

NOTE TO USERS

Page(s) not included in the original manuscript and are unavailable from the author or university. The manuscript was scanned as received.

This reproduction is the best copy available.

UMI[®]

UNIVERSITY OF CALGARY

Exploring Immigrant Women's Mental Health Care Experiences:

From a Health Care Provider's Perspective

by

Joyce Maureen O'Mahony

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE
DEGREE OF MASTER OF NURSING

FACULTY OF NURSING

CALGARY, ALBERTA

March, 2005

© Joyce O'Mahony 2005



Library and
Archives Canada

Bibliothèque et
Archives Canada

Published Heritage
Branch

Direction du
Patrimoine de l'édition

395 Wellington Street
Ottawa ON K1A 0N4
Canada

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file *Votre référence*

ISBN: 0-494-03795-4

Our file *Notre référence*

ISBN: 0-494-03795-4

NOTICE:

The author has granted a non-exclusive license allowing Library and Archives Canada to reproduce, publish, archive, preserve, conserve, communicate to the public by telecommunication or on the Internet, loan, distribute and sell theses worldwide, for commercial or non-commercial purposes, in microform, paper, electronic and/or any other formats.

The author retains copyright ownership and moral rights in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

AVIS:

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque et Archives Canada de reproduire, publier, archiver, sauvegarder, conserver, transmettre au public par télécommunication ou par l'Internet, prêter, distribuer et vendre des thèses partout dans le monde, à des fins commerciales ou autres, sur support microforme, papier, électronique et/ou autres formats.

L'auteur conserve la propriété du droit d'auteur et des droits moraux qui protègent cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this thesis.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de cette thèse.

While these forms may be included in the document page count, their removal does not represent any loss of content from the thesis.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.


Canada

Abstract

Immigrants coming to Canada have increased in the last three decades. Serious mental health problems exist among immigrant women, therefore the primary purpose of this study was to increase awareness and understanding of what would be helpful in meeting their mental health needs.

Informed by post-colonial feminist perspective and Kleinman's explanatory model this qualitative exploratory study was conducted with seven health care providers who provided mental health services to immigrant women. In-depth interviews were used to obtain information about the women's mental health care experiences.

The study's findings reveal that (a) immigrant women have difficulties accessing mental health care services due to insufficient language skills, unfamiliarity/unawareness of services and low socio economic status; (b) cultural background exerts positive and negative influences; (c) health care provider-client relationship had profound effects on the immigrant woman seeking help. Strategies are suggested to help provide more culturally appropriate and accessible mental health care for immigrant women.

Acknowledgements

I would like to thank my husband, Noel whose love and support was always there for me, as well as my children Patrick, Ruth and Eileen Kate, who were forever cheering for their mother pursuing graduate studies. I also thank my parents, Ruth and Kurt who taught me the importance of helping others.

In particular, I would like to give special thanks to Dr. Tam Truong Donnelly, my graduate supervisor, for her time, encouragement and mentorship throughout my graduate studies.

As well, I would also like to thank both Dr. Sandra Hirst and Dr. Geertje Boschma, the members of my supervisory committee for their interest in this thesis research.

I would also like to acknowledge the Alberta Association of Registered Nurses for supporting this project with some funding.

TABLE OF CONTENTS

APPROVAL PAGE.....	II
ABSTRACT	III
ACKNOWLEDGEMENTS	IV
TABLE OF CONTENTS	V
CHAPTER I: INTRODUCTION.....	1
BACKGROUND	1
PROBLEM STATEMENT	4
RESEARCH PURPOSE.....	4
CHAPTER II: LITERATURE REVIEW	6
FACTORS AFFECTING MENTAL HEALTH	6
UTILIZATION OF MENTAL HEALTH SERVICES.....	7
ROLE OF SOCIAL SUPPORT.....	9
GENDER ANALYSIS.....	12
SOCIAL POLICY.....	13
SUMMARY	16
<i>Research questions</i>	17
CHAPTER III: METHODOLOGY.....	18
THEORETICAL FRAMEWORK	19
<i>A post-colonial feminist perspective</i>	19
<i>Kleinman's explanatory model</i>	24
SITE.....	30
PARTICIPANTS	30
ENTRY INTO SITE.....	31
CRITERIA FOR SELECTION OF PARTICIPANTS:.....	31
METHOD OF DATA COLLECTION.....	32
ETHICAL CONSIDERATIONS	32
DATA ANALYSIS.....	33
CHAPTER IV: FINDINGS AND DISCUSSION: DIFFICULTIES ACCESSING HEALTH CARE SERVICES.....	36
LANGUAGE BARRIER.....	37
<i>English as a second language</i>	37
<i>Interpretive services</i>	38
UNFAMILIARITY AND UNAWARENESS OF MENTAL HEALTH SERVICES	42
<i>Mistrust of Western biomedicine</i>	44
CONSTRUCTION OF THE CANADIAN HEALTH CARE SYSTEM	46
<i>Fragmentation of care</i>	47
<i>Differing ideas of mental health</i>	49
<i>Systemic discrimination</i>	52
<i>Inequality within the system</i>	53
SOCIAL DETERMINANTS OF HEALTH	56
<i>Socio economic factors</i>	57
<i>Education level</i>	60
<i>Social isolation</i>	63
THE ROLE OF GENDER.....	65
<i>Role change and conflict</i>	65
<i>Commitment to the family</i>	67
<i>Shifting of roles</i>	68
<i>Domination and control of women</i>	69

<i>Differing experiences between sexes</i>	72
SUMMARY	73
CHAPTER V: FINDINGS AND DISCUSSION: CULTURAL INFLUENCES	77
COPING WITHIN THE FAMILY	78
STIGMA.....	81
INFLUENCE OF ETHNIC COMMUNITY	83
RELIGION AND TRADITIONAL HEALING PRACTICES	84
<i>Religious beliefs</i>	85
COPING SKILLS.....	87
<i>Importance of family relationships</i>	88
CULTURAL UNDERSTANDING OF THE HEALTH CARE PROVIDER	90
<i>Holistic view</i>	92
SUMMARY	93
CHAPTER VI: FINDINGS AND DISCUSSION: THE HEALTH CARE PROVIDER AND CLIENT RELATIONSHIP.....	95
HEALTH CARE RESPONSIBILITY	96
SIGNIFICANCE OF RELATIONSHIP.....	98
ROLE OF EMPOWERMENT	100
DIFFERING PERSPECTIVES AND VALUES	103
DISCRIMINATING ATTITUDES	104
TRUST OF HEALTH CARE PROVIDER WITHIN SAME CULTURE	108
SUMMARY	109
CHAPTER VII: DISCUSSION AND RECOMMENDATIONS	111
DIFFICULTIES ACCESSING HEALTH CARE SERVICES	111
CULTURAL INFLUENCES	120
HEALTH CARE PROVIDER AND CLIENT RELATIONSHIP.....	124
IMPLICATIONS FOR PRACTICE	127
LIMITATIONS	130
IMPLICATIONS FOR RESEARCH.....	130
CONCLUSION	131
REFERENCES	135
APPENDIX A: INTERVIEW QUESTIONNAIRE.....	144
APPENDIX B: ETHICS APPROVAL	145
APPENDIX C: INFORMATION LETTER.....	146
APPENDIX D: CONSENT FORM.....	147

Chapter I: Introduction

Canada's immigrant population has steadily increased over many decades. Numerous immigrants have chosen to establish new lives in Canada. Calgary's immigrant population reached 197,410 in 2001 or 22.5 % of the total population (Stats Canada, 2003). As a result, there is a stronger emphasis on the health care provider and health care system to provide culturally sensitive and appropriate care, as well as to promote equity within health care. Despite this rapid and continuous increase in the cultural diversity of the Canadian population, the unique health needs of immigrants have not received adequate attention (Matuk, 1995). It is well documented that immigrant women suffer serious mental health problems such as depression, schizophrenia and post migration stress disorders (Cheung & Lin, 1999; Li & Browne 2000; Thurston & McGrath, 1993). Evidence has shown that immigrant women experience difficulties in accessing and using mental health services (Morrow & Chapell, 1999). There is a call for health care providers and policy makers to increase their awareness of how to provide culturally appropriate and acceptable mental health care to immigrant women (Beiser, Gill & Edwards, 1993). The purpose of this research was to investigate immigrant women's mental health care experiences from a health care providers' perspective.

Background

An immigrant is commonly defined as a person who seeks lawful admission to come to Canada to establish permanent residence (Canadian Task Force on Mental Health Issues affecting Immigrants and Refugees, 1988). Alberta has had 14,672 immigrants settle in 2002, with Calgary claiming 61% or 8,997 immigrants from this total. Chinese represent the largest ethnic group of immigrants, accounting for 15 % of

the total for five years in a row. East Indians and Pakistanis respectively are the second and third largest groups. A review of the landing categories of immigrants in 2002 shows that 60 % were from economic class, 29 % from family class and 11% were refugee status (Citizenship & Immigration Canada, 2003). The family class immigrant requires a relative, spouse, common-law or conjugal partner who is a Canadian citizen or permanent resident of Canada to sponsor him or her. The sponsor assumes financial responsibility for the immigrant for up to ten years. Economic class differs in that the immigrants may enter and become permanent residents on the basis of their skills and ability to contribute to the economy. Refugee class includes those who are displaced and are in need of protection because of civil war, armed conflict or massive violations of human rights (Citizenship & Immigration Canada, 2002).

Over the last three decades, the majority of new immigrants are coming from non-European countries, with more immigrants coming from Asia and Africa (Health Canada, 1999). Recent statistics provide evidence of the continued growth of the immigrant population in Canada, thus the ongoing need for the investigation of how to provide culturally appropriate and acceptable health care for the diverse needs of this population.

Serious mental health problems exist among immigrant women. Depression and anxiety are common mental health problems among immigrants, according to several studies from the U. S., and Canada (Beiser, 1999; Berry & Blondel, 1982; Cheung & Lin, 1999; Dhooper & Tran, 1998; Tracy & Matar, 1999). Beiser found that 19 % of Vietnamese living in Canada suffered a depressive disorder. In order to decrease the severity of mental health illness and its consequences in preventing secondary problems, health care providers must address these issues. In this exploratory study I acknowledged

that it was necessary to go beyond the biomedical framework and other traditional social science perspectives. Past treatments of mental health problems have proven to be ineffective, because adequate attention has not been paid to the social context of immigrant women (Kinnon, 1999). Kinnon suggests a paradigm shift from a biomedical perspective towards a bio psychosocial perspective might help health care providers to better understand the needs of immigrant women and their mental health issues. Health care providers also need to recognize that difficulties immigrant women face in accessing and utilizing mental health services may not be due to culture but to historical processes that have produced systemic inequities and oppression (Reimer Kirkham & Anderson, 2002).

This project investigated immigrant women's mental health care issues from the health care provider's perspective. I also acknowledge the critical importance of recognizing the immigrant women's perspectives as well. In my research, I investigated immigrant women's experiences through the perspective of their health care providers. I was interested in obtaining information on the barriers that the immigrant women experienced in accessing mental health care services.

With over 25 years of experience as a registered nurse in acute care and community based nursing practice, I have been inspired to explore the difficulties immigrant women face. I have witnessed the fragility and vulnerability of immigrant women who felt overwhelmed and unable to seek appropriate care. I have also observed the strengths and resiliency of the hard working immigrant woman striving to keep her family moving forward. My present experience as a public health nurse in the community has motivated me to explore further the everyday experiences of immigrant women through a health

care provider's perspective. Furthermore, my ultimate goal is to illuminate and disseminate awareness of immigrant women's mental health care experiences. The knowledge gained in this research will provide important insight and help with implementing and planning more culturally sensitive mental health care for immigrant women.

Problem statement

Immigrant women suffer from serious mental health problems and often do not receive the care that they need. It has been pointed out that women's mental health care needs are not being met in the current system, despite what appears to be a rich network of services (Beiser, Gill & Edwards, 1993; Morrow & Chapell, 1999). The prevalence of mental health illness among immigrant women and the underutilization of mental health services puts this population in danger of exacerbation of mental health symptoms with associated physical illnesses and social problems. It has been reported through many studies that immigrant women suffer from mental health problems such as depression, schizophrenia and post migration stress disorders (Canadian Task Force on Mental Health Issues affecting Immigrants and Refugees, 1988; Fox, Burns, Popvich, & Ilg, 2001; Legault, Gravel, Fortin, Heneman, & Cardinal, 1997; Li & Browne, 2000; Thurston & McGrath, 1993). Barriers to accessing mental health services are language, cultural beliefs and practices, stigma of mental illness and racial discrimination (Beiser, et al.).

Research Purpose

The purpose of this research was to explore with the health care providers their concerns about immigrant women and mental health access issues. Through the health

Chapter II: Literature Review

Factors affecting Mental Health

In exploring the literature, the following concerns were identified in relation to mental health care of immigrant women. Immigrant women in Canada are faced with barriers in accessing health care that may be derived from social and material conditions in every day life (Anderson, 1987; Goodridge, 2002; Morrow & Chapell, 1999; Westermeyer, 1989). These include social isolation, age, language barriers, separation from family, unemployment, changes in family roles/norms and lack of information about available resources (Berry & Blondel, 1982; Fowler, 1998; Legault et al; Li & Browne, 2000). Women in particular may be prone to the stresses of isolation and childcare responsibilities, which may also affect their ability to acquire language skills because their access to English classes may be restricted (Kinnon, 1999).

Although immigrants are a higher risk population due to physical and mental stresses of resettlement, women are even at a greater risk for mental health problems (British Broadcasting Corporation News, 2003; Thurston & McGrath, 1993). Mental health issues affecting immigrants were reviewed by the Canadian Task Force (1988); it was concluded that the following factors affect the mental health of immigrants, a) negative public attitude toward immigrants, b) separation from family and community, c) unemployment and underemployment, d) inability to speak English/French, e) being a women from a culture where gender roles/values differ from those in Canada, f) being elderly or an adolescent. Other findings by the Canadian Task Force Review concluded that while migration may not increase the incidents of mental disorders, these kinds of

illnesses may be a result of a combination of a drop in socio economic status, separation from friends/family, and lack of employment opportunities (even if well educated from their home country).

Utilization of Mental Health Services

Another important finding in the literature was the variety in utilization rates and identified barriers of mental health care service access between the different groups of immigrant women. Ten Have's (1999) study supports this finding. The awareness of the social, cultural and economic differences in background between diverse groups of immigrant women is necessary to improve the accessibility of mental health care for immigrant women. Peters' (1988) study revealed that there were discrepancies in the rates of mental health care service utilization among different ethnic groups. In Peters' study, participants of the Greater Vancouver Mental Health Services revealed that Anglo-Canadians were markedly over represented. In contrast, South Asians and Chinese were under represented, while newer, smaller groups such as refugees from South Asia and Central America tended to use the mental health services at or above expected rates given their numbers in the population. Less visible barriers included the bureaucratic nature of services and the complexity of the service system, as well as physical and psychological distance between client and provider. Widely differing degrees of knowledge, understanding about health care services and different perceptions of who is entitled to use them has also been reported (Masi, Mensah & McLeod, 1993; Morrow & Chappell, 1999). Beiser, Gill and Edwards' (1993) study revealed that gender, age, socio-economic position, unrecognized needs, ethno-cultural status and availability of service do affect the utilization of health care services. It was concluded that substantial barriers limit

access to mental health care and compromise the equality of mental health care services.

There are mixed reviews in the literature regarding immigrant levels of mental health and accessing mental health services while living in Canada. Research suggests that immigrants (with the exception of refugees) arrive in Canada with a similar level of mental health as other Canadians (Tousignant, 1997). A study of Canadian suicide mortality rates and trends show first generation immigrant women have higher mortality rates from suicide than those born in Canada, with the highest being among Asians (Strachen, Johansen & Nair, 1990).

Bigby's (2003) study found that Asian Americans tended to underutilize mental health services and often were reluctant to seek help because of cultural and language barriers. Some reasons for this underutilization were cultural inappropriateness of services, stigma/shame over using services, lack of financial resources, use of folk healers and concepts about mental health and services that differ from those of the West. Li and Browne's (2000) study of Asian immigrants also found an underutilization of mental health services. The overall findings of this Canadian study report that many Asian immigrants experience a hesitancy to access and utilize mental health care services. It is strongly suggested that if the immigrant's experience is not better understood and accepted, the Asian Canadian will likely continue to remain outside the available mental health care facilities. Cheung and Lin (1999) also found low utilization rates of mental health services among Asians in their American research. In their study, Asian clients suffered more severe and chronic mental health problems than other ethnic groups, consequently requiring longer treatment, hospitalization or out patient care.

Fox et al. (2001)'s research suggests that because the decision to migrate is often

viewed as a positive change for immigrant women, mental health problems may be under detected. Dhooper and Tran (1998) studied refugee Asian women and found that the health care system was ill prepared to meet the needs of Asian refugees. Health care provider's lack of awareness concerning customs, cultures and experiences of Asian refugees was seen as a large barrier to effective care. They also found that existing policies and programs lacked a comprehensive, sustained approach to address mental health problems among refugee Asian women. In Laroche's (2000) study, health status of Canadian immigrant and non-immigrant populations and their utilization rates of health services were examined over time. Interestingly, it was concluded that neither the health status of immigrants nor their utilization rates of health services differed significantly from those who were Canadian born.

