos los que mandamos en la casa. Somos los jefes en la casa. Ese es un problema…. Por eso creo que la mujer es más fácil de que se nota cierta debilidad física o mental. El hombre trata de ocultarlo, no mostrarlo sino ocultarlo. Eso es machismo. (Men’s Focus Group participant)

(The latino man, we have a problem. It is machismo: not letting ourselves to be less than women. Believing ourselves to be superior than women. The latino man we like to put up fronts. Be strong, we are the ones that take charge in the house. We are the chiefs of the house. That is the problem. That is why I think that it is easier to notice certain physical or mental weaknesses in women. Men try to hide it, not to show it but to hide it. That is machismo.)

Men in our focus group disagreed over whether concealing health problems was a good practice or not. Some argued that talking with your spouse about emotional problems was a necessary step towards health and healing, and that avoiding the problem may make it worse. “It’s easier to catch a liar than a cripple!,” one participant joked (Se agarra más fácil a un mentiroso que a un rengo!). Others were concerned about their health problems becoming public knowledge. One man commented that “if you tell a friend about a problem, then the whole block will know” (si uno le cuenta el problema a su amigo, lo sabe toda la cuadra). Despite these disagreements, it is clear that men draw connections between their identities as men and how they deal with emotional problems.
To further illustrate the influence of gender on health care seeking behaviour, the women participants in this study shared ideas on why men are reluctant to discuss problems with friends or loved ones. These women emphasised that men in particular are afraid to express themselves:

(Y muchos hombres tienen miedo, lo que es diferente en las mujeres. Nosotras también a veces tenemos miedo, pero siempre mandamos al marido. Por ejemplo a veces escucho ruido en casa y lo despierto a mi esposo y mi esposo me dice: “Ok, vamos vamos.” Yo soy la miedosa, pero él también porque es miedo. Los hombres también tienen mucho miedo pero no lo expresan, no dicen: “tengo miedo”. (First Women’s Focus Group participant)

(And many men are afraid, that is different in women. We are also afraid sometimes, but we always send the husband. For example, when I hear a noise in the house I wake up my husband and my husband tells me, ”ok, let's go, let's go”. I am the one that is scared, but him too because it is fear. Men also are very afraid but they do not express it, they don't say, ”I am scared”.)

In these narratives, “fear” is used as a general idiom to describe reactions to difficult situations. According to these women, both men and women have fear but men neglect to admit to and discuss the problems that produce fearful or stressful situations. These women feel it is their responsibility to encourage husbands, boyfriends and brothers to
talk about their problems. They emphasised their roles in teaching men how to learn to talk about their problems and concerns.

**Barriers to Health Care**

*Perceptions of Health Professionals*

A primary focus of the interviews and focus group sessions for this study was to discuss participants’ perceptions of—and encounters with—health professionals in Toronto. This approach was taken to understand any barriers or facilitating factors to the utilisation of formal health services, such as family physicians or psychiatrists, within this population. Questions included: What health services have you used in Canada? How do you deal with (or try to prevent) problems with nerves, stress or depression? (see Appendix A)

Although some participants had had positive experiences with health professionals—emphasising that health care in Canada was better than in their home country—several men identified a lack of trust or inadequate time spent with the patient as key barriers to formal health care utilisation.

When we asked Marcelo if Central American immigrant men were aware of the health services available in Toronto, he replied:

Yeah. Pero la cuestión que digo, es que son desconfiados, muy desconfiados…. Puede ser porque han tenido malas experiencias, cuando ellos hablan pueden ser malinterpretados, de temor a meterse a un problema.
(Yeah. But the issue that I am saying is that they are suspicious, very suspicious. It could be because they have had bad experiences, when they talk they could be misinterpreted, for fear that they might get into problems.)

Julio also emphasised the feelings of fear that men have towards doctors:

Yo creo que el problema más que todo, es que no quiere ir con el médico. Se evita ir a lo del médico, uno por miedo o otro porque ya tiene ese.... Hasta que no están grave van a lo del médico, van al hospital.... Más que todo es miedo, miedo, temor de exponer su idea, de hablar con el médico. Eso es uno de los cosas. Eso depende de dónde vengas y de la cultura.

(I believe that more than anything the problem is that he doesn't want to go to the doctor. He avoids going to the doctor, on the one hand because of fear and on the other because he already has this.... They won't go to the doctor when they are seriously ill they will go to the hospital. More than anything it is fear, fear, fear to express their idea, to talk with the doctor. This is one of the things. This depends on where you come from and the culture.)