Role of Social Support

The role of social support has been well documented as a significant contributor to health (Cheung & Lin, 1999; Kinnon, 1999; Li & Browne, 2000; Westermeyer, 1978; Wu & Hart, 2002). Social support influences such as separation from family and community, negative public attitudes, poverty/lack of education and role overload present barriers for immigrant women in accessing mental health services (Kinnon, 1999; Meadows, Thurston & Melton, 2001). In Li and Browne's (2000) study, it was found that the majority of Asian participants would seek help for mental health problems from family members and friends rather than a health care provider. The roles of informal social support within the family was highly regarded and help seeking often a joint family venture (Cheung & Lin).

The reliance on traditional healing practices and spiritual beliefs by immigrant women

were cited in the literature as being an important contributor to their mental health (Choudhry, 1998; Kinnon, 1999; Meadows, Thurston & Melton, 2001). For some immigrant women utilizing these practices was a normal and accepted way to manage their health concerns and very much a part of their culture and way of life. Spiritual and religious practices were seen as sources of strength and comfort and part of the context of their health practices (Meadows, Thurston & Melton).

Choudhry's (1998) study reported that immigrant women are reluctant to talk about family and personal problems with outsiders for fear of being judged. They reported that immigrant women feared that the health care provider would meddle in private family matters. Many suffer quietly as they are expected by their community to maintain cultural and gender roles. This may further isolate and limit their ability to access health care services in the community. In addition, the complexities of daily living in a large Canadian city and a heavy workload isolate many immigrant women (Ralston, 1988).

Legault et al. (1997) conducted a study among young immigrant families and practitioners to examine the health, social and cultural problems encountered and the ways in which problems were resolved. It was found there were multiple perceptual differences between families and practitioners. In the health sector, families gave priority to their children's problems whereas practitioners identified the mother's mental health problems as first priority. Problems relating to social settlement were ranked similarly in that both practitioners and families ranked unemployment and financial problems as dominant concerns. In the cultural sector, families rated isolation as the first problem, followed by day care issues and the host country's educational practices. In contrast, practitioners viewed couple relationships as the main concern. Families preferred to seek

help from formal services network when health or settlement problems occurred.

However, if a socio-cultural adaptation problem occurred, they would turn to the informal network. Interestingly, difficulties related to accessibility and compatibility of services was seen to be less serious by families than by practitioners.

There are limited and varied Canadian research studies exploring the health care provider's perspective concerning immigrant women's mental health care experiences. Bodnar and Reimer (1979) examined the accessibility and relevance of social services to immigrant women experiencing mental health problems. Interviews of health care providers revealed family physicians viewed the women's problems as unsolvable and generally the result of not adapting to Canadian society. If the immigrant woman was viewed as unmanageable, they were labelled with a psychiatric diagnosis and referred to a psychiatrist. Treatment focussed on psychological causes while not taking seriously the everyday organization of the women's lives. This study suggests that the individualistic therapy and approaches of professional social workers often tended to ignore larger socio-economic and structural factors in immigrant women's lives (Bodner & Reimer).

A qualitative study of service providers' perspectives examined the impact of policy changes on the health of recent immigrants in Toronto's inner city (Steele, Lemieux-Charles, Clark & Glazier, 2002). Exploration of the service providers' opinions revealed that reductions in funding for welfare, hospitals and community agencies had major effects on newcomers. Those effects included deteriorations in mental health, increase in wife abuse, erosion of the social determinants of health and reduced access to health care. Browne, Johnson, Bottoroff, Grewal and Hilton (2002) interviewed health care providers to obtain a description of their experiences in providing care to South Asian women.

Findings from this study revealed that discriminating attitudes of health care providers can be unintentionally demonstrated in health care interactions. These attitudes may include generalizations to explain complex issues related to marginalization and access to health care. Generalizations may also be used to explain the reluctance of immigrant women to participate in existing health care services. The researchers concluded issues of racism and other forms of discrimination coexist and continue to conflict with Canadian values related to justice and equality.

Gender Analysis

Gender analysis has been identified as particularly relevant and helpful in immigrant research. Barriers in access to services and cultural conflicts may arise when women from other countries have different expectations of sex roles. Gender is a complex variable due to the changeable and dynamic nature of social and cultural systems. The cultural and social environment affect immigrant women's responses in accessing and using mental health services. A well-supported notion is that women and men have very different physiological and social differences in relation to mental health issues (British Columbia Centre of Excellence for Women's Health, 2003; Morrow & Chapell, 1999).

Social conditions such as poverty, violence and abuse all serve to influence the immigrant women's experiences in the mental health care system. Migrant women are vulnerable to violence because of the integrated nature of the race, class and gender discrimination they experience. It has been pointed out those connections between violence and mental health issues is not always taken seriously nor is effort made to link somatic complaints with violence (Blehar & Norquist, 2002; Jiwani, 2001; Kalinowski &

Penney, 1998). Jiwani maintained that the present health care system reproduces social inequalities by privileging those who have power and abusing others. She viewed the health care system as being deeply structured around hierarchies that were based on interlocking influences of race, class and gender. She contended that the lack of language skills, unfamiliarity with how the health care system works and the bureaucratic nature of the health care system are barriers that impeded access to services for these immigrant women. Kinnon (1999) asserted that many immigrant women face double discrimination (ethno-cultural and gender), greater cultural and role conflict, and generally lead more complex lives.

Social Policy

It has also been identified that social policies create bias against women (Kinnon, 1999). Social policy in Canada has tended to view immigrant women as dependent on their spouse or family. They have limited income and make less social and cultural contributions to the economy. There is a suggestion in the literature that a bio psychosocial understanding would benefit these women as compared to a biomedical framework that has been historically used as a model for understanding mental illness (Kinnon, 1999; Morrow & Chapell, 1999).

The Immigration Act originated in 1976 and was updated in 2002 to provide laws that govern immigrants upon entry to Canada (Citizenship & Immigration Canada, 2002). It has been based on three sorting categories: family, economic and refugee classes. A relative, spouse, common-law or conjugal partner who is a Canadian citizen or permanent resident of Canada may sponsor the family class member. The sponsor is required to

assume financial responsibility for the immigrant for up to ten years. Economic class differs in that such immigrants become permanent residents on the basis of their skills and ability to contribute to Canada's economy. Although the independent class has been changed to the name 'economic class' the Immigration Act reinforces patriarchal control. Men are defined as economic agents/heads of households and women as dependents as in the family class. Immigration officers have tended to process applications of women under the family class, while men are more likely to be processed under the independent class as heads of households (Abu-Laban, 1999; Boyd, 1998; Ng & Strout, 1977; Thobani, 1999). Thus, immigration policies might have denied women a chance of being independent and autonomous.

Immigrant women are affected disproportionately by restructuring in health care that result in reduced access to health care services (Morrow & Chappell, 1999). Women of colour, Aboriginal women, ethnic minority groups, elderly and low-income women experience a myriad of impacts from actions that limit access to mental health services. It is clearly described in the Romanow Report (2002) that major changes are necessary in the funding and delivery of health care services in order to improve access for all Canadians. Access can be affected by social and cultural factors, such as gender, education, language and wealth. Language barriers may inhibit both the access and the quality of care. It was reported that the diverse needs of some immigrant ethnic groups should be reflected in Canada's health care system. Romanow identified that fragmented funding for health care services, inadequate access to services and diverse cultural and political influences will direct changes in the future of the Canadian health care system.

Manzankowski's (2001) "A Framework for Reform" reported that Alberta regional health authorities have done a good job of integrating and organizing health services. While there was better integration of many health services, mental health continued to be an exception. Separation of mental health services from regional health authorities meant limited progress in the community. The fragmentation and lack of integration with the health care system caused problems with delivery of services and resulted in communities being underserved. There was poor communication between the Alberta Mental Health Board (AMHB) and the health regions in Alberta (Manzankowski). However, in April 2003 responsibility for the delivery of mental health services was transferred to the nine regional health authorities. The numbers of health regions were reduced in order to give health authorities the population and resources to meet a wider range of health care needs, attract and retain professionals and achieve cost efficiencies. The AMHB has retained governance of province-wide services and programs. These would include forensic psychiatry, suicide prevention, Aboriginal mental health and promoting and advocating for all Albertans. Therefore, these progressive changes indicate that improvements are being implemented in the delivery of mental health care services.

The total amount allocated for mental health services in 2004/05 was 265.8 million (Government of Alberta, 2004). In addition, there are funds paid by the regions for mental health services to family physicians, primary care centres and emergency rooms. Alberta Children's Services as well as Alberta Learning also commit funds for the provision of mental health services. The amount of mental health funding provided to the AMHB in 2001/02 and 2002/03 was 214.7 million and 232.9 million respectively (Government of Alberta, 2004). However the population has also increased per capita.

Thus, funding has slowly increased each year, which hopefully will help support and improve the delivery of mental health programs and services for the immigrant population.

Summary

The literature review has shown that there are knowledge gaps. Many studies have paid attention to how health care practices based on Western cultural concepts influence the ways in which immigrant women use mental health care services. However, not many studies have examined how social support, gender, institutional and organizational structures present as barriers to women's health seeking behaviour. Thus, further attention is required to investigate whether or not underused services reflect societal and cultural barriers or if immigrant women simply do not perceive the need to seek help.

Additional research investigating barriers and facilitating factors would be beneficial in providing a clearer picture of service usage by immigrant women with mental health problems. Investigating the reasons for differences in health care utilization may prove useful for developing mental health care programs that are culturally acceptable and appropriate to immigrant women.

Little research was found addressing the extent and effects of discrimination and racism on women's mental health. However, discriminating and negative behaviours may be a part of the contextual factors that affect women's health care. Health care providers' perspectives about forms of discrimination were rarely addressed in the literature. Issues of discrimination, racism and inequities in health care have largely been ignored (Anderson & Reimer Kirkham, 1998). A better understanding of the kind and the extent of racism and discrimination experienced by immigrants is necessary to determine direct

effects on physical and mental health and indirect impacts on the determinants of health, i.e. - income, employment, social support and access to health services (Kinnon, 1999).

There is a need for more gender analysis in order to fully understand immigrant women's values and experiences. Such understanding will enable the health care system to provide more appropriate and accessible mental health care. New research is warranted in areas of policy concern where there are gaps in knowledge. This includes building on existing knowledge and the development of research methodologies for immigrant populations. A stronger focus should also be directed towards the strengths of immigrant women and their positive attributes (Kinnon, 1999).

Research questions.

To meet the purpose of this study, I will answer the following research questions:

- 1) What are the experiences of health care providers regarding immigrant women's mental health concerns?
- 2) What are the contextual factors that influence immigrant women accessing mental health services in Calgary through a health care providers perspective?
- 3) What intervention strategies would help health care providers to meet the mental health needs of immigrant women and provide higher quality care?

Chapter III: Methodology

Evidence from the literature review has suggested that qualitative methods are most appropriate in answering the research questions that form the purpose of this study.

Denzin and Lincoln (2000) state, "Qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings individuals bring to them." (cited in Wood & Haber, 2005, p.166).

"Methodology" in this research study is defined as the means to how I obtained and analyzed the data through qualitative methods. These methods focus on the whole of human experience and the meaning ascribed by individuals living the experience (Wood & Haber, 2005). By using an exploratory and descriptive method, I was able to embrace and focus on the immigrant woman's mental health care experiences through the health care provider's perspective. Wood and Haber suggested that the method be congruent between the researcher's worldview and the research question. My worldview is that as humans we are intimately connected to each other and the environment. There is special meaning attached to our everyday context. With these beliefs in mind, my effort was directed to uncover the meaning of the immigrant woman's mental health care experiences. My essential goal was to increase the understanding of what would assist the health care provider to best meet the mental health needs of the immigrant woman.

Particular research questions helped to guide the study and also formed the research purpose. I was able to investigate the women's experiences and gain insightful data through in-depth interviews. Rich data was obtained by asking the health care provider certain questions concerning the immigrant woman's mental health concerns. By exploring with the health care provider the contextual factors that influence the

immigrant women accessing mental health services, the barriers the women face were made clear. Throughout data collection and analysis, I was informed and guided by my theoretical framework as it provided the basis to help me describe and understand the data and rich details of context in which the immigrant woman lives.

Theoretical Framework

A post-colonial feminist perspective.

A post-colonial perspective challenges ideas of a universal standpoint on development of knowledge. There is a need to forge links between post-colonialism and other discourses to challenge and address injustice and inequalities, and to correct imbalances in the world (Quayson, 2000). Post-colonial feminism is one of the critical theories that provides a theoretical lens which allows access to the everyday experiences of marginalization as structured by the macro dynamics of structural and historical nature and the micro politics of power. This lens raises analysis beyond the micro level to provide an enquiry into the multifaceted socio-economic, historical and political forces which shape the human experience (Reimer Kirkham & Anderson, 2002).

This post-colonial feminist perspective enabled me to direct and investigate the experiences of immigrant women through a health care provider's perspective. A primary aim of this perspective is to correct social injustices and thereby address unequal social power relations that contribute to the unequally distributed health care resources and inaccessibility of health care services for immigrant women. This perspective supported my understanding that each woman's life is shaped by history and that by asking questions from a particular epistemological perspective one can take into account the context in which each life is situated. My open-ended interview questions were aimed at

obtaining data on how race, gender and class relations influence social, cultural, political and economic factors, that in turn could have effects on the immigrant women's everyday life. For example, one of my first questions explored the immigrant women's experiences with mental health care access: "In your opinion, do you see immigrant women having difficulties accessing mental health care services?" This question provided invaluable data on the health care provider's view of the difficulties and structural barriers immigrant women face. It also increased the researcher's awareness of the contextual factors that intersect and help organize the woman's experience at any given time. Social and economic position is extremely important to consider when looking at the immigrant woman's situation. I also explored with the health care provider how the role of gender might affect the ways in which immigrant women access mental health care services: "In your view, do you think gender issues affect immigrant women's mental health care experiences?" This helped me to understand the significance of gender roles in influencing how immigrant women seek help. Viewing this population's situation within a larger social context and exposing social inequities, policies and practises may be fostered which result in better social justice (Reimer Kirkham & Anderson, 2002). Exploring negative attitudes and relationships between health care provider and client also provided important insight into how these factors contribute to mental health care access issues. Lastly my questions were aimed at seeking methods to decrease the access barriers and improve the understanding of intervention strategies that will help meet the mental health needs of the immigrant women.

Although post-colonial discourses are not well known in nursing research, there is an emerging need to incorporate post-colonial perspectives into nursing science as an

alternative to the culturalist approaches that dominate nursing theory. Such theories perpetuate stereotypical views of culture and race in our health care settings and communities. Ideas about different cultures are often used to explain difference, without an appreciation of the ways in which culture and race operate (Reimer Kirkham & Anderson, 2002).

Cashmore (1996) defined post-colonialism as empirical, theoretical work centring on issues that stem from colonial relations and the various forms of cultural and political resistance. Post-colonial theory offers nursing scholarship with its interpretation of culture, race and racialization, a set of powerful analytic tools to move forward to address social aspects of health and illness and existing inequities. The feminist perspective lays the groundwork to analyze gender, race and class relations as simultaneous forces and to examine the production of knowledge from different social and political locations. Therefore, these perspectives together with a gender and class analysis inform a post-colonial feminist methodology of the study (Anderson, 2001).

A post-colonial feminist perspective was utilized in this project to provide a valuable analytic perspective in the development of knowledge for nursing practices (Anderson, 2000; Anderson & Kirkham, 1998). It also provided a theoretical lens for unmasking the colonized processes which have been formed through racialized and gendered identities. However most salient is that this perspective recognizes the need for knowledge construction from the marginalized female whose voice has been silent during the process (Dyck, Lynam & Anderson, 1995).

Three primary tenets of post-colonial feminist research characterize how this entire

research project was viewed. Firstly, post-colonial feminism is critical of the traditional social sciences; its ontological and epistemological underpinnings argue against the objectivism and value free epistemology of traditional scientific inquiry (Ghandi, 1998). Thus researchers theorize that knowledge is socially constructed and value laden. Viewing through a political lens attends to the micro politics and macro dynamics of power and explores how domination and resistance mark the cultural encounter at individual, institutional and societal levels (Reimer Kirkham & Anderson, 2002). Also paramount to the research study was the researcher's awareness that his or her race, class, gender and culture may shape the research process. Positionality of the researcher was also acknowledged and incorporated into research analysis (Anderson, 2001). As a researcher I am aware that I may bring certain biases, values and beliefs into this research process. My background as a Canadian, middle class woman and health care provider are acknowledged. Through years of providing nursing care to immigrants, I am highly motivated to conduct this research in order to provide more appropriate and quality care to immigrant women in need.

Secondly, post-colonial feminist research situates human experience in the larger context and is committed to examining how race, gender and class relations influence social, cultural political and economic factors, which in turn shape the lives of immigrant women. Therefore, in this project I explored how racialization, gender roles, expectations and class hierarchal relations may shape individual health care practice. Such a perspective may encourage researchers to shift their focus toward examining how health care institutions and policy affect women's health and health care rather than viewing the immigrant women as totally responsible (Donnelly, 2004). One of the most important

functions of post-colonial feminist research is to illuminate the ways in which unequal social power relations contribute to the unequally distributed health care resources and inaccessibility of health care services for immigrant women. In doing so an understanding was reached that difficulties immigrant women face in accessing and utilizing health care services may not be due to their culture, but rather to historical processes that have produced oppression and systemic inequities (Anderson, 2000).

Thirdly, a feminist project is a social justice project that places women's experiences at the centre of analysis (Anderson, 2002; Collins, 2000). A basic concept of the post-colonial feminist perspective is that knowledge must be set within the conditions of the world today and in the multiple perspectives of class, race and gender and other group affiliations (Anderson). Goals of the feminist perspective are to establish collaborative and non-exploitive relationships. This perspective places the researcher within the study to conduct transformative research. An essential element of feminist thought is the viewing of gender as a basic organizing principle that shapes the conditions of individual lives. It is a lens that brings particular questions into view (Fox-Keller, 1985). Lather (1991) viewed this ideological research as a relevant way to end women's unequal social position. The aim of feminist research is not only to generate a more accurate account of women's lives from everyday experiences, but also to communicate new knowledge to change the oppressive conditions in which they live. Feminist research is politically driven in the sense that it challenges the dominant forces that shape women's lives and seeks answers as to how to address and correct injustices (Anderson, 2001). In this research, the immigrant women's experience was investigated from the health care provider's perspective. I do acknowledge and recognize the importance of both the

immigrant women's perspective and health care providers' perspective. Due to time and financial constraints, a thorough investigation of both perspectives was not feasible for this project. Furthermore, I also acknowledge that the health care provider participants in this study worked directly with immigrant women and were committed to providing quality mental health care services for them. Hence this study will provide relevant information to future development of mental health services and research for immigrant women.

Concepts of culture in the past have been treated as static and factual. Through a post-colonial feminist perspective one can illuminate how cultural concepts are socially produced and constructed. This perspective directs health care providers to not see health from a neutral standpoint of belief systems stripped of social context (Anderson, 2001). New insights bring us a step closer to deconstructing and re-writing knowledge to redefine the relations of power and privilege. These shifts in cultural meanings are not neutral and one must recognize that they are constructed with relations of unequal power (Anderson, 2001).

Kleinman's explanatory model.

For the purposes of this thesis, I draw on Kleinman's (1978) definition of culture whereby culture is viewed as a system of symbolic meanings that may influence the experience and social reality of the immigrant woman. The environment that one lives in is linked to culture as well as to experiences of health and illness. Therefore one must be aware that to understand the immigrant woman's health care behaviour there is a need to understand their conceptualizations of health, illness and disease, as well as how their cultural values and knowledge may shape this experience. The importance of local context and culture is paramount in understanding and making sense of everyday life.

There are many complex factors that shape the immigrant woman's responses to health and illness.

Culture can shape individual responses to health and illness. Cultural background has a significant influence on people's lives: perceptions, emotions, languages, diet, dress, body image, behaviours, family structures, concept of space and time and attitudes to illness and pain. However, culture must be seen in its particular context in relation to historical, economic, political and geographic elements (Donnelly, 2002; Good, 1994; Helman, 1985; Kleinman, 1978). Although health care decision making in illness and health occurs within a cultural context, factors such as social, political, historical, and economic differences influence the immigrant women's situation and shape their mental health experiences. Health care providers must strive to recognize difference in perspectives and the complex interplay of factors to provide holistic care. Furthermore, health care providers need to pay attention to how culture is conceptualized in research and in everyday nursing practice.

Kleinman's (1978) explanatory model concept was used as a theoretical perspective in this study. To increase the understanding of how cultural concepts in mental illness could be useful, Kleinman presented concepts and a model for comparison of medical systems as cultural systems. He maintained that health, illness and health care are parts of a cultural system and need to be understood in relation to each other. Three structural domains of health care in society are suggested: 1) professional sector includes health care providers; 2) popular sector contains family, social network and community; 3) folk sector is comprised of non-professional healing specialists. Each domain possesses its own explanation of health and illness. This is key in recognizing that

different views of health and illness may be brought to the health care provider-client encounter. The meanings assigned to events within the context of the immigrant women's experiences provide an awareness and understanding of how the immigrant women may develop their ideas about what is salient in relation to an event and how their ideas may influence their behaviours.

With these thoughts in mind, I developed my interview questions to explore whether there were differing views of health and illness by the immigrant woman as seen by the health care provider. The question: "In your opinion do you see immigrant women having difficulties accessing mental health care services" helped to provide a comprehensive way of viewing the context in which immigrant women accessed mental health care services. The popular sector comprised of family, social network and community was seen as most influential in the decision making of whether to seek outside help and treatment choice. This is particularly important information to understand when you are trying to provide and negotiate meaningful care and support for the immigrant woman. In the data analysis stage it became very apparent to me that conflicts between the professional and popular sectors were bound to occur, resulting in misunderstandings and difficulties between the health care provider and immigrant woman. Recognizing and placing special attention to the three structural domains will help to gain increased understanding by the health care provider as to how to effectively bridge gaps between the sectors. I interviewed the health care provider to find out what would be helpful to meet the immigrant woman's mental health needs. This kind of question revealed data concerning the importance of the health care provider-client relationship as well as the problems that may arise when explanatory models are not shared by others. These

conflicts may also be the result of unequal power relations within the health care relationship. Relevant information as to how the health care provider-client encounter could influence the immigrant woman seeking help was obtained. Although different perspectives and views would occur, the most salient issue is the negotiating process between health care provider and client in providing acceptable and effective health care (Kleinman, 1978).

Kleinman (1988) also addressed professional and cultural barriers involved with mental illness and prevention. Social forces overwhelmingly play a significant contribution to the onset and course of mental illness and therefore do play a role in its prevention. He believes there is a systemic resistance to dealing with social sources of mental illness conditions. Due to difficulties in establishing practical social programs, health professionals and policy makers may focus more on providing drugs and psychotherapy to treat individual episodes of disease.

Kleinman's model also directed me to understand and explore the immigrant women's mental health care experiences in relation to the health care system. The discourse of biomedicine shapes the ways in which illness, disease and health are conceptualized and in turn promotes a certain kind of treatment for the health problem. Dominant biomedical ideologies neglect the wholeness of the person and little attention is paid to the complexity of the interrelationship between subjective experience and socio cultural contexts (Kleinman, 1980). Health care providers may not always be aware of the complex interplay of factors that influence client responses to professional care.

The impact of culture on the assumptions health care providers and clients bring to the negotiation encounter often goes unrecognized. Dyck (1995) suggested using a "local

context”, i.e.- making sense of everyday life and organized behaviour. This is a salient point for health care providers to understand and use in their every day communication with patients. By making room for shared perspectives, shifts in perspectives are created as new-shared knowledge. Health care providers working with immigrant women need to recognize that cultural differences shape and influence the individual’s coping choices and strategies. However, the individual’s circumstances need to be considered (Donnelly, 2002). As noted earlier, Kleinman (1978) stressed the importance of negotiation in each patient-health care provider encounter. Bhabha’s (1994) notion of hybridity viewed culture as partial and ambiguous, constructed in a space of negotiation. His powerful writings extend our thinking about culture as a negotiated process, rather than fixed in time or handed on complete from one generation to the next.

It is suggested that a postcolonial feminist scholarship is useful in offering an alternative perspective on knowledge development in nursing that would help to address more thoughtfully issues of equity in health and health care reform (Anderson, 2001). Anderson stated that it would enable the health care provider to view with increased clarity the complex issues at the intersection of gender, race, class relations, and culture, and increase our understanding of how material existence influences health and is shaped by history. When immigrant women experience difficulties in accessing and utilizing health care services, this may not be due to their culture but rather historical processes that have produced oppression and systematic inequities (Anderson, 2000 a, b). Anderson (2000) suggested that the post-colonial discourse provides ground for interrupting ahistorical, essentializing, generalizing, culturalist and racializing discourses. A potential to reframe these dominant discourses is possible through dialogue and to create

knowledge that reflects multiple social locations. However, according to Anderson (2000) this is not possible until the marginalized experiences are recognized, respected and treated as legitimate in the social production of knowledge. In this study, the marginalized immigrant women's health care experiences was the focus of my analysis. Through interviewing health care providers that were directly involved with immigrant women and their mental health care experiences, the immigrant woman's mental health care experiences were illuminated. This study will provide information pertinent to the development of mental health services and future research among immigrant women.

Through postcolonial perspective, a theoretical lens was provided to critically examine how racialization, class, gender and history intersect to shape socio, political and economic agendas in health care. In this research I conceptualize the interlocking influences of race, class and gender, and other social relations that influence immigrant women's lives, because health and illness are closely allied to the complex interplay of these factors. This awareness will help health care providers put into context immigrant women's life experiences and the intersecting of social relations that influence their health and health care behaviour. These social relations shape health and illness meanings and organize the ability to manage illness. Therefore when health care providers understand this population's experience and social relations, institutional and organizational infrastructure and policies will hopefully be changed to better serve the needs of immigrant women. By developing a heightened awareness of structural barriers that are imbedded in the health care system, health care providers will benefit in practice, research and education to overcome both institutional and individual barriers to care (Browne et al., 2002).

Site

This research was conducted in Calgary, Alberta. The population of Calgary in 2001 was 878,866 with immigrants being 22.5 % of this total (Stats Canada, 2003). Data collection was conducted in several Calgary health care facilities that provided mental health care services to immigrant women. Interviews were conducted with health care providers who provided direct mental health care services to immigrant women.

Participants

Seven participants were selected from different health care settings to illuminate diversity in perspectives and gain insight from individuals who practice on various levels of health care. Acute care and community based health care providers were chosen who were working in direct contact with immigrant women and promoted mental health care. Several health care disciplines were included to see whether they viewed the immigrant woman encountering specific kinds of barriers and contextual factors. Participants were from diverse ethno cultural backgrounds such as Chinese and South Asian, and included two Caucasians. Both genders were represented in the sample. The rationale for using seven health care providers was based on the supervisory committee recommendations due to time and financial restraints of a Master's thesis. As well my decision to interview seven health care providers was not to obtain data saturation, but rather to gain insight and understanding concerning the immigrant woman's mental health care experiences. Participants profile follows:

Pseudonym	Area of Practice	Years of Experience
Ruby	Immigrant family counsellor	28
Lisa	Outreach/education Counsellor	33
Hannah	Acute care-Mental Health	19
Charles	Acute care- Mental Health	20
Marie	Community Health outreach & counseling	20
Charlotte	Individual family counsellor	10
Christie	Immigrant family counsellor	5

Entry into Site

Gaining entry was a gradual process that was negotiated through several organizations. The Calgary Health Region, Calgary Immigrant Women's Association, Calgary Family Services and Catholic Family Services were organizations that were instrumental in providing contacts. I was also afforded the opportunity through a course practicum to visit health care providers in various community agencies that offered mental health services to immigrant women. This networking proved invaluable, as I later was able to purposively select suitable participants for the study.

Criteria for Selection of Participants:

- 1) English speaking
- 2) Health care provider (i.e. psychiatrist, psychologist, registered nurse, social worker or counsellor) working in direct contact with immigrant women and mental health issues in the community
- 3) At least two years working experience

Through the guidance and permission of key individuals, I was able to gain access to health care providers working directly with immigrant women and mental health issues in

the community. Through many referrals and conversations with health care providers in settings where mental health services were provided to immigrant women, I carefully selected my participants. My aim was to obtain a rich information source. A purposive sample of seven health care providers was selected. Each participant had two interviews lasting 30-50 minutes. However, due to work obligations and time restraints one participant was unavailable to do the second interview.

Method of Data Collection

The method of collection was in-depth interviewing using a semi-structured interview questionnaire. The semi-structured questionnaire encouraged the participants to explain their experiences in their own words (Morse & Field 1995). Open-ended questions (see Appendix A) were used as prompts to encourage the participant to talk about narratives that provided rich, descriptive context.

Ethical Considerations

Permission to conduct this study was obtained from my thesis committee, the Conjoint Scientific Review Committee and the Conjoint Health Research Ethics Board (See Appendix B). All participants were given a letter that provided information about the study (See Appendix C). Consent forms were signed prior to the first interview (See Appendix D).

In the writing of this thesis, I paid great attention to preserve anonymity and protect the privacy and confidentiality of the participants. Participants were identified by pseudonym and code only. All data published will maintain the confidentiality of all participants. Data collected is kept in a locked and secure environment. The interview tapes will be destroyed seven years after the completion of the study.

I was attentive to the fact that by interviewing health care providers I may uncover sensitive issues concerning clients or co-workers, which may be distressing for the participant. In this situation I was equipped with information concerning counseling supports.

I acknowledge that as a researcher I may bring certain personal biases, values and experiences to the research process. With this awareness I have been careful to monitor this during the research activities by keeping a journal to write down my feelings. This process of “reflexivity” is where researchers constantly challenge themselves to see that their own perspectives are not affecting the research method, analysis or interpretations (Wood & Haber, 2005). In addition the second interview allowed me to return to the participants to present a preliminary analysis of the data and ask for validation and any further clarification.

I am also well aware that the way in which I asked questions could influence the data obtained, therefore every effort was made to avoid asking leading questions in the interviews.

Data Analysis

Each participant had two interviews. The duration of these interviews was approximately 30-50 minutes with the second interview being a member check. The second interview involved returning my preliminary data to the participant along with my initial analytic interpretations. This process enabled me to clarify, expand and discuss with the participants emergent themes, ideas and concepts. The process of data analysis and data collection occurred concurrently. Particular direction was taken from Carspecken (1996) Sandelowski (1995) and Denzin and Lincoln (1994).

Four steps were involved: 1) The interview data and field notes were taped and transcribed verbatim as soon as possible following the interview. As data was obtained to ensure accuracy, transcripts were rechecked against the audiotapes, corrected and a hard copy obtained for preliminary analysis. 2) In the early stages of analysis, transcripts were coded to identify preliminary themes from the data and a list of code categories were formulated for organizing incoming data. Code categories were refined as subsequent data was gathered. 3) Data coded in one category was sometimes seen relevant to other categories. The outcome of this analysis was a set of complicated interrelated concepts and themes. This process involved a systematic and rigorous development of code categories and sub-categories and was flexible and evolving. It was also used to draw on in the coding of subsequent transcripts. Meetings with my supervisor occurred regularly to review and share reflections on the process of conducting the interview, personal feelings and analytic descriptions. 4) Themes and concepts were used to compare within and across transcripts in the data set and across cases. Generated from these themes was a higher level of data conceptualization and broader theoretical formulations. The second interview permitted me to return the data to the participant along with my analytic interpretations. This step in the process enabled me to develop a deeper understanding of the data and gain insight that helped to move my analysis from individual experiences to the exploration of the social processes and structures that organize experience.

The dominant themes that emerged from data analysis were difficulties of health care service access, the influence of culture and the health care provider-client relationship that also may affect women's health care experiences. My data revealed that immigrant women face difficulties with access to mental health services, cultural values and

practices, and the health care provider-client relationship exerts great influence on the ways in which immigrant women seek mental health care. The next three chapters focus on the findings and discussion of these themes. The final chapter is a discussion and recommendations of this study, including implications for nursing and future inquiry.

Chapter IV: Findings and Discussion: Difficulties Accessing Health Care Services

This chapter focuses on the findings and discussion of the difficulties that immigrant women face when accessing mental health care services. Through the health care provider's perspective, the immigrant women's experiences and contextual factors such as language skill insufficiency, the unfamiliarity and lack of awareness of available services and low economic status are examined as to how these factors might influence immigrant women's access to mental health care services. I also investigated the role of gender and structural barriers to access in mental health services. Throughout the chapter, various intervention strategies identified by the health care providers are presented. The participants cited numerous difficulties for immigrant women wanting to access mental health care. However, five dominant sub-themes were consistent throughout all interviews with the health care providers. Firstly, the most evident sub-theme was the language barrier, which created a myriad of problems for many immigrant women. Secondly, the participants voiced consistently that the unfamiliarity with the mental health care system and the lack of awareness of mental health services available were real concerns affecting immigrant women's access to mental health care. It was suggested that the unfamiliarity of mental health services may result in the immigrant woman's fear and mistrust of Western biomedicine. Thirdly, it was suggested in the data that the structure of the Canadian health care system might also be part of the difficulties experienced by immigrant women. Fourthly, it was reported that the social determinants of health presented challenges to accessing mental health care services. Socio economic factors, education level and social isolation influenced the immigrant women's situation and shaped their mental health care experiences. Fifthly, the role of gender was viewed as a contributing influence with far-reaching effects on how the immigrant women would seek mental health care

services.

Language Barrier

Language barriers have far out-reaching effects and may present multifaceted challenges to both the immigrant woman and health care provider. According to some participants, many immigrant women living in Calgary experience not only practical difficulties but also emotional distress. These difficulties are often in the social context of these women's lives. Major problems arise in the social context of living as a non-English speaking immigrant and as a woman in an industrialized urban setting. The following statements by a participant described what she saw as dilemmas and realities of the immigrant woman:

What often happens is we see some very confused clients with whom you have to spend a lot of time putting pieces together, because they'll come in and describe maybe a doctor they have seen, but sometimes they are not able to explain. I think because of the language barrier, they do not understand the context in which they have seen the doctor or they will receive a letter from Alberta Health, which they don't understand. When they come to tell me their story, I only hear a fragment of the story... to hear what's really going on you have to spend a lot of time with them.

English as a second language.

Several factors preventing women from acquiring English language skills were very prevalent in the data. English language training is not easily accessible to immigrant women. Coupled with the demands and responsibilities of childcare, housework, and a job outside the home, the expense of the language training classes may make it difficult for the women to attend. This is clearly identified by one participant:

A lot of times they might have stayed longer in this country, but they have not had a chance to practice their English, so they have to pay for it; the classes can be quite

expensive 300-400 dollars a course. So English as a Second Language (ESL) is not totally free here and then you have other issues... transportation, the commitment to home chores... so it's really hard.