Julio views doctors as a “last resort” for serious problems. And like many other participants, he finds it difficult to explain why men have this fear of professionals. “It depends on the culture you come from,” was a common explanation for this attitude.
Encounters with health professionals in Central America are also important as men attempt to adjust to Canada's health care system and Canadian professionals. Often men's attitudes and expectations towards physicians may be colored by personal experiences or attitudes expressed by friends and family in their country of origin.

Sergio reflects the health care system he had come from and his lingering expectations:

*In El Salvador there are doctors like that, that don't listen. If you pay, then they listen. So that makes a difference here. One doctor, Dr ..., he talk to you, he listen, he explain me what I have. That nice, that is nice.*

Women participants, however, provided more nuanced explanations for men’s reluctance to use services except in life threatening situations.

*Yo creo que si una familia tiene un problema grande, muy grande, muy serio, y el hombre no quiere para nada buscar un lugar, si es posible que usted, digamos, podría dedicar aunque sea media hora, no todos los días, ir a la casa, como amigo. (First Women’s Focus Group participant)*

*(I think that if a family has a very big problem, very big, very serious, and the man does not want to find a place at all, then it is possible for you, let's say, to dedicate even half an hour, not every day, to go to the house, as a friend.)*
Several participants complained that health professionals do not take the time to listen to problems or to take an interest in the patient’s background. These and other factors were considered barriers to health care for Central American immigrant men.

Language

Language was identified as a barrier to services for all immigrants from Spanish-speaking countries. Several participants reported on difficulties communicating with care givers in both clinical and hospital settings. Others complained of the lack information about services for non-English speakers. Although the efficacy of language- or culture-specific services is a matter of debate in health care research, some participants insisted that services in Spanish are critical to health:

*My wife, she was in the hospital in 1991. And there was no doctor, no psychiatrist, no nurse, nobody who can speak the Spanish. I feel so bad, you know…. I was losing hope. Like ah, close to suicide, really thinking so much. But no, I never found nobody in Kitchener who can…who can speak [Spanish].*  
(Alejandro)

The language proficiency of health professionals can have a profound influence on the well-being of non-English speaking newcomers. While the provision of health services in Spanish alone will not alleviate the suffering of newcomers and facilitate access in all cases, it is an important part of a broad range of necessary improvements to health care for immigrants and refugees.
Another important finding of this study is that many Spanish-speaking newcomers are not aware of the health services available in Toronto. Some feel there is a lack of information about services made available to newcomers. Several participants commented that although they suffer from regular bouts of nervios, they do not know where to go to talk about their problems. In addition to stories about personal struggles to find a good doctor or a reliable friend to discuss emotional problems, some subjects commented on the lack of health awareness within the entire “Hispanic community”:

Porque a veces también los hispanos no conocemos los centros, los centros de ayuda…. Eso es muy importante porque a veces eso son unos de los problemas, que no conocemos, no sabemos dónde ir. Nadie dice nada. (Matias)

Because sometimes hispanics we don't know centres, help centres. That is very important because sometimes that is one of the problems, that we don't know, we don't know where to go. No one says anything.)

Hay personas que no están orientadas con lo que tienen en las comunidades estas. No están bien orientadas con las clases de servicios que hay. No saben que hay un arte, que aquí hay una escuela, que aquí hay alguien que los orienta para cualquier... lugar, para cualquier ubicación.... No saben que existen muchas cosas aquí. Es gente que no saben que hay una escuela aquí. Hay muchos hispanos que no sabemos los servicios. (Ricardo)
(There are people that are not in tune with what these communities have. They do not know what types of services they have. They don't know that there is art, that there is a school, that there is someone that can guide them to any place. They don't know that many things exist here. It's people that don't know that there is a school here. There are many Hispanics that don't know about the services.)

These narratives suggest that Central American immigrant men may not know about the services available to help them salir adelante. While some participants argued that men lacked motivation to look for services—suggesting that underutilization is the fault of particular individuals—others maintained that underutilization was a structural problem. In this view, agencies can do more to provide adequate information about services for newcomers.