Language training will continue to be an important issue because of the increase in numbers of immigrants from non-western source countries. In 2002, 49 % of immigrants to Calgary had no official language ability, an increase from 45 % in 2000 (Citizenship & Immigration Canada, 2003). Thus, continual funding for ESL education is critically needed to meet the increasing demands. The Calgary Board of Education reported that the enrolment of ESL students has increased from 3,073 in 1991/92 to 8,836 in the year 2000/01 year. This is an increase of 187 % (City of Calgary, 2003). A recent update from the Albert government revealed that grants to support non-profit immigrant serving agencies for provision of settlement services and ESL training has increased to a total of 4.5 million in 2004/2005. For comparison the grant was 2.9 million in 2000/2001; a total increase of 25 % (Government of Alberta, 2004).

Learning English is essential for enhancing employment, daily activities and quality interactions within the healthcare system. Language continues to be a barrier for many immigrant women, and recent increases in funding for ESL will help to alleviate this problem. However, it remains to be seen if an increase in funding meets the demand for English training by the immigrant, given that 22.5 % of Calgary's population are immigrants.

Interpretive services.

Some participants also stated that next to acquiring ESL there is a need for interpretive services. It is not always available to all health care service providers in the community as depicted in the data. In the past several years, the Calgary Health Region (CHR) has worked toward improvements in this area. Participants from CHR sites were optimistic and reported

an increase in the availability for interpretive services. In contrast, participants from community based service agencies that did not work for the CHR spoke of the shortages of bilingual health care providers available to do this kind of work. This would include not only interpreters, but also bilingual health care providers. Hannah commented: "I don't think there are enough professionals available to do this kind of work... there are very few doctors who speak the language and those who do, have waiting lists so full, and long, they have a hard time getting in." Ruby agreed: "Major languages are covered but it can be quite difficult with a lot of languages; it's hard to hire people just for a few hours here and there."

A social worker that counselled the non-English speaking woman maintained: "There is two month long waiting lists for some of these individuals when they're trying to see a psychiatrist with Canadian Mental Health... sometimes I would recommend seeing their family doctor first."

A bilingual health care provider spoke about the frustration and lack of support for these women in the community. Not only is there a lack of interpreters but also a shortage of health care providers who speak the language. This is especially challenging when providing mental health care counseling. Christie, one of the participants, wondered why there are no support groups for non-English speaking immigrant women who have mental illness related issues:

It's simply not available... if they get an interpreter to the group it just wouldn't work for it drops the group dynamics [response she gets from service providers in the mental health system] They are not able to go to the support groups because of language barriers.

Lisa, another participant, stated it was not an easy task to provide bilingual support groups because of the complexities of the situation. She maintained it was not the sole responsibility of just one group to provide those kinds of services: "Resources are just not there...there has

to be inter-organizational and agency cooperation. Ethno cultural communities have to take some lead in providing support.”

For some of the non-profit agencies in the community, providing services to immigrant women can be very challenging due to time and financial constraints. Although the CHR has made great improvements in providing interpretive services and provides interpreters in many languages, these services only provide for the most common languages based on Calgary’s demographics. The health care providers also have access to the United States based language line that is now used for back up services. This is a welcome improvement for many health care providers who are involved with the non-English speaking population. However, this interpretive service when accessed by smaller non-profit health care agencies can be very costly. Other counseling agencies in the community must rely on internal staff or finding their own interpreters. As a result, some agencies provide counseling in only certain languages but will refer clients elsewhere. Therefore, the access to interpreters is quite dependent on where one works in the community. This, in the participants' view, limits immigrants' access to mental health care services.

An interesting observation by the participants interviewed was that they themselves were predominantly from different ethno cultural groups and were able to speak more than one language. It was generally agreed that more emphasis should be put on this strategy of recruitment and retention of bilingual health care providers. It was also suggested that attention should be directed toward educating and creating interest within the immigrant youth population to pursue careers in these health care fields. Long-term support would involve expanding and ensuring bilingual, competent health care providers, within our mental health care system. Charlotte offered these suggestions:

Change needs to happen in the system...more outreach to communities and the youth

of those communities about the education...kind of interest building in terms of those fields to create and support....It is another level of systematically reaching out to have educated, bilingual culturally competent professionals within the community... Creating those career fair situations within those communities to target the youth that are already in the university or about to go

The CHR has recognized that stronger emphasis should be placed on professionally trained interpreters. An external ethno-cultural consultation project at CHR (2002) found that access to trained health care interpreters was the single most critical barrier to health care for those populations. Action was taken to develop a health care interpretive program within the region to reduce these access barriers. CHR's interpretation and translation services now consist of certified interpreters who have had specialized training in health care interpreting. In the community setting this effort has supported many health care providers in striving to deliver appropriate care. In trying to improve access and communicate effectively with a non-English speaking immigrant woman, it is particularly important to have a trained interpreter present. One of the participants attested to this well: "You do not have to allow the family members [in], which again with women particularly if there are all these gender hierarchal issues, their voice isn't heard or their access is limited."

Also of note is the Calgary Health Region's strategy to increase the awareness of bilingual health care providers within the region and in the community setting. This will be a directory of key people and areas related to mental health offering bilingual services. The directory will be made available to all health care providers working with immigrants and refugees within the next year (personal conversation with CHR official, 2004).

Another major problem was lack of translated materials, according to most participants. There was very little in terms of written materials, audios or videos that could be helpful to immigrant women. One participant noted that although there have been many initiatives to improve services for the ethno-cultural population and form partnerships within community agencies, there is an ongoing need for translated materials. One of the participants, Marie, questioned: "Why are we still behind in that? Even Grace Women's Centre should be equipped with all kinds of resources. They don't have very many multi-cultural resources at all." Lisa also pointed out:

[Immigrant women] will often say 'yes, I know English to be able to function on a day to day basis, but when I am stressed or upset it is much easier to communicate in my own language'. Having access to interpreters and translated materials is very important... providing [resources] in their language enhances the information.

Another participant, Ruby stated: "It's complicated, there is cost but I see more places looking at it. We're providing first language services, hiring more diverse staff, and now [we need to look at] the written materials... what are the tools needed?"

Translated materials are an essential in making information available and increasing the awareness of what mental illness is and what are the mental health services and resources for immigrant women.

Unfamiliarity and Unawareness of Mental Health Services

Throughout all interviews the lack of information and lack of awareness of mental health services by immigrant women was a prevailing theme. Most participants agreed that there was a lack of awareness of what resources are available to these women and that these resources would be too expensive for this group anyway. As Charles phrased it:

It prevents them from even accessing the health care system in the first place

[because] they think they are not able to afford it...and then lack of awareness [has] resulted in family members not identifying issues for a long time, so when we see them they are actually quite ill.

Most participants expressed their concerns about service provision. They felt that some immigrant women do not understand what the services can do for them. Counseling may be an unfamiliar process and not a part of how these women coped with their problems in the past. Talking to someone outside the family about these issues may be seen as disloyal and an unacceptable choice of treatment. Thus, the unfamiliarity of the social services and delivery of mental health care might have kept the immigrant women from accessing services. As Lisa clearly stated: "If you don't know the services exist why would you go and access them?" Hannah was mindful of the enormity of changes for the new immigrant woman: "It is a huge change when they [immigrants] first arrive...even in terms of how to shop for groceries and clothes." She reflected on a past client with depression who was not only unfamiliar with the health care system, but also with basic activities of daily living:

[The immigrant women] did not know that you had to pay before you took food out of the shopping centre. She picked something up and she had money in her hand to pay but she heard the bus coming...she ran out and got caught. She was quite depressed to begin with... [now the client] was so terrified... completely psychotic and very paranoid.

Ruby offered a strategy from her practice that many times has linked the immigrant woman to the community for support:

Recognizing the vulnerability of this population ...knowing the rocky, difficult long road they may have had getting to me and it may be another five years if connections [aren't made].... maybe [the immigrant women] decides that counseling is not what they wanted... you let them know what other [resources] are available, whether it is a

translation line they can call or a women's group where they can go and talk. You try to give them as much as you can as quickly as you can so that if they stop coming to see you...

Concepts of prevention and follow-up were foreign to many immigrants. Most participants agreed that "talk therapy" is a significant part of standard treatment but may be viewed as intrusive and unacceptable for many clients. One participant stated also that many cultures do not have an extensive range of professionals. However, the Canadian mental health system relies heavily on interdisciplinary teams and often the individuals just don't know who these health care providers are or what they can do for them.

Mistrust of Western biomedicine.

The misunderstandings of service delivery and the unfamiliarity of Western biomedicine affected the immigrant women in various ways. Participants often mentioned fear and mistrust of Western biomedicine. Another difficulty voiced by participants was unfamiliarity with the mental health services. Often the mistrust centres around not understanding or trusting medications for their mental illness. Many immigrant women use alternative medicine practices and prefer to use their own medications. Charles states:

It's almost an irony because a lot of them put their trust in their physician but when they go home they don't follow...[directions]. They [the immigrant women] don't tell us, they are afraid. They tend not to trust the medication as much."

Lisa also stated:

Many of us don't even think how our systems programs or services are delivered... the treatment modalities, they are all based on Western medicine; so if the medical culture you have come from is very different, you are not going to understand.

Historically, mental health services and treatment regimens have been centred on the Western biomedical model (Morrow & Chappell, 1999). The biomedical model has traditionally focused on disease while patients have focused on the experience of illness, and the societal reaction to it (Kleinman, 1978). There is great debate about the utility of using a disease model for understanding women's mental health problems (Morrow & Chappell).

As well, the biomedical focus is on modifying the behaviour to increase compliance and reduce risk factors rather than addressing social and psychological issues. This dominant discourse of biomedicine shapes the ways in which illness, disease and health are conceptualized and promotes certain treatment of mental health problems. There may be neglect of the holistic approaches for these women and little attention paid to the complex interrelationship between subjective experience and socio-cultural contexts in their lives (Morrow & Chappell, 1999). For the immigrant women, this may result in their needs and concerns are not being fully understood or taken seriously. These same women who have not felt understood or welcome are less likely to access or seek appropriate health care within the health care system. The unfamiliarity of Western biomedicine combined with past inappropriate treatment perpetuates their fears and confusion about accessing mental health care services.

In the past, biomedical practices and theories have often excluded an analysis of the unequal distribution of health care, social inequities and policies that have created barriers for immigrant women to access health services. These exclusions have resulted in the medical profession giving less attention to historical and macro social factors of the health care system (Donnelly & Long, 2003).

Construction of the Canadian Health Care System

The construction of Canada's health care system may also be part of the difficulties that affect immigrant women's everyday lives and influence their health. The health care system cannot be separated from broader economic, social and political contexts. It has far-reaching effects as it is intermeshed in a gendered and racialized construction of nation. The Canadian health care system is one of the best in the world, yet one sees the contradictions that reveal the deeply structured hierarchies based on race, class and gender (Jiwani, 2001). These difficulties experienced by immigrant women in the health care system cannot solely be explained through a cultural lens. Jiwani stated that it means addressing the structural issues and viewing the complexities of social inequities from different angles. She maintained that in the health care system there are multiple forms of inequities based on race, gender, class, social background and sexuality. The structure of the health care system may make it inaccessible for many immigrant women. For example, scheduling of clinic hours, inability to take time off work and the need for interpretive services can make access problematic. Ruby captured this:

You take ...the regular barriers that a person might have looking after themselves...it's really exacerbated for immigrant women... worried ...whether they're able to explain themselves...the cost of transportation to get there, not knowing how to take the bus, childcare....they don't have the flexibility...there's kinds of jobs where if they take any time off it's at no pay.

There are individual and systemic access barriers that make it difficult for the immigrant woman to access mental health services. In the present section, I will discuss findings that are more specifically related to systemic and structural access barriers of the health care system. Acknowledging that both systemic and individual access barriers may

exist for the immigrant women, in a subsequent section pertaining to the relationship of health care provider and client, individual structural barriers will be addressed.

Fragmentation of care.

Several of the health care providers agreed that some immigrant women might be aware of services available, yet were vulnerable and easily confused as to how the system worked. A health care provider from a community service agency encountered this often and viewed the problem as resulting from a lack of coordination among different health care providers: "No one has the whole story, everyone has a piece of it." Christie, who counsels many immigrant women, attested to this:

[The immigrant women] has a complaint... They don't know where to go or who to go to address those issues. Maybe they feel ignored or left out by the system...

They've been told to do one thing, [to see] someone else, only to be told they don't offer such service... they don't have an interpreter, [they've] been told someone will call them back and no one does call...

Christie related this back to herself: "If I am dealing with someone who speaks a language that I don't [know]...when you are so busy and have so many cases to manage... usually those are the ones you tend to [put off]...you know." She also believed that a reformation of case management surrounding complex cases would help the client to avoid starting all over again with another health care provider. One participant noted:

If you are a counsellor in a stand-alone agency you have to work with other agencies... other child welfare workers. We already have many cases, [health care providers] working together... we have a tight network among ourselves and that facilitates the case management process....

A criticism of the health care system by one health care provider was the assumption

that everyone has someone who can support him or her. She felt that the expectation is that somehow the individual will survive and cope after discharge from hospital, with or without help at home. Limited discharge planning and support is an example of the fragmentation of care within the health care system. Lisa explained:

Our health care system is over extended... we all know about discharge and home support services aren't overly extensive...so by looking at how our system works...you throw in newcomers who might not have [anyone] it takes a lot of strength and courage to survive.

Conversely Ruby observed that in her experience with immigrant families, she has noticed improved levels of care. There was more coordination of services with immigrant families as compared to the non-immigrant ones. These complicated multifaceted cases may present an overwhelming challenge and usually one is not able to work in isolation. Ruby maintained that these kinds of cases demand a strong coordination of services; otherwise clients ultimately will not get the appropriate support needed. Furthermore Ruby felt that follow-up from hospital had improved and health care providers were also reaching out to the hospitals. She commented:

[Many health care providers are saying] instead of dumping somebody out onto the street, once you have stitched up a gash from a domestic violence issue, send them to me... there is more coordination of services but definitely there can always be more done.

Another participant, Charles validated this also: "It is getting better. We try to make sure before [discharge]... We have a good team of continuing care [post discharge]... This is a team that will bring the patient [for follow-up mental health care].

There was also a suggestion by a participant that stereotypical views might compromise

the kind of treatment offered. This occurred when generalizations were used to characterize certain ethnic groups with labels such as “mentally ill.” They may also have other medical problems, but are overlooked because of the attributed label. In the literature review, for example, Beiser (1998) found family physicians were less likely to refer non-English speaking patients to specialists and that there was over diagnosing of schizophrenia for specific ethno cultural groups. Charles suspects after many years of experience: “A lot of people with depression might have underlying medical illness...it just doesn’t get investigated because they are just mentally ill... there is a systemic discrimination.” Whereas Christie questioned: “Is this a competent care system in itself? ...Let alone culturally competent!” She reflected on her experiences of various immigrant women who have apparent mental illness but have never formally received treatment. This puzzled her: “[The client] was very paranoid, hard to engage...seemed like a red flag for a psychiatric disorder that needed to be treated...she had several counsellors.... even a psychiatrist.... [They told her] she didn’t have any problems.”

Differing ideas of mental health.

Another underlying idea was that immigrant women had a different understanding of what mental health and illness really is. It was felt that immigrant women might not understand Western discourse around illness and emotional difficulties. This lack of understanding can result in confusion as to what the health provider is talking about. There was strong suggestion by one participant that education is needed to bring clarity and increased awareness of mental illness to these women.

Lisa, who has done a lot of outreach work, knows this all too well. She has been told to identify mental health as an issue by organizers of the event, but not to mention mental illness when speaking to various ethnic cultural groups in the community. She was warned

firmly: “You can talk about stress and wellness but don’t talk to [the ethnic group] about mental illness” Consequently, two years later Lisa is still not addressing the term “mental illness” because it has its own barriers. The stigma of mental illness and the lack of knowledge about mental illness contribute to isolating women from outside support sources. Systemic changes are not easy, however finding ways to promote acknowledgement of mental illness problems amongst different cultures will potentially have an impact on immigrant women and how they access mental health care services.

The understanding of mental health and mental illness varies from culture to culture. Ideas of health and what actions are taken can be quite different. It is well supported through the literature review that for example, in some Asian cultures individual treatment models that do not reflect the interconnections between family and the community are considered inappropriate. Another example is the Aboriginal cultures whereby a person hearing voices or experiencing hallucinations may be considered a visionary with extraordinary spiritual insights. In the contemporary mental health system, there is no standard recognition of differing perspectives on mental health and illness. Most individuals are offered the same type of treatment and responses; therefore responding to specific needs of ethnic cultural diversity may be inadequate or non-existent in the system (Morrow & Chapell, 1999).

Furthermore, designing mental health care programs and integrating these programs will strengthen services to all clients. Increasing service to ethno cultural communities involves different health promotion strategies than those sufficient for a Canadian born and educated population. Some immigrant women may not be fluent in English nor have a high level of education. Some of the systemic struggles of the participants were reflective of the inadequate resources provided for health promotion such as health fairs and provision of translated materials. As one health care provider pointed out:

Certainly in terms of educating and helping people to learn about our system and how we treat people... you have to find that level of connectiveness that you're communicating about the same thing.... That is a bigger challenge than in other health problems.

Christie spoke out in the woman's defence:

You see a gap between immigrants and the system... the gap needs to be breached.... [The immigrant women] shouldn't feel imposed on, rather that their knowledge is valuable and that they wouldn't have to change their total ways of thinking, because they won't.