Gender-Specific Services

Many men perceive health services as being for women, and therefore believe it is not appropriate for men to seek professional help. Pablo argued that there is a greater focus on women in service provision and that men don’t get the attention they need:

Una parte para el hombre, bastante problemático es que aquí le dan más prioridad a la mujer. He visto bastante casos y he oído que- - existe la discriminación contra el hombre pues tiene más derecho la mujer.... Lo que pienso es que deberían dar un poquito más de importancia a [uno de] hombre. Que yo veo en las informaciones que- - en las informaciones de periódicos, en la
Both men and women in our sample stated that strategies to improve access to care for Central American immigrant men should be a service priority. The women focus group participants, in particular, emphasised the importance of increased care for their husbands, boyfriends, and brothers:

Y en este país le han dado más ayuda a las mujeres que a los hombres. Porque muchas veces la mujer es la que busca ayuda porque es agredida, porque es golpeada, pero, en realidad, el que necesita ayuda es el hombre. (First Women’s Focus Group participant)
(And in this country they have given more help to women than men. Because many times it’s women that looks for help because they are assaulted, beaten, but in reality, it is men who need help.)

In critiquing the lack of services for men, Sergio was particularly aware of the politicised nature of the issue:

…Since I came to Canada, there are not too many things provided for men. You know, I’m not trying to, how can I say, defend the gender. I’m not trying to sound that way. But I think it’s fair in a way, you know, to do this type of research because we’re human beings also, you know what I mean?

Sergio’s reflection on the gendered nature of the issue of access to emotional support for men demonstrates that many men are aware of problems that they face, and are able to articulate the needs within this population.

This section has illustrated the variety of health issues faced by Central American immigrant men, and the changes that this population believe are necessary for improved health and access to care. The next section introduces the stories of those men who have discovered ways to salir adelante. In our view, these narratives have several policy and service implications, as they reflect the challenges and struggles faced by men and women newcomers. While these narratives are produced within particular social, historical, and economic contexts by particular groups of people, we would argue that
these stories may provide the basis for improved access to health care among other newcomer groups as well.

**Finding the Way**

*Responsibility*

An overwhelming number of men interviewed for this study asserted that “moving on” and maintaining well-being was a matter of personal responsibility. Walking, resting, reading, playing soccer, learning English, keeping busy, staying organised, eating healthy foods, and abstaining from drinking and smoking were identified as key sources of emotional well-being. Keeping composed and having control over your own body were also considered ways to maintain individual health, as well as good relations with friends and family.

Also, in order to “move on”, some men are relearning what it means to be a man. Francisco found a way to deal with his violent behaviour towards his wife by re-thinking his own sense of responsibility to himself and to the people around him:

*The first thing is to learn that we are responsible for our own behaviour, this is a main focus. You are responsible for any behaviour. Women are not responsible; she doesn’t deserve to be beaten. It is not her fault if we are violent. It is not her fault if we feel sad, upset angry, it's not her fault, it's our responsibility to express our feelings.*
Francisco attributed his abusive behaviour to his *macho* upbringing:

> As a man from Guatemala I was the one who decides what to do at home and how [my wife] is supposed to do, so I have a role. I was the one who was in charge, but here I hear that it's different. So that made me feel more understanding to get more information how things work in Canada.

**Friendship**

In addition to taking personal responsibility for individual behaviour and health, men view friends and social connections as important sources of well-being. Friends can be a source of support, as well as a source of motivation to quit drinking or smoking. Having friends is a way to counter feelings of loneliness in a new society. In the case of Ricardo, meeting fellow Spanish-speaking men was an important step towards improving his life after problems with depression, sadness, and loneliness:

> Ahora ya llevo sobre 7 años de estar acá. Y la vida ha cambiado bastante en mí. Y no soy el mismo que el que vino aquí, aquellos tiempos, sin conocer nada. *Conozco todo Toronto, conozco toda el área donde yo vivo. En realidad tengo amigos, ahora tengo personas con las cuales comparto momentos maravillosos.*

> (Now I have over 7 years of being here. And life has changed a lot in me. I am not the same as the one who came here back in those times, not knowing anything.)
I know all of Toronto, I know the area where I live. Now I have friends, I have people with whom I share marvelous moments.)

This finding resonates with other studies which suggest that Latino men tend to have a sociocentric identity, whereby friendship, public activity, and group belonging are central to personhood (Gutmann 1996).

**Institutional Belonging**

Above all, belief in God and belonging to a particular church were major enabling factors for men to improve emotional well-being. Membership in Catholic and Evangelical churches was common among the men and women in our research sample.

*Me sentí tan solitario. Pero encontré unos de una iglesia y ellos me dieron apoyo allí. Seguí con ellos, conseguí un empleo de mudanzas.* (Gustavo)

*(I felt very lonely. But I found some people from a church and they supported me there. I continued with them, I found a job in a moving company.)*

*Yo voy a la iglesia. Me siento mejor. El pastor enseña que Ud. tiene que olvidar el pasado. Porque el pasado ata, tiene amarrado, atado a muchos hombres. Entonces, si el hombre logra olvidar su pasado, las cosas malas que hizo o le sucedieron, el hombre podrá ser feliz en el futuro.* (Roberto)
(I go to church. I feel much better. The pastor teaches that you have to forget the past. Because the past ties down, keeps one tied up, it ties up many men. Then if a man succeeds in forgetting his past, the bad things that he did or that happened to him, he can be happy in the future.)

In addition to spirituality and church attendance, having a good job enables men to contribute to household income and provides them with a sense of self-worth.

_I got this job and things started changing._ (Edgar)

_Mi trabajo me ha ayudado bastante y también la escuela me ha dado bastante aporte. Pero también uno necesita de las amistades, tener amigos, participar en algo, participar en algo bueno que sea en beneficio de la comunidad._ (Ricardo)

(My job helped me a lot and school also gave me a lot of support. But one also needs friendships, to have friends, to participate in something, something good that can be beneficial to the community.)

A few men in our sample have actively sought out emotional support through institutions such as Alcoholics Anonymous (AA) and community-based parenting support groups. Roy described the ways in which the Spanish-speaking AA programme had helped him, and also recommended that we include this suggestion in our report. When asked why he liked the programme, he replied:
Because in the way it is very flexible. For example, those steps are saying things are like this, life is this; you can take this way, you can take this [way]. They are putting it as a mathematic. They are giving you a programme and then...this is the way I'm teaching you, but then if you find another way that can go to the same result, that's fine.

In similar fashion, Francisco had found a way to deal with his violent behaviour by joining a parenting group. Notably, Francisco’s family was a key motivating factor in his ability to salir adelante:

I decide to stop going to school for a week and then I saw in the hall of the school a sign, it was about a parents group and I decided to join them and this group were about twelve women, and then I join them and the first session I was crying. I just open the door and I say “This is a parenting group?” They said yes, so I start crying and they listened to me, they were saying “If you want to talk just talk. You want to cry, just cry but we are not judge you, we are not criticize you”, and then they were listening to me. I tell them that I have problems at home and I don’t know how to deal with them, and it was when I realized I was under depression.

What I wanted to do is to keep my family together and I realized that I was the one who has a problem, I was blaming my wife and my kids. I thought they didn’t
understand me, but I got information from the community centre, I then realized that I was the one who had problem with my dealing with my anger, and I identified that I was losing my identity as a man because I couldn't deal with the situation like I did in Guatemala.

In contradiction to crude stereotypes about the macho Latino man that emphasize sexual prowess and stubborn individuality (Gutmann 1996), the stories of Francisco and other men in this study demonstrate that the family and fatherhood are key factors that influence personal health, and the ability to move on.

Women’s Role

A final factor in helping men to move ahead, or salir adelante, is the supportive role that is played by wives, girlfriends, and sisters. Women emphasized that they could be critical sources of support for men suffering from nervios, alcoholism, depression, and loneliness. While these women pointed out that both men and women have problems with nerves and other forms of emotional distress, they suggested that men in particular have less success salir adelante in Canada. Communication and patience were considered important tools for women to help men salir adelante:

Las mujeres tenemos que tener siempre esa paciencia y nunca perder la comunicación, ser fuertes. (First Women’s Focus Group participant)
This brief statement indicates that the family may be an important source of support. When a man suffers from nerves or commits a violent act towards a loved one, the family is a site where healing can begin. Despite men’s emphasis on personal responsibility and self-reliance, “finding the way” is never solely an individual act. Access to all forms of care depend on the social and structural relationships in peoples’ lives.