Charlotte also endorsed this integration:

There is some real active work getting done within the professional community of getting together as a network...the next step is getting that information to a comprehensive level that other professionals could access. We have great resources in the community that just are not known about.

Lisa commented:

Those who are marginalized don't feel that the system is changing fast enough... Those within the system think it is moving too fast and if you are the change agent it is... How do you move your system forward and how do you move your population forward... [when] they are not on the same page?

Health care responsibility involves multiple players and the health care system is one member. With minimal resources all health care players need to look at how to maximize, collaborate and work together to discover solutions. Lisa commented on meeting these goals and maximizing limited resources: "It's everybody's responsibility, not just the health care system... We play a part and should be a member in consideration, but we can't be

everything to everyone.”

Systemic discrimination.

Although the commonly held views of Canadian society is that the health care system is equitable and non-discriminating, there is evidence that racism is enacted within institutional and organizations and is embedded in the structures and value systems of society (Brown, et al., 2002). Access is therefore not equal for everyone. For the marginalized immigrant women facing multiple forms of inequities based on race, class and gender, access to mental health care services may be very constrained (Morrow & Chappell, 1999). These multiple inequities intersect and have great influence on the immigrant women’s life. An outreach educator with thirty-three years experience spoke to this: “I’ve raised the issue of both individual and systemic racism. The way our systems are defined is based on white power and privilege.” She maintained that change needed to come at various levels both the individual and also at the program level. Educating people about racism is essential, yet it can be a very threatening topic. Health care providers may feel hesitant to acknowledge racism in themselves or in their institutions. Lisa explained: “You have information on racism...at a display not many people stop to talk to you...most people see the word racism and beat it the other way!”

Some participants expressed the view that immigrant women were vulnerable targets for systemic discrimination. Characteristics of some immigrant women such as being non-English speaking, older and poor compounded the likelihood of being treated unfairly. Ruby spoke about issues of childcare and translation services being part of the outreach services for these women: “If our [health care] systems don’t allow for us doing outreach [such as] provision of translation and childcare then systemically we can discriminate.” Christie also supported this idea and made it quite clear that typical hours of health care service may make access difficult or impossible for many. The woman may have jobs with long hours and no

medical appointment or sick time benefits, or they may have child care responsibilities and no one to care for the children in their absence. She also pointed out that many health care providers are women and have their own family responsibilities. They have no desire to commit themselves to work on weekends or evenings.

One health care provider questioned whether lack of interpreter services or choosing not to use these services was a form of discrimination against these women. Again Ruby, who has extensive experience with counseling and human rights for women, felt that this was a form of systemic discrimination. She clearly stated: "Non-provision of translation services [is discriminating]... people are receiving a different kind of service because things aren't explained clearly... in order to be expedient." Ruby reflected on a past case where many extreme misunderstandings took place, to the point that the immigrant women's children were apprehended. They were a refugee family with health and language issues present, yet no interpreter was involved. Ruby maintained:

If they would have had an interpreter she wouldn't have had to deal with losing her kids...the trauma...I mean it was for a day or two, she got them back but she had them taken away. This family has enough problems without... now she's horrified to do anything!"

Inequality within the system.

As referred to in the literature review, the past few decades have seen many changes in Canada's policies with the ideologies of equal opportunities for all and individual effort being responsible for success of reducing inequities. Government documents such as "Achieving Health for All: A Framework for Health Promotion" (Health Canada, 1986) stated that reducing inequities is one of the first challenges to face. Despite a widely accepted and shared ideology of equality, Li (1988) asserted that social inequality remains

well entrenched in Canadian society. It is represented by the popular mobility dream. The mobility dream is an idea of an open society where everyone has equal rights/opportunities and the failure or success reflects self-efforts. This embedded ideology of self-care responsibility and individualism are given as solutions and in the best interest of the consumer, even if systemic inequities are identified.

Li (1988) also pointed out that social forces widen inequalities, for example gender, nativity, ethnic origin and age are often used as grounds for discrimination. There is verification of this in the data, where participants confirmed that inequality does exist however subtle or disclosed. A counsellor for over two decades pointed out: "As Canadians... we tend to think of ourselves as very accepting... accept everybody and everyone is treated equally... There is a major difference between equality and equity... accepting everybody, that is not true."

Charlotte, who has helped immigrant women for years perceives that even though the discrimination may be unintentional, it exists in the way service is delivered: "They are not equal [the immigrant women], So how do we kind of make [services] equally accessible or in handling the assumption of discrimination. I don't have the answers...it is very difficult." However on a more positive note Charlotte also believed that immigrant women's strong inner core and spiritual nature would eventually help them, however many of the structural barriers in place countered those strengths. She maintained that immigrant women would be willing to try an unfamiliar method of treatment. If given an opportunity the women would find a way to create community and do what they had to do because of their social nature and the desire to have their knowledge heard and included.

One participant identified that job discrimination was also a factor in affecting the

immigrant women's mental health. The inequality of the sexes in certain professions was there, no matter which way one viewed it. Hannah, a seasoned health care provider, maintained that professions such as engineering and some areas of medicine continue to be male dominated. Therefore, for the immigrant women: "It's like a double whammy, they usually have to compete not just within the same [occupation] but with the other cultures."

The following narrative truly captured the essence of the difficulties and negative attitudes some immigrant women face. Marie, one of the participants, shared her experience from twenty years ago as an immigrant woman and also as a health care provider new to Canada. Although in this study she was a health care provider participant, she also provided a rich description of her experience as a newcomer to Canada. She related having extreme difficulty acquiring a full time job because she had no "Canadian experience" as a health care provider. She had left a well-respected position and job back in her country of origin and now in Canada was met with a myriad of challenges. Marie expressed her suffering:

I had no money...[I had] loss of power... I was dependent on my in-laws. You may suffer from very low self-esteem and it takes you a long time to get back... You're expected to go out and earn money because you are an immigrant, you need to make money.... When you have to establish a new relationship, a new family. It's a very, very hard job... [there are] arranged marriages... you come and meet these new people and family that you don't know and [try to] build up those relationships.

Ultimately triumphant, Marie's situation gradually improved because she was a fighter and determined to succeed:

You do become a fighter, which was something that was in me... I took it as a challenge and thought... I have this and I'm going to prove it. If I didn't have that in me I probably would have become very, very depressed. I did have a very supportive

husband who supported me throughout.

She asserted that without her determination and her supports she would have become very depressed. It seems clear that the immigrant women who may not have a great deal of support or a strong determination to adapt and succeed may be further at risk for mental health problems.

Charlotte worked with senior immigrants and reflected on her counseling experiences. She perceived that inequality might not necessarily exist around services but around the Canadian laws for seniors. She specifically identified that there was differences in perception concerning the age of when one became a senior citizen. Through her experience she has found that for some cultures such as South Asians, traditionally they may perceive themselves as a senior at about 55 years of age. They may also view this senior role as a time when health may start to decline and more support is expected from their family. In Canada, it is at 65 years of age where support and services commence. Charlotte has found that difficulties and negative perceptions result because immigrant women perceive themselves as seniors and behave as such, yet are not able to access services for seniors. Charlotte cautioned that health care providers should be aware of the context in age and aging and its effects. She thoughtfully reflected:

Not all South Asians but some [immigrant women] are holding that traditional role.

As professionals [we may think] you're only 55, you're not doing very much or they expect their kids to do more for them...that can be in their eyes, discrimination.

Social Determinants of Health

The socio economic status in health has far-reaching effects on the immigrant woman and also can be used to examine the inequalities experienced. The awareness of the multiple factors affecting the lives of immigrant women which are related to not only power relations between the sexes but also to key structural issues and the class position of the immigrant women in society needs to be recognized. As cited in the literature review, poor immigrant

women are trapped in lower echelon jobs by the institutional structures and interests of dominant groups (Anderson, 1987). The non-English speaking immigrant women are more likely to come from a low-income family. The majority of immigrant women work because of economic necessity and they may be overworked while juggling several poorly paying jobs. In addition, many immigrant women are unaware of their rights, such as unemployment insurance, workmen's compensation and overtime pay.

Socio economic factors.

Some participants reported that immigrant women do not have the luxury of taking time off from their job to see a mental health therapist or counsellor. It was emphasized they needed the health care provider to take time and listen to them. The marginalized voices of the women needed to be recognized and respected as an accurate account of their everyday experiences. Needs such as food, clothing and shelter were first priorities. One health care provider concluded that many of these women were looking for more than counseling through the agency but rather wanted their instrumental needs met. For example, they may be expecting help with getting the food they need, safe housing and obtaining children's school supplies. These women often feel overwhelmed by everything they are responsible for, and this was also a real barrier in getting help. Several participants echoed these concerns. Ruby maintained: "They're worried where their next meal is coming from or whether or not they're going to be able to explain themselves when they meet the teacher, so there is a lot of worries going on." Christie pointed out: "She [the immigrant woman] was so excited that she got some bus tickets... they're struggling with some of the basic needs. Sometimes these are the most difficult [needs]." Lisa is of the same mind:

If you're trying to juggle several jobs to support your family and you don't have the benefits to go and seek help, you're not going to pick seeing a mental health

therapist; it's a priority between maintaining your job, feeding your family versus going for counseling. most people will pick the basic need.

Lack of resources makes it difficult for the immigrant woman to maintain physical and emotional well-being. Poverty and lack of social support greatly impact the immigrant woman's abilities to access services in the mental health system. Social conditions such as economic insecurity, family responsibilities and experiences of violence influence the ways women access and optimally utilize services. For many women social conditions of inequality, particularly experiences of violence have precipitated their entry into the mental health system.

It is important to recognize that social support and access to financial resources may determine the type of mental health care a woman can access (Morrow & Chappell, 1999). The data reported is consistent with these notions. Poverty impacts on women's abilities to access services. Women without financial resources have less treatment choices. The "working poor" as one participant noted, don't qualify for social assistance, but at the same time are unable to afford the newer medications. There is no money available within the family for such treatments. Sometimes the mental health concerns are related to family problems, which do not qualify under the mandate of severe mental illness. The two-tiered system of public and private health care services makes it more difficult for the immigrant women to access counseling because of lack of financial resources (Morrow & Chappell). For example, if the immigrant woman does not meet the criteria for severe and persistent mental illness, they are referred for counseling which is not covered by health care. Another example is that immigrant women on social assistance are only able to access publicly funded services, which makes it almost impossible for women living in poverty to access counseling or alternative treatments. Health care consumers who have the ability to pay have a much

wider range of treatment choices for many health services.

Two health care providers articulated these concerns about gaps in the mental health system, which is strongly related to the financial status of the immigrant women:

Mental health psychotherapy sessions are from a two-tiered system; they have to pay at private clinics or agencies for the psychotherapy. Many immigrant families aren't able to afford the cost of medication... it can be quite expensive. They can't afford the newer medications so they end up being given the cheaper, older medications which have more severe side effects ... a drawback.

Christie agreed: "For depressed women it's something [economic status] that prevents them from accessing [mental health services] in the first place."

Some participants felt the inability to pay was only part of the issue. Charlotte, who has counselled immigrants for ten years, felt there was a real resistance among immigrants about paying fees and that service should be covered by government health care. Perception around the value of service was deemed an important piece as well: "It's very possible they do have money, but perceive it [counseling] as something they would not spend their money on... for these kinds of services."

Differing values and beliefs about the services may prevent the immigrant woman from accessing even if she is financially able to pay. Counseling may not be valued as a treatment modality because it is unfamiliar to many cultures. One participant summed it up: "If it were the difference between paying your rent and eating, versus going to talk to someone when there are language barriers and other issues... why would you do it?"

There are also compounding factors that accompany low economic status. For example many participants talked about practical issues, such as transportation. It can be a huge

concern for immigrant women to travel to appointments. For some immigrant women taking the bus can be confusing and difficult. The cost of transportation and getting time off work can be challenges. It could mean taking time off without pay, which compounds the cost of the treatment itself. The hours in which services are delivered may also be problematic especially when they are mainly offered between 8:30 pm and 4:30 pm, and usually weekdays. Immigrant women with young children may have to pay for babysitters or try to keep appointments while their children are in school. Another participant suggested that money is made more available when there is a crisis or more urgent need:

Many people seek help when it's a crisis; to go for ongoing help may not be something that is meaningful. In many countries people also have to pay for health care services so you would go only in a crisis.

It was quite evident that an immigrant woman's mental health status and health opportunity depends on a multitude of social conditions. Health status is not equally distributed among individuals because the individual opportunity to achieve health is not equal. The social circumstances of immigrant women profoundly affect their ability to obtain help. Economic inequalities are among the important social determinants of mental health status. As Charles, one participant noted: "There is no equality in economic factors...not getting the proper medications because of lack of money and no health plan [are examples]."

Education level.

The level of education of the immigrant women was explored to discover whether it impacts their health care practices. The contention that women with higher levels of education would look after their health better was examined. Was the assumption true that immigrant women with lower education less able or inclined to take care of themselves than their more educated countrywomen? Several participants felt that the

level of education played a large part in how immigrant women tend to access mental health care services. The lack of education from the home country may affect the immigrant women's level of awareness of Western cultures as well as how to problem solve. The levels of English skills were also very much a part of how quickly the immigrant women adjust to Canadian society and learn how to work the system.

Some participants felt that socio economic status and education levels were closely tied to the kind of treatment one might receive, as well as how assertive one would be in accessing health care. Therefore, an immigrant woman in a lower echelon job with poor English skills may have little or no access to health care services, even though she may have an overwhelming need to obtain care. However, Charles, with over twenty years experience, felt that a higher level of education could actually be a barrier due to the immigrant questioning so many things: "So it can be a barrier or a benefit; more education might have helped their English skills but the more you explain the more they question, they really don't want to accept an answer." An experienced counsellor for over thirty years who has seen a broad range of people in different settings commented that a higher income individual would have greater access than somebody who was less educated. In other words: "If you're more educated probably your level of awareness of social issues and wellness may be quite different from somebody who is in survival mode." Another health care provider suggested that in Canada a certain level of education is taken for granted, whether it be junior high or high school because that's what most people would get in this country. Some immigrant women have never been to school in their home country, therefore a heightened awareness of their past educational experiences will help the health care provider plan treatment. Although it is generally

assumed that immigrant women who are well educated adjust more quickly to Canadian ways, one must also give credit to immigrant women who have only minimal education. Christie, a family counsellor noted:

Even women with minimum education have a lot of survival skills. Something I've learned from them... You may not connect with them on the same level but if you pay attention to the little things... they are very smart and have their ways of getting information.

However, a higher level of education does not guarantee employment for recent immigrant women. Coping with unemployment or being under employed may predispose many to feel discouraged or put their mental health in jeopardy. With the increasing number of immigrants there is a growing need for settlement and support services. However, funding for such services has not grown accordingly. It was reported in 2000-01 a total of 464.2 million in processing and landing fees was paid, while the Canadian government spent 336.4 million on integration and settlement. Immigration settlement services are estimated at approximately 3,000 per individual. It is interesting to note that with a national target of 300,000 immigrants, this represents a shortfall of about 600 million in support to immigrants (Citizenship & Immigration, 2002).

Knowing the woman's education status might influence the attitude and approach of care by the health care provider. For example, there are many immigrants that are well educated but their credentials are not recognized in Canada. Loss of occupation status and being in a poorly paid job may alter their self-esteem immensely. It was suggested by a participant that in some instances this may affect the kind of mental health care given. Lisa has worked many years in health care and pointed out that attitudes might change with the knowledge that the client is well educated: "When she [the health

care provider] found out that this particular patient had three degrees and was much more educated than she herself, her tone of conversation changed.” This example demonstrates the recognition and respect that may be attached to the well-educated individual. However, the participants also stressed that one must treat each individual’s circumstances uniquely and recognize the challenges and stresses that they have experienced. The awareness of social and historical factors is necessary to provide appropriate support to the entire individual.

Social isolation.

The problems associated with social isolation were elaborated upon by many of the health care provider participants. It was most significant within the senior immigrant population and the new immigrant women who have recently arrived in Canada. These social isolation problems are due to a variety of factors. Language difficulties, transportation issues, traditional roles and isolation from the ethnic community were some of the examples given. The newly sponsored immigrant woman who enters Canada through family class status may find herself in a powerless and generally dependent position. Due to her second-class status in relation to the labour force, government benefits and services, she is frequently isolated and dependent on the family. This dependency of the immigrant women may create very unhealthy situations and serious conflicts. Marie who works with immigrant families described this well:

Definitely it is a control issue that happens when they can’t go out because of the family enforcement... They’re basically dependent on them [the family] and they are dependent on the husband. They don’t have their own family, so they feel totally isolated and calling home is not cheap. So they don’t know anybody because they are immigrants... that can lead to depression.

For the younger immigrant woman, who is isolated in the home and may not know anyone to help, this oppressive situation continues. It was felt however, that the younger immigrant woman with children are often in contact with health care providers and family services through their practical problems of everyday life. Some comments were: "Their saving grace is their children. They meet others professionally and non- professionally... it's a good thing that networking does happen." Another participant voiced this as well: "Younger women are less of an issue because they are quite good at speaking English by the time we see them!" It was felt that over time these situations improve and do get better. Through job attainment, going to school and making friends, the isolation was reduced. However, the stronger emphasis by the participants was on the isolated senior. All participants agreed that isolation was a serious problem for this population. Ruby, who has worked extensively with immigrant women expressed with great emotion:

With the senior population my heart breaks; I just struggle, like what service do I have to provide [for senior immigrants] what can be provided for the senior women? I mean they have so many losses... at their age they're here because their spouse is gone. They will often have a child care role, but there seems to be some big problems.