Resource Card for Spanish Speaking People

The findings from this report support the argument that gender plays a role in the process of adjustment to Canadian society among newcomers. More specifically, these findings suggest that among Spanish-speaking immigrants and refugees to Canada, Central American immigrant men face numerous barriers to accessing informal and formal sources of emotional support in the GTA. As a tangible solution to this problem, the researchers collaboratively designed the Resource Card for Spanish Speaking People based on the findings of the study. The process of designing this card included the comments and suggestions of participants, as well as the input of key informants. Several features of this process are outlined below.

The importance of this community contribution to the card cannot be underestimated. While the original proposal for this project suggested the inclusion of a “Mental Health Resource Card” as a potential outcome, the design for this card did not gain momentum.
until participants were actively consulted. Perhaps the most important suggestion was that researchers should pay close attention to the language and terminology used on the card. For example, several participants drew attention to the stigmatizing nature of the phrase “mental health” (*salud mental*) among Spanish-speakers. These participants felt that this phrase would likely detract men’s attention away from the card by potentially labeling them as “crazy” (*loco*). Alternatively, expressions such as “alone” (*solo*), “feeling bad” (*sientes mal*), “sad” (*triste*), or “insecure” (*inseguro*) were recommended. Without attention to and incorporation of these key suggestions, this community outreach tool would likely fail to encourage men to seek help for emotional distress.

This card will be distributed to participating agencies, and to Spanish-speaking clients at YCS and other community-health centres serving Spanish-speaking patient populations. Social and health professionals will distribute cards to clients, and clients can then distribute cards among friends and family. This relatively “private” approach to outreach (as opposed to poster campaigns or television and radio advertisements) was favored among participants given the sensitive nature of the issue.

*La Historia de Miguel*

Once the research team had gathered the suggestions of participants, key informants were asked to comment on the content and format of the card and the “composite narrative” (see Appendix C for Spanish newspaper article). This narrative—a vignette based on the dozens of stories collected for this project—is another community outreach tool intended to illustrate the findings of this study for the larger Spanish-speaking community.
Originally written by the Principal Investigator and Project Coordinator, and later revised with comments from the other research team members, key informants, and participants this narrative aims to present the findings of the study in an anonymous but personal manner. It was used to seek feedback from participants on the interim interpretations, a form of member checking, and will be used to encourage further dialogue among Spanish-speakers in Toronto on men’s health.
RECOMMENDATIONS

1. Services targeted for newcomer men

The results of this study suggest that there is a need for innovative gender-specific services for Spanish-speaking newcomer men. Clearly, many men within this demographic group suffer from emotional distress and, most importantly for this study, do not seek care for these problems. These health services should be linked to employment and language services, promote the role of fatherhood in Canada, and include diversity training for both staff and patients. This study calls for the development of programs that meet the unique settlement needs of both newcomer men and women, especially those who have experienced violence in their home countries and are unemployed and lack English-language skills in Canada.

2. Support groups for men

Support groups for men played a large role in helping men shift and reconstruct their responsibilities and male identities in Toronto. Men and women as well as health professionals need to be aware of the importance of support groups. Both formal and informal groups should continue to be developed to further explore the use of support groups in the newcomer population. This study would suggest innovative linking of gender-specific support groups with workplace health promotion.
3. Spanish-speaking health care professionals

Since many participants felt more comfortable seeking formal health care from Spanish-speaking doctors, psychiatrists and nurses rather than their non-Spanish-speaking counterparts, this study supports the call for increased health services in Spanish in Toronto. Research in family medicine has indicated that communication and listening skills on the part of health professionals is critical to effective patient care. As such, it is strongly recommended that policy makers pay attention to the language make-up of health services in Ontario, and strive to ensure that accessible sources of formal health care are available to the Spanish-speaking population.

4. Reception and “front line” services in Spanish

The above recommendation dovetails with the suggestion that accessible health services not only include the language competency of health professionals, but also receptionists and other people working on the “front line” at community-based health centres, as well as larger mainstream health institutions. These people are the source of “first contact” at health agencies for many newcomers, and it is important that these initial contacts are accessible for newcomers who may be reluctant to use health care services—such as Central American immigrant men.

5. Quantitative investigations of health care utilisation by gender

In terms of suggestions for future policy-oriented, applied health research, this study suggests that future research address the gendered dynamics of health care utilisation. Quantitative studies measuring the use of health care services by gender—among
immigrants and native-born Canadians—would provide a broader scope on this policy and service provision issue. Future health and settlement research should focus on who does—or does not—use formal health care services and why.

6. Narrative-based applied research

Finally, the authors recommend that future health and settlement research continue to explore narrative-based outreach tools. Recent innovations in narrative theory and method provide important groundwork for applied research to use stories and vignettes—rather than conventional prose articles or “step-method” self-help advertisements—to convey research results and contact target populations in innovative ways. In this investigation, the use of narrative has proved to be an effective tool for raising interest among participants and key informants in the research topic, and provides a model for future projects to design culturally appropriate health awareness tools among newcomer populations.
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APPENDIX A

Mental Health and Access to Mental Health Care
Among Central American Immigrant Men

Sample Interview Questions

General
★ Where are you from?
★ How old are you?
★ What is your marital status?
★ What is your educational and cultural background?
★ When did you come to Canada?
★ Why did you come to Canada (as a immigrant, as a refugee)?

Health and Illness
★ What have been your experiences, positive or negative, with your health in Canada?
★ Have you had problems with nerves, stress or depression since you have lived in Canada?
  Why or not why not? (miedo, triste, trauma, nervios, depresión)
★ Do you have any stories to tell about when you had difficulties with nerves, stress or depression?
★ In your opinion, are there differences between these mental health problems?

Utilization of Mental Health Care Services
★ How do you deal with (or try to prevent) problems with nerves, stress or depression? Do you deal with them privately or with other people?
★ Where would you go to get help with problems with your nerves, stress, depression? (priest, friend, natural healer, wife/girlfriend, family member, psychologist, family doctor)
★ What health services have you used in Canada?
★ Have you had any difficulties trying to use health services in Canada?
★ Do you have any memorable (positive or negative) stories about when you tried to use health services in Canada?
★ What difficulties do you think Central American men face with health services in Canada? (hombres están cerrados)

General Health: Perspectives, Opinions, Ideas
★ In your opinion, what is the biggest health problem that Central American men face in Canada?
★ How do you think this problem should be dealt with?
★ What services would you like to see improved?
★ What should be done to make health services more accessible for Central American men?

Mental Health Resource Card
★ What is your opinion about a card that suggests resources for Central American men facing mental health problems?
★ What improvements could be made?
★ What other ideas do you have to get information about mental health services to Central American men? (Telelatino, Spanish radio, anuncios)
La Historia de Miguel

Miguel tenía amigos, familia y trabajo - hasta que llegó la guerra. La guerra trajo cambios que no había anticipado, como por ejemplo, su emigración a Canadá. Después de tres años en Toronto, aún se sentía extranjero. En medio de tantos ajustes a un nuevo ambiente, a un nuevo idioma, a una nueva cultura, Miguel perdió su rumbo. Había buscado trabajo, pero su Inglés no era muy bueno, y de todos modos, no había trabajo. Su mujer lo dejó y él mismo no estaba muy contento con la forma en que él la trataba. Tampoco estaba contento con la cantidad que bebía y estaba frustrado con su falta de motivación.

Se preguntaba que hacer con tantos problemas y su nerviosismo. Se decía a sí mismo, -No quiero molestar a nadie, yo puedo arreglármelas solo.

Y así trataba de olvidarse de todo. Sabía que tomaba demasiado y se sentía cada vez más solo.

-Me estoy hundiendo como la gente en mi propio país, no puedo hablar con nadie.

Miguel sabía que no vino a Canadá para hundirse. Trataba de pensar en que forma podría salir adelante. Pensó.

- Si estuviera en mi país le hablaría a un amigo, a mi mujer, al sacerdote o quizás hasta a mi doctor. Pero en Canadá, ¿que puedo hacer?
Un día un amigo le contó que para salir adelante tendría que considerar formas de integrarse a la comunidad, como por ejemplo, usando grupos de apoyo para hombres, participando en los distintos actividades de las iglesias o recurriendo a los diversos centros comunitarios con servicios integrados de salud.

Bueno, pensó Miguel, hay posibilidades para explorar.

(English Version)

Miguel's Story

Miguel had always had friends, family and a job; that is, until the war. The war brought changes he could never have anticipated, like his immigration to Canada. Even after 3 years in Toronto he still felt like a stranger. At some point in the turmoil of adjusting to a new country, a new language, a new culture, he had lost the way. He looked for work but his English was poor, and anyway, there were no jobs. His wife had left him, and he was unhappy with his treatment of her, unhappy with his drinking and frustrated with his lack of motivation.