The socio economic condition of senior women's lives, particularly poverty and social isolation, has a huge impact on their mental health. Over time the situation may not improve for seniors, as it often does for younger immigrants. Some participants suggested that seniors are less likely to get the care they need for mental health problems. Limited access to services occurs especially in rural areas. Immigrant senior women become the most disenfranchised because of the language, lack of knowledge and core beliefs around culture. Isolation may also be their choice, because they feel safer. Cooking, cleaning and childcare activities are familiar but they also keep the senior in the home.

The ethno cultural community was seen as an extremely important resource for seniors. Participants felt that the ethnic communities with good social structure and networks gave strong support to their senior population. Unfortunately many seniors do not have the means to access their own communities because of transportation and language barriers.

The Role of Gender

Role change and conflict.

The double burden of engaging in paid work and having family responsibilities while adjusting to a new country, even while maintaining the cultural norms of the old, is a familiar pattern for many immigrant women. The notion of role change is well documented in the literature as being one of the defining stressors in immigrant women's lives (Jiwani, 2001). Role overload and cultural conflicts make it almost impossible for immigrant women to consider reaching out to access appropriate mental health care treatment. These multiple roles and high expectations of immigrant women put them in a vulnerable high-risk position for high levels of stress and stress related illnesses.

Participants emphasized many immigrant women from, for example, Asia and Africa had very different roles compared to Western or Caucasian women. Often the traditional female role may be seen as subordinate and sacrificing. As Charles, one health care provider phrased it:

A lot of their roles are very subservient, ... Their role is homemaker, housekeeper... they have a lot of stress, but of course they don't know where to go to deal with it.... Lots of immigrant women [when] they get married they go to the husband's family... they not only serve their husband and kids but also the in-laws. You see a lot of conflict, especially in Calgary, in terms of their role. Sometimes they feel rejected

by not just their husband but also by their in-laws.

It is not an easy process for the immigrant woman and her family due to role conflicts and cultural expectations of family elders. Hannah gave an example:

Culturally the older folk... may live with their children... In most parts of India they live with their oldest son, no matter what. It is really difficult to separate them because culturally it is their right. They have someone to look after them... I would say it is two kinds of extremes... Here it is the norm, when one gets older you retire in a senior citizen place and you are on your own and not dependent on your children.... Some [immigrants] want to live on this side of the world but totally follow the cultural [norm] that they were raised in.

Also, due to the socio economic demands of being in a new country, immigrant women may have to take on a new role; one that is very different from the traditional roles that they were raised with. Charlotte, who has counselled for ten years, noted:

It's a direct challenge to that particular psychological process, just because of basic economic status.... Regardless of it being a basic necessity the perceptions becomes about the power, balance and hierarchy.... It becomes a battle, because here are the women trying to assume the position of the male, which may not be traditional.

Charlotte maintained that the women do not necessarily want to give up that traditional role because it was a familiar role; one that may have its own kind of power. With changes in role, confusion and feelings of powerlessness may take hold. These findings are similarly echoed in the literature review (Kinnon, 1999). Gender is a complex variable, which is inextricably tied to the dynamic and changeable nature of social and cultural systems (Brown, et al., 2002; Greaves, 1999). Therefore, these changes in gender

roles will affect the immigrant women's responses in accessing and using mental health care services.

Commitment to the family.

Gender roles influenced whether mental health care services were accepted and accessed. For example, participants reported that immigrant women might have a strong commitment to home chores and childcare. The time frame of when mental health services were offered and the practicalities of getting there could also be problematic for the women. Often if women needed long-term psychiatric care the family may not agree to it. Charlotte felt that although some cultural practices may be a barrier, there is also another very significant aspect to this gender role analysis. For immigrant women there is a core belief that they are responsible for the stability of the family and have the caregiving role.

With limited resources and access, the immigrant women continues to maintain honour within the family. This traditional role is so powerful that it impacts the choices these women make. If they make a choice to accept some of these mental health services, it may be somehow betraying the family or abandoning their traditional role. To create shame and dishonour, within the family further complicates the situation.

For the low-income immigrant family, survival of the family necessitate the woman engage in paid work, as well as maintain the household and care for her children and her husband. However, by going to work her husband's authority is undermined because she has gained economic power in the relationship. This may produce conflicts and marital problems. As Lisa described: "Maybe the woman who has never worked is the one who gets the job.... [She] is now earning the money, so her self-esteem and independence might be increasing while her husband's self-esteem is decreasing." Lisa noted this

precarious situation may lead to abuse and family violence if the husband attempts to reassert authority in the relationship. Charlotte observed that role expectations may also shift:

There is movement that women are very capable and will work outside the home.

There are highly educated [women] back home but this was not the norm... So when they come here they want to continue with that education and their expectation is that it will happen...it is a reversal on the family.

Shifting of roles.

Similarly Marie, another health care provider has observed the shifting of gender roles within the senior South Asian population. She stated that when seniors are immigrating from their traditional male dominated society, often there is a shift in power within the extended family. Once living in Canada, she described how the senior male's role might be changed. The senior male may have less to do and also may become depressed. In contrast, the senior female may be to a very large extent in charge of the household. This mother-in-law power continues to grow as she involves herself with childcare, household work and deciding what should or shouldn't happen within the family. In some families the son might contribute money to his mother instead of his wife. Consequently, the senior women may play a very dominant role, subsequently neglecting the male or in some cases exacting a revenge for her own years of oppression. Marie described this well:

She may call the shots on him, [and tell him] you don't have anything else to do...

Why don't you clean the floor? [The senior women] may be telling and

giving him more instructions.... to keep him busy. I've also seen taking revenge for

the back home relationship where the male was more dominant on her.

Marie, however described another potential shift in roles when the newly immigrated family has lived here for a while. The daughter-in-law gradually starts to take over the household and this power may shift from the mother-in-law to her. In this situation the senior woman who has had power might then go through the grieving process of losing her own power and self-esteem.

Domination and control of women.

In the past, cultural differences may have been used to help rationalize and explain why partners of immigrant women use behaviours of control and dominance (Jiwani, 2001). However, by conforming to this dominant ideology that may hold cultural differences responsible, there is less attention given to other powerful structural barriers and environmental stressors that immigrants face.

As seen in the literature review, women represent over half of all immigrants and are more likely to enter the system under the family class (Boyd, 1998). Many women come as the dependent spouse of a male independent immigrant. Right from the beginning of their new life in Canada, immigrant women have compromised autonomy and independence. Also cited in the literature review is the fact that Canada's immigration policy has further contributed to the immigrant women's dependency and vulnerability (Citizenship & Immigration Canada, 2002). It has been pointed out that biases and hierarchies in immigration policy creates unequal social relations between the sexes and places the immigrant women in a socially disadvantaged position (Anderson & Reimer Kirkham, 1998).

The health care provider accounts clearly indicated that these situations of dependency

and abuse are very real for many immigrant women. Some health care providers are also well informed about the limitations of the immigration policies. Charles expressed concern for these women: “If they are being sponsored...it is for ten years.... They are quite reliant on their husbands and in-laws and they can’t move out because of that situation.... They cannot support themselves for ten years!” He added:

[Some] Asian men are involved in gambling... the women is working and it is hard to see her money going to her husband who spent it on gambling and she couldn’t do much about it. She is obliged to stay with him, although there may be some abusive issues... She would have to leave her children and live somewhere else.

Charles goes on to say:

We can never really overemphasize... a lot of [immigrants] carry traumatic issues from their past... We have noticed posttraumatic stress cases. And a lot of boat people from Vietnam that was subject to all kinds of torture and pirates abuse...

[Other cases] from Africa and South America where women have been tortured, their family killed.... There is suppression going on in other countries...[Immigrants] who have come here have been subject to much abuse.

However, Ruby maintained that immigrant women could legally charge a man if he is being abusive and possibly have him sent out of the country. She cautioned however that one must consider the many factors at play: “If you’re pushing people to do things without having all the information [the immigrant women] could end up worse off!” The health care provider’s perspective may not always be the best choice: “If it was me that guy would be out the door so fast...I would go on welfare and get all these supports in

place...start a new life for myself.” However the immigrant woman’s situation may be different than that of a Canadian-born woman. Ruby recapped a situation:

“If she left him he was the only one in her family that could sponsor other family members over from their country of origin.... [The immigrant women] could be fine over here and managing okay. [But] she has no hope for quite some time for getting other family members over. Getting them over for their love and support.... so that they are not dying somewhere in refugee camps or involved in political [violence].

Another participant was reflective on how historical factors have influenced his Chinese clients, women from the mainland China but have lived here for fifty years:

[Chinese women] were taught that they are all equal, but no they are not equal. A lot of women are still subject to systemic abuse by men. They see their role as inferior or dependent on men, so it would be almost shameful...to ask for a divorce or a separation even if they are being abused by their husbands.

It should be noted that most of the health care provider participants found that even though the immigrant women wanted to seek support, access was either limited or forbidden once the male partner found out about counseling. Furthermore, if there was any continued involvement with treatment, the women’s restrictions and abuse could escalate. Charlotte has found in her experience that male domination and the disapproval of counseling in some instances made it very difficult for these women to seek help. She noted: “[Family] work is so guided by the power, the structure and the consent that the male partners provide.”

However even if the women are allowed to come to counseling, despite the consent or not the impact of change is particularly limited when they go home. One health care

provider revealed that over time this controlling and dominating behaviour by the male partner may trigger destructive and volatile actions by the immigrant women: “This [immigrant woman] was controlled by the in-laws and the husband...she was not allowed to go out...[This] patient actually killed herself and nobody even knew outside the family because they were afraid to tell people.”

Marie also agreed and noted through her experience that these control issues may make it difficult for the health care provider to provide resources that are helpful for the immigrant women. For example, the need for an interpreter for the non-English speaking women may be met with resistance. She described a situation where the husband would not leave the wife’s side: [Marie says]“I would like to meet with you once alone. [Husband angrily says] Well what for? If you want to meet my wife, meet my wife with me...I am the interpreter” As the story unfolds this woman client ended up with severe postpartum depression and there were implications of family violence and child apprehension. Hannah reaffirmed these same concerns: “To do any family work you need an interpreter. If you have the patient’s father or husband interpreting...a most unhealthy situation because you don’t know what they are saying to you.”

Differing experiences between sexes.

It should be noted that past research findings have found many differences between men and women’s experiences of mental health concerns (Kinnon, 1999). This is especially so when linking between women’s mental health and their social conditions. Although these physiological and socialization norms are different for women in relation to their mental health experiences nearly all health care providers interviewed did not want to elaborate on how this affected their clients. It is not clear to me why this gendered understanding of the differences in the women’s specific needs was perhaps

difficult for the health care provider to discuss. It may imply that they don't perceive a difference in mental health care needs between the sexes. However, one participant did want to expand on the differences in men and women's needs for counseling. Ruby felt that immigrant men focused more on problem solving and often their aim was to get the task done and move on. Conversely women focused predominately on issues of depression, self care and self esteem. Ruby described this phenomenon:

Many of the immigrant men that I'm working with, their aim is to get the women back... with the women the aim is more coping with a new circumstance. So it's...emotional issues versus this is my task.... The men might be coming [to counseling]because there was family violence and the probation officer said they have to come.

In her second interview Ruby agreed that although men and women's mental health experiences can be different, they might also have many similar problems. For example, depression and feeling isolated were not uncommon for either sex. However, she emphasized that how the situation is dealt with and how the experience is played out may be somewhat different for each individual. For immigrant women Ruby maintained: "[When] the women are being discriminated against or harassed...that affects them emotionally."

Summary

In summary, the health care providers interviewed agreed that immigrant women do experience difficulties when accessing mental health care services. It was highly evident that language barriers had far reaching effects and presented complex challenges to both the health care provider and the immigrant woman. However, the awareness and continuing

advancements in interpretive services has clearly supported the reduction of this access barrier.

The unfamiliarity and unawareness of mental health services were prevailing concepts that continue to impede access for these women. The misunderstandings of service delivery and the fear and mistrust of western biomedicine also compounded their difficulties.

The health care system has layers of contexts that shape the immigrant women's experiences of health and illness. Systemic structural barriers continue to influence the immigrant women's contacts with the mental health system and in turn affect their everyday lives. The health care providers identified that fragmented health care delivery and system design were somewhat responsible for the kind of treatment immigrant women experienced. The focus of the health care system on mental illness as a biological problem combined with the decreased level of understanding of these women's mental health needs also created barriers. The structure of the health care system and the absence of services such as interpreter's services discouraged immigrant women from obtaining care. It was strongly suggested by some participants that immigrant women are vulnerable clients because of factors such as poverty, language skills, age and ignorance of how the system works.

Inequality within the health care system was also voiced as a real barrier for immigrant women seeking health care, despite the popular shared ideology of equality. These inequalities however subtle or disclosed continue to exist within Canadian society and conflict with Canadian social values related to justice and equality (Brown et al., 2002). Age and occupational opportunities were other examples given by the health care provider to illustrate inequities within the system. Clearly most health care provider participants supported these ideas that access to services is not equal and that health care providers need

to explore and acknowledge how one can remove some of the barriers and work towards truly integrating everyone.

Socio economic and other related factors were also seen as major influences in preventing access to mental health care services. Poverty and lack of social support greatly impacted the immigrant women's abilities to access services in the mental health care system and the kind of treatment and care received. Level of education, which is often linked to low socio economic status was also thought to be an influence in how the women accessed mental health care. Awareness of world knowledge, how to problem solve and level of English skills were other examples given.

Social isolation was deemed significant within the senior population. It was suggested that language differences, transportation issues, isolation from the ethnic community and gender issues affected the older women's access to health care resources.

The role of gender influences the immigrant women in her everyday experiences and might limit or make it impossible to even consider accessing help for mental health needs. The multiple changing roles of immigrant women situate them in a vulnerable, high-risk position. The shifting of the gender roles and the underlying power relations within the family greatly influence the immigrant woman's access to mental health care services. This was well supported in the data and literature review (Greaves, 1999; Jiwani, 2001; Kinnon, 1999).

It was also important for the health care provider to be aware and recognize the kinds of structural barriers that these women are subject to. As mentioned in the literature review, Canadian immigration policy further contributed to the immigrant woman's dependency and vulnerability. It has also been pointed out that these hierarchies and biases create unequal social relations between the sexes. It was clearly depicted through

the health care provider's accounts that situations of control, dependency and abuse are very real for many immigrant women. This embedded power which is based on race, class and gender relations affect the immigrant woman through domination and subordination. It is essential to that we understand the specific mental health needs of immigrant women for the implementation and planning of future mental health care for immigrant women.

As this chapter closes, the focus now shifts toward the next theme, which is culture. This theme is yet another dimension of the immigrant women's experiences of accessing mental health care. Culture represents more than practices, beliefs and values of a particular ethnic group. It is within a shifting and complex network of meanings that is intertwined with economic, historical, political and social processes (Anderson, 2001; Donnelly, 2002). In the following chapter, the exploration continues as to how culture shapes the immigrant woman's responses to her health and as well as accessibility to mental health care services.

Chapter V: Findings and Discussion: Cultural Influences

As discussed in Kleinman's writings (1978), cultural background has significant influences on individual lives and shapes their responses to health and illness. Cultural background has an effect on individual perceptions, emotions, language, diet, dress, behaviours, family structures, concepts of time and space and attitudes to illness.

This chapter illuminates the ways in which culture can shape immigrant women's responses to health and accessing mental health services. This key theme of culture is representative of a constant evolving network of meanings intertwined within social, economic, political and historical processes. Therefore, it is essential that in order to provide adequate care to ethno cultural groups an awareness and consideration of all factors that influence their responses is necessary.

Data analysis revealed a number of sub-themes, which reflect strong influences on immigrant women's access to mental health care services. Firstly, the health care providers saw dealing with issues within the family as having both positive and negative outcomes in terms of providing informal support for immigrant women. Participants also mentioned barriers created by the stigma of mental illness, as well as the danger of subsequent shunning by the ethnic community. This attitude could lead to the family's concealment and denial of the mental illness, which could serve to exacerbate the situation. Traditional beliefs and practices, as well as strong religious beliefs, were identified as sources of strength and support for the immigrant woman. Coping strategies such as reliance on strong family and community-centred values, the resiliency of the immigrant woman and relying on the cultural community were recognized as effective and positive. Lastly, the health care provider's understanding of cultural influences was

considered a significant factor in providing appropriate and quality health care to the immigrant woman.

Coping within the Family

The health care providers' accounts noted that informal support was a critical influence over whether the immigrant woman sought help for her mental health problems. The participant observations were consistent with the theoretical framework of this study. Kleinman's (1978) explanatory model which conceptualized the health care system as a cultural system composed of three sectors: professional, popular, and the folk. The popular sector was made up of the family, social network and community. Much of the decision making as to whether to seek aid or comply with treatment were made in this sector. Kleinman's framework is congruent with the participant observations, which described the family as a strong and controlling influence over the immigrant woman's health as well as her source of support. All participants agreed that having the support of strong family ties was an important factor. The role of the family was extremely important for emotional support during the illness experience. However, some participants observed cultural background exerted both positive and negative influences that contributed to how women seek mental health care.