He wondered how could he cope with his nervous problems? He would say to himself, “I don’t want to be a bother, I can handle things on my own.” Then he would try to forget about everything. He knew his drinking problem was getting worse and he felt more and more alone. “I am disappearing like the people in my country and I can’t talk with anybody.”

Miguel knew he did not come to Canada to disappear. He tried to think of what he could do to improve things. He thought, “If I was back home I might try to talk with my friend, my wife or maybe the priest. I might even go to the doctor. But in Canada what is there?
One day a friend said to him that to move ahead in life you have consider ways to integrate into the community like, for example, using men's support groups, participating in church activities, or taking advantage of various services at community health centres. Well, thought Miguel, there are possibilities to explore.
LA HISTORIA DE MIGUEL

Miguel tenía amigos, familia y trabajo - hasta que llegó la guerra. La guerra trajo cambios que no había anticipado, como por ejemplo, su emigración a Canadá. Después de tres años en Canadá, aun se sentía extranjero. En medio de tantos ajustes a un nuevo ambiente, a un nuevo idioma, a una nueva cultura, Miguel perdió su rumbo. Había buscado trabajo, pero su inglés no era muy bueno, y de todos modos, no había trabajo.

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participando en los distintos actividades de las iglesias o recurriendo a los diversos centros comunitarios con servicios integrados de salud.

Bueno, pensó Miguel, hay posibilidades para explorar.

Esta historia de Miguel es una compilación de las historias de hombres que participaron en un estudio intitulado: ¿Problemas con tus nervios?, ¿Que puedes hacer? (Central American immigrant men and mental health: a qualitative study). Este estudio fue a investigar cómo los hombres latinos inmigrantes se adaptan a la vida en Canadá. Otros estudios mostraron que inmigrantes latinos tienen muchas barreras como el idioma y la cultura. Los hombres también son vulnerables a problemas emocionales como la depresión, las inquietudes, el alcoholismo y le adicción de drogas. Marlinda Freire, una psiquiatra en Toronto, dice que hombres tienen mas dificultades de mujeres a ajustarse porque pierden más estatus social y frecuentemente tienen problemas a reestabilizar su trabajo, cosa que es central a su identidad.

El equipo de este estudio fue un médico de familia, Kevin Pottie (Universidad de Ottawa), un antropólogo, Samuel Dunn (Toronto) y una trabajadora social, Magnolia Mazzeo (York Community Services, Toronto). Si bien se ha realizado en Toronto, piensa que los resultados se aplican a otras ciudades en Canadá.

Casi todos los hombres han sufrido de violencia antes de venir a Canadá, perdiendo familia, amigos y trabajo. Une tema muy común entre los hombres estuve que el perdió el rumbo expresadolo a travez de violencia contra las mujeres, alcoholismo y drogas y depresión. La mujere puede ayudar al hombre pero ellos necesitan también otros hombres para salir adelante. Ellos necesitan hablar y discutir de sus problemas y así poco a poco
poder aprender de la nueva cultura. Muchas veces ellos son demasiado orgullosos para hablar de sus problemas emocionales con otros hombres. Muchos hombres en el estudio dijeron que grupos de apoyo para hombres eran muy importantes para la integración. Otros hombres hablaron de actividades en iglesias latinas o grupos de fútbol entre otras actividades..

Los médicos de familia y trabajadores sociales en Canadá necesitan escuchar y entender este tiempo difícil y conocer los recursos en su comunidad. El sistema médico en Canadá da derecho a tener un médico de familia y otros profesionales de salud y todos estos medios pueden ser un primer paso para salir adelante.

**Para más información llame a:**

Magnolia Mazzeo, York Community Services, Toronto: 416-653-5400

Dr. Kevin Pottie Bruyere Family Medicine Centre, Ottawa: 613-241-3344
Appendix D

Resource Card for Spanish Speaking People

Front

SALIR ADELANTE

Resource Card for Spanish Speaking People

Back

Cuatro pasos hacia una buena salud:
1. Busque un grupo de apoyo
2. Busque buenos amigos
3. Hable con su esposa(o)
4. Consulte un médico de familia
   o visite un centro comunitario

Para más apoyo llamar:
1. York Community Services:
   416-653-5400
2. Center for Spanish Speaking People:
   416-533-8545
3. Counterpoint Counseling Services:
   416-920-0268 (extensión 2)