Charles stated: "In Western culture, most people live in isolation from their family members. When they come from other countries, they usually stick together... so I think that's a positive." Participants also found that many times the family would try to deal with the illness on their own and not involve others unless the illness became a major crisis. If the mental health problem was overwhelming, as in the case of a major psychosis or schizophrenia, the health care provider felt the family would seek outside

help. As Lisa observed: "People in other cultures will often tell me they have extended family or friends to talk to when they have problems... families, that whole extended family network... somebody in that family will be helpful to them." Ruby, an immigrant counsellor, also felt that immigrant women's ability to deal with mental illness was strengthened if they were able to draw upon a large support system, including extended family and spiritual leaders:

If you've got extended family it seems the most natural way of dealing with things. Where they don't have that... then counseling would be the second best choice... or if there is serious mental health issues such as depression. There are cases where their normal way, their cultural way of handling things would be the better way ideally.... We [health care providers] have to change the way we do our work and you really have to look at who the client is.... Our concept of family has to include those extended family members and the adopted family members.

Christie, also an immigrant family counsellor, agreed that the family was very important in providing strength and support. However, she added that health care providers must pay attention to the intricacies of the immigrant family dynamics:

Sometimes they might tell you something really odd... especially financially they are intertwined with their in-laws... you may look at it as an abuse issue... if you understand the concept and the context in which that happens you [will] understand.

Although dealing with mental health problems within the family was seen as a positive notion, the participants also voiced concern over the power and control exerted over the immigrant women by the family. Positive and negative interactions may occur within the

family. The message of keeping the mental illness a secret within the family at any cost, jeopardizes the chance of obtaining treatment for mental health problems for the family member. It has already been noted that gender roles do influence and shape the ways in which immigrant women seek help. Dominance and control by the partner was seen as a contributing force in preventing the women who experience distress due to family problems from accessing services. Furthermore, the family was also seen as exerting pressure and deciding how the mental health problem should be solved. Hannah validated this: "Many cultures do not see the patient in... biochemical changes... the recommendation of treatment for the patient is... 'pull up your socks'. Family support from friends... there is enough within the family." Marie also asserted: "The mind set is that they can solve their problems on their own... back home it is dealt with differently." As well, Charlotte stated these messages are barriers in terms of accessing mental health counseling services:

Keeping it within the family... if the woman makes changes that could change everything, there is a lot of pressure on that... not only in the same country... like as immigrants but there is extended family back home... that social pressure is as real as it would be of those in the same country [living here]. So that even if [the immigrant woman] choose to make choices around accessing services and engaging services, staying with the service is highly impacted by woman's perceptions and pressures from home.

Lisa also confirmed that family support exists on different levels and does not always improve the woman's situation: "If there is a serious psychiatric disorder all the family support is not going to improve it. [For example] if you have schizophrenia... it is not

going to solve the problem always.” Marie also wondered: “[immigrant women] who don’t have family care or who don’t have the support of the family... What do they do? How do they cope?”

Stigma

All participants felt that the cultural stigma attached to mental illness and help seeking was a strong access barrier for immigrant women. It was felt that in many cultures there were significant negative feelings around the concept of mental illness and towards the taking of medication. For example, Christie stated that the Chinese clients she has counselled found it is easier to hear that their problems are caused by a physical reason rather than a mental reason. In trying to explain the nature of their illness this health care provider had numerous challenges: “For them mental illness is a taboo subject... so they are even afraid to let their own family members know about it... even their husband or wife.” Another health care provider expressed her concerns:

How do you respect where people are at? It is a scary concept, mental illness.... The stigma is great if they think God is punishing them, how can the little mental health care system do something? So there are a lot more complicating factors.

Hannah put it plainly: “Anything psychiatric is looked upon as stigma.” Charlotte agreed that stigma was associated with mental health services such as counseling. Particularly from a cultural perspective, accessing mental health services was difficult for many immigrant women. She spoke about her encounters with South Asian women:

The accessing of mental health services is a new concept [for them] ... while there are some of those services coming from India or Pakistan, there is this concept of being called “Pheal” which is just... crazy. Any time there is significant mental

health issues being perceived then they are seen as crazy, so they may not really go out and look for specific mental health services... their access is limited because of a barrier from their culture and from the perspective of that.

The participants clearly articulated that some clients would outright deny the diagnosis of being mentally ill. Sometimes the family is complicit in trying to conceal the illness. Therefore by the time the woman or her family seeks treatment, the illness is usually in the crisis intervention phase. In other situations, it meant that the immigrant woman would isolate herself in order to conceal her problem from her community. This creates further barriers for the immigrant women. Therefore even if mental health services were available for these immigrant women, the stigma and potential shunning from family and community would act as a barrier to treatment. Charles attested to this:

They are being stigmatized as mentally ill and that is also very hard for them to deal with the community because they are not allowed to tell other people that they are seeing a psychiatrist or have a mental health problem. There is a stigma attached to it.

Marie also echoed similar encounters of the strong cultural taboos:

They don't want counseling... it's considered a taboo... something is wrong with you... they don't want people [health care provider] to tell them what to do. They like to deal with their problems themselves... when you try to tell them that there may be different ways of doing things it is not considered good in the culture. So they are very hesitant and reluctant to reach out... unless somebody is going through a major crisis, they won't reach out. That is something I have seen among immigrant women. Resources are offered... they will not because of the taboo that they have

placed on the condition.

Another health care provider described the feelings of some families concerning the acceptability of medicine versus counseling: [The immigrant woman asks] 'What is counseling going to do? It doesn't help. Give me some medicine that will help to cure'... That is a very common belief." However, Lisa also noted this: "Many cultures use foods and talk about balance in their life... certainly medication may or may not be accepted. If you think your body should be in natural harmony... why would you take a foreign substance?"

It is suggested in the findings that although there are resources such as counseling, women might not access these services because of their strong cultural beliefs. Therefore, cultural beliefs can impact the way immigrant women address their mental health problems individually and within the family.

Influence of Ethnic Community

The health care providers in this study also recognized that not only was the family a powerful influence but also the ethnic community as a whole. Participants felt that the ethnic community had a very definite impact on how the immigrant woman and her family dealt with mental health problems. Marie, a participant noticed:

Women are hesitant to speak out about it [mental illness problems] or seek help...some woman would go to their family doctor...who speaks the language because the whole family goes to them and they understand...but if somebody in their community knows, that is always painful with this...it is considered a taboo towards the family.

Another participant viewed the ethnic community's practice and stigma regarding mental

health illness as yet another barrier for the immigrant woman to face. Ruby reflected on a past case whereby the immigrant woman was dealing with an abusive husband and depression. By helping her through this negative situation she found:

[The immigrant woman] had asked for permission from her community to leave her husband because the situation was quite extreme...they did not grant her permission to do that.... if your community is not in agreement with you leaving then you leave behind...a husband or even if you are not leaving a husband but you are doing something that the community doesn't agree with. That is your whole support system.

Due to the strong desire to keep the peace within the family and within the members of the community, women keep quiet. The stigma of having a family member with mental illness clearly outweighs the desire to access mental health services for fear that the ethnic community would find out. Thus, lack of community support might be yet another barrier for some immigrant women to seek mental health care services.

Religion and Traditional Healing Practices

The health care providers identified that reliance on traditional health practices and spiritual beliefs can provide a source of strength and healing power for the immigrant woman. Traditional healing practices were commonly used to manage health care matters. Charlotte noted that immigrant women were more likely to turn to those methods first if they are experiencing a mental health problem. She has seen this especially in senior women:

For example in the South Asian culture...older woman turn to 'majar' which is like an evil eye...It is the perception of somebody trying to look at you with the evil eye

or jealousy... that can create some of the mental health issues.... [The family] might turn to the rituals that they know of how to remove the majar from this person. They might do something like that before they would even turn to the system or mental health services.

Christie also reminded the health care provider:

They believe in the strengths of the person that you will heal...you may not have to see a professional.... They believe in moving on with their lives... They don't think they have a problem because they have had a lot of hardships...They have seen their parents go through much harder times...They never took medication or saw a psychiatrist and life went on.

Religious beliefs.

Several participants mentioned the powerful influence of religious beliefs. The health care providers recognized that a strong sense of religious and spiritual beliefs were important to these women for maintaining good health. They emphasized that spiritual beliefs were on the one hand often a real source of strength and wisdom, but on the other hand could present as barriers to seek mental health care.

Ruby validated this: "Many of the immigrants that I have contact with, spirituality and that aspect of who they are... is very prominent." Christie shared this concerning her Chinese clients:

Many Chinese women believe in fate and destination...if they believe their ill fate is caused by...If it is part of their destination, sometimes they don't try to change it...If they have to suffer it is their fate and they have to accept it.

Christie also acknowledged that sometimes the woman has tried to access services and

has encountered a few barriers. This was further proof to the woman that she needed to be punished. Christie maintained: “[The immigrant woman] will say you know what maybe this is my punishment.” Lisa added:

If you don't think your problem is caused by a biochemical imbalance but... by some other reason related to your spiritual beliefs and you think God is punishing you, why would you go to the mental health system to seek help?

One participant was firmly convinced that recognition and awareness of how a particular group deal with spiritual beliefs was necessary. For example, in the Aboriginal population the use of sweet grass was a traditional practice and a highly regarded component of the health care treatment regimen.

It is of interest to note that most of the health care providers had an awareness of these culturally related tied concepts such as beliefs in Karma or astrology as they relate to immigrants' coping and understanding of their life situation. Charlotte observed:

In the Hindu religion they are turning to astrology...the books...the next seven years are to be really difficult, so ascribing to that destiny and faith...Maybe you are depressed and actively seeking ways to resolve and control your destiny...This is part of their traditional coping strategies.... Knowing it is going to be seven years of difficulty sometimes enhances their ability to know they have to do it and bring some control back or to manage it through that time.

Charlotte maintained that access to mental health services may be limited because of some immigrant women's religious convictions around Karma:

Concepts are still valid around the belief of Karma...you have done something in the past life that has created some conflict and difficulties you are experiencing today.

For woman who might be depressed they may attribute their depression to Karma.

Again that is going to limit their access to services or if they access the utilization of treatment...their belief is so engrained because it didn't work in the life before.

Several of the participants identified that the immigrant women's spiritual well being was a part of their culture and way of life. Spiritual and religious practices were sources of strength and hope, and provided a way to accept their mental health problem. These findings are consistent with research studies in the literature review (Choudhry, 1998; Kinnon, 1999; Meadows, Thurston & Melton, 2001). It was also well noted in the data that due to the immigrant woman's deep religious beliefs such as Karma and destiny, sometimes it was not necessary for the women to consider accessing services.

There was a suggestion by some participants that outreach services such as informal presentations or workshops could be held at common meeting places in the community, such as the temple, mosque and other spiritual domains where the immigrant women would congregate. Some participants suggested that targeting the spiritual places would be an effective strategy for the provision of outreach services. Links with spiritual leaders and community organizations would lead to a more visible outreach service for the immigrant women. Charlotte supported this: "My sense is that the [immigrant] women if they do make it to anything, they make it to mass...to the temple...or to cultural events."

Coping Skills

Faith and religious practices were identified as being a part of the every day activities of the immigrant woman. Several participants viewed spirituality as a positive strategy to cope with the immigrant woman's mental health concerns. Lisa, a participant expressed a realistic viewpoint:

Everybody is unique and different, certain people have strong religious beliefs and values that help them cope with stressful times. Our inner resources...some can cope with it...some can't and that is not just unique to immigrants and refugees that is true of all of us.

Lisa also viewed immigrant women as having certain survival and adaptation strengths: "When you encounter barriers every day to cope...There is a certain resiliency...If you think of some of the experiences that refugees have gone through...They have survived in refugee camps often for many years!" Charlotte echoed similar views:

When [immigrant women] are coming from a different culture there is this sense of strength and resilience in terms of adapting... There might be initial difficulties...

Immigrant women may have had multiple immigration experiences in their history...

So a strength can be developing and adapting new coping strategies that come easily... a familiarity with change.

Ruby was astonished at the immigrant woman's behaviour: "They are amazingly resilient... given the situations that they find themselves in...and somehow they still keep it together." Ruby also cautions health care providers:

If there is a serious mental health issue or problem in one area, we can lose sight of where there are also strengths and where that strength can be transferred...It's important to remember that and not to pathologize everything.

Importance of family relationships.

The health care providers recognized that other positive strengths and coping skills lay in the woman's strong family and community centred values and collective ways of sharing. Another participant discovered: "You thought you were helping one

person...then it would grow...you got them a table or chair...The next time a voucher and they gave it to somebody else...that is the way it works, because they share.” This puzzled the participant at the time: “Why am I helping and getting these things for these [immigrants] and then they are giving it away?” Through increased experience she can now answer this: “Because it is [the extended family] They want all of them to become better off...not just the isolated unit.” Charlotte agreed too:

With South Asian immigrant women they are so adaptable to learn what others need...They are more likely to talk to others so that they know about other services...So they are attuned to knowledge, learning and watching about others being healthy.

It should be noted that some participants were keenly aware and proud of the hard working qualities that many immigrant woman had displayed to them. Even with minimal resources, the unfamiliarity with food, trying to learn English and power structure changes within the family, immigrant women were not deterred. Ruby commended them:

Somehow they put one foot in front of the other and keep on going with very, very difficult circumstances. I think they rely a lot on their history and their culture to help them and to tell them what to do. [As health care providers] we have to open our eyes to what it [history] does for them in terms of their coping.

Marie also endorsed the women’s positive hard working intentions to improve their situation:

They are hard working so that really pulls them out...They will work two jobs to make ends meet. One thing here that is helpful is that woman are used to doing

everything at home... just like back home...So they are used to it...They fall back on some of the things they have learned at home. They want to contribute to the family and look after their family health...they do seek medical attention when they need to. I think they do try to get out and seek information and learn about whatever they can.

Thus, an awareness and understanding of how culture influences immigrant women's mental health care is necessary to provide culturally appropriate health care.

A participant reported that steps have already been taken towards improving cultural competency and initiatives involving partnerships with other community health care service providers. For example, a cultural competency resource kit for clinicians was being developed within the Calgary Health Region. It was described as a fusion of topics, handy tools and information regarding cultural issues. This participant affirmed: "We are trying to provide those terms of reference for the [health care provider] so that [we] ...are improving and thinking beyond our work and our narrow view of how we treat people."

Cultural Understanding of the Health Care Provider

The health care providers recognized that to improve access to mental health services, it was also necessary to look at improving the cultural competencies of health care providers and to foster a better understanding of ethno cultural groups. Although great strides in the past decade have been taken to increase cultural competency of the health care provider, Lisa one of the participants felt it was an ongoing educational process for the health care provider:

You have the broad range... Some [health care providers] have no idea what cultural competency of diversity means, all the way to...this is really exciting I want to

improve my skills.... Often [health care providers] who sign up are the converted. So again you are working with a different audience.... To identify the uniqueness of the cultural background it shouldn't be a foreign concept for some health care practitioners.

In addition Lisa also felt that until cultural competency is a requirement and comes with a mandatory performance appraisal there will always be those health care providers who are less interested in improving cultural competency skills.

Participants consistently voiced the opinion that an understanding and familiarity of the culture would considerably improve the mental health care encounter. For example Hannah commented: "If they [immigrant women] don't get the [health care provider] that understands their language and culture it is a total waste of time [treating them]. Charlotte had a similar position:

What I have found is that [immigrant women] who end up seeking out counseling are looking for someone who speaks the language or at least has some cultural familiarity.... They just want someone to understand their culture and point of view.

However, Christie cautioned the health care provider to view the immigrant woman not only as someone from another culture: "I see service providers implying categorical knowledge to all clients from the same culture... getting to know the client as a person rather than overusing knowledge."

Another participant also pointed out: "[Health care providers] need to have an understanding of how health care systems work in some of those countries so [that] you get some insights into why they do or why they don't do certain things."

Holistic view.

There was much feedback from the participants concerning a holistic attitude towards the immigrant woman's situation. That includes not only attending to the mental and physical aspects, but also lifestyle issues. The health care providers strongly recommended the development of a holistic approach to mental health care to serve the needs of different ethno cultural communities. One health care provider suggested: "Meet them [immigrant woman] half way, take a more humanitarian approach rather than the medical model...I think that will make the process easier." Another suggestion offered by a health care provider:

The answer is to really be able to understand their culture so that [the health care provider] can know what factors might help or mitigate against their treatment... treating them as human beings, that is the basic thing having that understanding rather than going overboard.

In addition, Lisa also advocated for the health care provider's holistic stance:

When working with people from diverse cultural backgrounds...remember that there is a whole person there.... everybody's life is unique and the [health care provider needs] to recognize that when [the immigrant woman] comes to Canada it is not necessarily that easy.... So if you have been well educated in your own country... maybe you were a physician or whatever... now you are the cleaning lady or the taxi driver...remember what that means from a self esteem point of view [for that person]...I think to recognize the challenges and stresses that the immigrant women have gone through are something we should appreciate more and be supportive of the entire individual.

Summary

The data clearly demonstrated that culture can shape the immigrant woman's responses to health and accessing mental health services. Culture is part of the contextual factors that influence the immigrant woman's mental health care experience. An awareness of the social cultural context is necessary to provide appropriate and quality care.

The health care provider viewed family support as having positive and negative components, which influenced the immigrant woman's choices to access mental health services outside the family. Informal support within the family was seen as a significant factor influencing the immigrant woman as to whether she sought help for her mental health illness. These findings were consistent with Kleinman's (1978) explanatory model whereby much of the decision-making as to whether one should seek aid or to comply with treatment was made in the popular domain.

The stigma attached to mental illness and help seeking was an overwhelming access barrier for the immigrant woman. It is suggested in the findings that there are in many cultures significant negative feelings surrounding the concept of mental illness and the forms of treatment, such as medication and counseling.

Most participants viewed family and the extended support as a positive influence on the ethno cultural family. However, this influence can also take the form of exerting control and dominance over the immigrant woman, and not always in a positive way. Family beliefs and values could also lead to concealment and denial of the mental illness by the family, according to the health care providers.

The ethnic community influence was also seen as a powerful and controlling force. The shunning and stigma attached to mental health problems by the ethnic community

contributed to increased access barriers for the immigrant woman and her family.

Important contributions such as spiritual and healing practices were sources of comfort and support for the immigrant woman. Religious beliefs and practices were also identified as providing strength and guidance in dealing with a mental health problem. Some participants suggested that many immigrant women are most likely to turn to those methods first. These participants viewed these coping strategies as positive and effective sources in dealing with many mental health problems.

Positive attributes of immigrant women, such as the ability to share their burdens with the cultural unit, strong family and community centred values and resiliency were recognized and praised by the participants.

The health care provider's level of cultural understanding was seen as an important factor in providing appropriate and quality mental health care. Participants suggested that viewing the immigrant woman in a holistic manner would contribute to the health care provider's understanding of the social cultural contexts experienced by these women.

The final chapter of findings focuses on the health care provider-client relationship and the exploration of additional factors that may influence immigrant women's access to mental health care services. This influential theme surrounding the health care relationship was perceived by participants as a significant contributor to the immigrant women's experience.

Chapter VI: Findings and Discussion: The Health Care Provider and Client Relationship

The final theme that emerged from data analysis was the health care provider- client relationship. This critical relationship may greatly influence how immigrant women seek help for mental health problems. Health care providers may not always be aware of the complex interplay of factors that influence patient responses to professional care. Inadequate communication also has been cited as a major determinant of client compliance, satisfaction and appropriate use of health care facilities.

It was seen in the previous chapter that treatment interventions were constructed culturally and socially in context and that the health care provider negotiated between popular and professional perspectives. Negotiation therefore, was a process that takes place in the context of the health care provider-client encounter and requires mediation between the health care provider and client explanatory models (Kleinman, 1978). However, dealing with clients where basic communication is impossible, or obtaining accurate information is difficult, negotiating meaning and arriving at treatment decisions are even less likely. In part, this may also be the way the health care system is organized and priorities determined. For example, the structure of the health care system and absence of basic interpreter services would not give the immigrant women an opportunity to set priorities or be a part of resource allocation (Anderson & Reimer Kirkham 1998). Therefore access may be limited because immigrant women have no voice in health care decision-making. In some ways, there is exclusion because of unfamiliarity with the ways in which mental health care services are delivered. As well, health care provider interactions may sometimes leave immigrant women feeling devalued.

A number of sub-themes were illuminated from this fundamental theme of the health

care provider and client relationship. The first important sub-theme was the notion of whose responsibility it is to obtain mental health care services, and should this responsibility be divided. The health care providers had conflicting ideas concerning who should initiate the first contact for mental health care services. Secondly, participants reported that the health care relationship was a crucial factor influencing the ways immigrant women were able to access mental health services. Thirdly, the role of empowerment was seen as a useful and effective strategy. Fourthly, differing values and perspectives between the health care provider and client potentially disengage the relationship. Fifthly, discriminating attitudes were identified in the data and these attitudes were often not acknowledged or generalized to explain complex issues related to access of health care. Lastly, the importance of having a health care provider of the same culture was paramount for some women to obtain satisfactory and appropriate care.

Health Care Responsibility

Most participants addressed the prevalent concept of health care responsibility. From the health care providers' perspectives there were conflicting ideas on who should initiate contact for mental health care services. Although it is not entirely clear what immigrant women could do to access services, there was a suggestion that the women need to be aware first of the mental health care services available. One health care provider stated his position: "We have to give it to them first, because if they're not aware of it, they don't know what the symptoms are, what to look for, where to go... so we need that first." Both Charlotte and Ruby maintained that it was difficult to have one group take the responsibility and accountability for mental health care, especially when the awareness is not there for the women in the first place: "There are many more questions in that area

than answers!” (Ruby). Charlotte’s stance was advocating for awareness building for immigrant women: “They’re not even aware of what’s out there. You want the women to be responsible for [accessing health care] themselves but at first I think... We have to be doing something with the women before responsibility is addressed.” Ruby isn’t certain what women themselves could do to access the services but she is very convinced that health care providers need to get the information out to immigrant women:

That initial contact if they are totally isolated, which they so often are...they are out in a house somewhere in a community... it can be quite a distance to access services and they don’t necessarily speak the language very well.... once you’ve got access to an individual or a family you make them aware of all the other services as well.

Christie, who has counselled many clients of different cultures, agreed:

In many cultures... clients believe that the health care providers should contact them; they’re the ones who should initiated contact.... Clients who tell me when I ask them why they never call their psychiatrist, they say ‘Oh but they never call me’ but you know here you have to call them.

As well, community outreach was seen as a necessary strategy in making contact and providing appropriate information to the immigrant women. As one participant described: “If you go out to their community then part of the access barrier is removed. You are in their territory as opposed to [the immigrant] coming into yours.”

Other health care provider opinions included a broader view in that health care responsibility should be a mutually divided task. Hannah felt that issues between the family physician and client should be discussed openly together. It didn’t matter who initially brought up the problem, only that it would be addressed in a timely manner to

provide optimal health. Lisa stated there were complicating factors in figuring out whose responsibility it was. She maintained: "Everybody has a responsibility, if you look at who was the first support to immigrant women beyond their family or ethno cultural group... [either was an]immigrant serving agency or an ethno specific organization... Those are the first line of contact". She expressed how critically important it is to educate those first lines of contact concerning what might be a mental illness:

You have the individual person having to acknowledge to somebody that they're having stress, whether it's your family physician or an immigrant serving agency... those people have to make some type of assessments and support people to move them to the next level.

Significance of Relationship

Several participants felt that the relationship between the health care provider and client was very important. The relationships between the physician and client were deemed to be the critical entry point into the system. As Charlotte suggested:

That relationship is really a significant one in either direction, a powerful one. The health care professional relationship has a lot to do with how this person seeks health services else where... if the physician doesn't take the proactive steps to connect this person... mental health services or counsellors and bridge that gap... of trust building... that can do a lot... of whether they will access other services or not.

Christie reported health care relationships may vary:

In many cultures they have not only a professional, but a personal relationship with that person [physician]... In many countries the boundaries are not so clear-cut... If they live in a small town they know a lot about the doctor. [Physicians] are known to

go out for lunch with their patients... Some view it as a friendly relationship because it is a way to get to know the patient...It is very different...[here].

Within the health care provider-client relationship, trust and confidence influenced whether or not individual woman would continue to obtain necessary support. Christie substantiated this: "Once they've had a bad experience, they don't want to go back". She reflected on a past experience whereby an immigrant woman was afraid to go back to her family doctor because she hadn't taken the medication prescribed:

[The immigrant woman] thought it violated the patient-doctor relationship, so she didn't go back... maybe there was something in the doctor's attitude that led the client to believe that she had to heed to all of his instructions and if she didn't... there was a fear that she wouldn't get the proper care.

The establishment of trust is necessary if the helping relationship is to continue.

Feelings of fear may result in a broken trust, which acts as a further barrier for these immigrant women.

One health care provider noted that family physicians were pivotal in the assessment and referral of immigrant women for appropriate mental health care. Charles was firmly convinced:

Most immigrant women do have family doctors...It is really important to be able to detect that there is something going on... when the family physician notices something...they can refer [to mental health services] to investigate more of what is going on and find out about the whole situation.

It was suggested that continuing education, especially for new physicians, would increase their awareness of non-Western alternative treatment options.

Role of Empowerment

It should be noted that several participants felt that the strategy of empowerment was effective and useful for providing mental health care for these women. However, they also felt that some of these women wanted to be advised by the health care provider on how to deal with their mental health problems. This issue of empowerment may have consequences because of the unequal positioning of power relations between health care provider and client. In order to offer appropriate and meaningful health care, the health care provider may need to consider the context of the conditions under which the immigrant woman lives. For example, even with knowledge the immigrant woman may still be unable to change or manage her health care needs effectively. The immigrant woman's social and economic situation may be very influential as to whether she could take action. In terms of power relations between health care provider and client, drawing from Anderson (1996), it is not clear how class and power differentials may be addressed or how marginalized women living in poverty will acquire the resources to become empowered to assume greater responsibility for their health care. Although one has awareness of the social and economic structures that perpetuates inequity and influence health and well being, the emphasis may still be on the individual and the processes by which individuals can assume greater responsibility for their health. Anderson further asserted that by focusing on empowering immigrant women, there is a risk of glossing over the institutionalized practices that perpetuate inequities and barriers to health care.

One must also consider that the individual has varying needs and to consider other mediating factors in their lives. Factors such as recognition of the multiple forces of class, race, gender and history all influence and impact the delivery of health care (Anderson,

2001). The data reflected power distribution, as one health care provider verified:

[They] see us as their superior... we're here to empower them... a lot of times they think the answers have to come from us...that's part of it, but I think we need to work together... so to make some changes too...[not just] telling them what to do. So it makes them empowered.

Christie also agreed that empowering the individual is useful and therapeutic, however she sees that many immigrant women from other countries don't understand the concept of counseling. For these women, the counsellor is an authority figure, someone who they look to for advice and suggestions. When being asked: 'What do you think I should do?' Christie endeavoured to educate her clients and make them comfortable, yet at the same time she was careful not to impose her own worldviews on them. Christie's impression was that immigrant women wanted advice given and to feel that they had received some help for a warranted health problem. Christie maintained:

You don't want to leave the client with that feeling... it's a therapeutic situation so you write down different options and they can view it as their options... they'll still say 'what do you think that I should do?' they want something concrete they can take away from it.

Charles offered this strategy:

To show them [immigrant women] that they do have power and also to educate their husband that it is probably not her fault. There are cultural influences there...they have to respect each other and there can be no verbal or physical abuse...then that would empower the woman. To give her avenues, to let her know that there are resources, community agencies and services they can access...if we can bring the

husband to her side. In order for them to get better the husband becomes an ally in the treatment process rather than an enemy or antagonist... The main rule is for them to work together and to show the [immigrant woman] that she has choices and can make choices, which is very hard to be shown.

These examples seem to suggest that clients' expectations of the health care provider will vary depending on their situations. For example the severity of illness, age, availability of resources and other mediating factors in their lives influence their needs at different times. The responsibility is on the health care provider to recognize the forces present in immigrant women's lives. Anderson (1996) suggested the need for fluidity in the health care provider and patient relationship to accommodate for the evolving situation of the individual. This maintains a location for exploration and negotiating during the health care provider-client encounter. Lisa described:

You look at the unique aspects of a helping relationship... a client that is unique and your helper that is unique, your helper has different levels of insight and awareness... we have an obligation to help this individual... it's a two-sided [situation] what does the client want... and making them aware of how things are in Canada... if they want to even think about choices to help facilitate [change].

She cautioned that the health care provider needed to be aware of differing values within the health care relationship and not to assume values are all the same. Cultural values and meanings influence the health care relationship. Health care providers may bring their biomedical culture as well as their beliefs and values derived from their own socio cultural background. These values and beliefs may conflict with those of their immigrant clients'. Kleinman (1978) asserted that difficulties or misunderstandings arise when

others do not share these explanatory models.

Differing Perspectives and Values

Differing values between health care provider and client may precipitate misunderstandings in the health care relationship. Charlotte encountered this in her practice and sometimes found it was related to communication style differences. Pride and honour issues were often a part of the misunderstandings. Many immigrant women have commitments to maintain honour within their family. Therefore to create shame and dishonour within the family would only further complicate the situation. She asserted that different styles of communication might be perceived as discrimination, however unintentional. For example, in the West there is acceptance toward a more direct and even confrontational style of communication in our health care interactions. Charlotte believes that, for example, in Asian and South-Asian cultures communication in such situations is very indirect and non-confrontational. She observed:

It's already taken [the immigrant women] a lot to overcome shame and stigma to be able to access or even consider certain services... when there is even an initial direct confrontation challenging response... communication style can become one of the barriers to their continuing... I've had people say 'I'm not going to go there... [they are] so disrespectful.'

Ruby also supported this: "[The immigrant women] experiences shame and over what kinds of things, there is so many [issues] ... privacy... so if they value different things, differently, it's very hard to assess."

With differing values, there are also different priorities between the health care provider and client. The main focus for the immigrant women may be everyday survival

of her family and maintaining a job, whereas for the health care provider it is to manage the client's current mental health problems. Misunderstandings may develop on both sides which might decrease the possibilities of meaningful treatment. An experienced mental health counsellor confirmed that differing perspectives and values in the health care relationship may even place immigrant women at risk:

If you take a real feminist perspective... it can become dangerous. You can have all these things, live on your own... aspire to these things. That's very much our perspective... that's very different for [immigrant women] she is seeking more harmony with the community.... How it affects the community if she and her husband separated, it's not all about her or an individualistic way of looking at things.

Lisa also endorsed that offering alternate choices to immigrant women may cause disruption within the family. It is suggested that the health care provider be sensitive yet cautious deciding how best to advise in each unique situation. Ruby warns us:

We just have to be very careful of the lens that we are looking through... so if they [immigrant women] value privacy, independence and community self-sustenance more than getting some complete stranger in from the outside to give a different view... or to help in a different way... [the health care provider] might think it can be valuable! We have to be careful about getting our foot in the door and sticking our nose in business that they maybe don't want. I try to be sensitive to that as well.

Discriminating Attitudes

Several participants were of the opinion that discriminating attitudes and biases by the health care provider did occur. Inconspicuous forms of discrimination such as

stereotyping and not recognizing one's own racism were also recognized as harmful behaviours. Stereotypical views and assumptions needed to be questioned because of the fact one may be acting upon generalizations and biases that are untruthful. Lisa insisted that: "Stereotypes come up frequently, we all have stereotypes... [one must] check them... is this based on something valid or something learned from our own upbringing?"

Health care provider's socialized views may be quite different and deeply affect the health care relationship. The health care providers need to be aware of how their own life experiences can influence the service provided. Another participant reflected on her experiences:

I think there are [health care providers] who can be very hard on clients... I think sometimes those are personal.... If you are going through a divorce and you are angry with men, you have a client who comes in and she's angry with her husband that can trigger a lot of things that have nothing to do with the client.

Some participants also noticed that there seems to be an expectation that immigrant women should conform to mainstream health care standards and expectations. There is an assumption that immigrant women now living in Canada should be able to access health care just as other Canadians do. However, Lisa felt that sometimes health care providers might have unrealistic expectations: "There are people who think... this is our system in Canada ... we do it this way now they have to fit in. The expectation is they will speak English... understand our assessment and treatment processes." Ruby also admitted that attitudes should be questioned: "Are they discriminatory... or chosen differences and beliefs?" She reflected on a past case involving a Somalia family and a

nurse who was also involved regarding birth control management:

I believe the family had at least six kids. In their culture the size of the family says a great deal about the man and he gets his esteem by having many children... now the nurse's view was very contrary to that... she was looking at it very practically 'you can barely afford to feed four people let alone the eight you have'... and never mind not being on birth control and planning for the future!

Therefore the health care provider attitudes may come across as discriminating even when unintended.

Passive complicity with the discriminating attitudes of others was also a form of discrimination. Two participants expressed concern about some health care professional's apathy or non-involvement when witnessing blatant discrimination in their work place. In the working environment one participant, Charles attested to this: "You may see discrimination being done by one nurse or physician towards their patient, [you see] someone shouting at somebody... a lot of times people do not want to get involved." By the same token this health care provider was unsure of the solution: "We should probably have more involvement but I'm not sure how... because it would most likely interfere with somebody else." This would seem to suggest that it is much easier to remain safely uninvolved.

The data reflects behaviours such as refraining from addressing discrimination issues and denial of racist attitudes. Another participant reported: "Some people claim that they are not racist but they are condescending and that can work against them, too ... I'm not sure if they're really helping the patient." Lisa also validated this observation:

Some people are very receptive and others are hostile [a staff member made this

comment] Canadian women are not racist, when you open your eyes you can see all kinds of examples... certainly racism is alive and living, but you have to be looking for it.

An immigrant family counsellor felt frustrated by the fact that some service providers from community service agencies do not take a genuine interest and do not take the onus to make arrangements for immigrant women. For example, instead of arranging an interpreter they tell the client that their programs do not cover the fee for interpreters. She sees this quite often and their attitude has frustrated her: "It's kind of irrelevant [whether there is an interpreter] that's the attitude, that is the kind of message that's given to me...we don't see a lot of immigrant clients here." Christie maintained a different attitude is required from the community service provider; one that is positive. She suggested:

[Community service providers] need to provide competent care, not just culturally sensitive care. It is a matter of providing competent care to people with diverse backgrounds... people who needed wheelchair access to services didn't have that before... they realize they need to accommodate these patients... we need to do the same for people speaking different languages. It needs to be built into their philosophy and services, not something extra which is the attitude, an add-on.

Lisa also commented on existing practice challenges:

How do you get staff who are overworked...and feel overextended and unsupported...to change their attitude? ...[or tell about] racist attitudes or stereotypes or that they are not providing service adequately. That is not a strength based model... part of the strategy is looking at how it is raised...the issue of diversity and

its' many forms.

Changes in attitude by the health care provider at the individual level will help to increase competence in provision of services for immigrant women.

Trust of Health Care Provider within Same Culture

It was earlier noted that the physician-client relationship was a significant entry point into the system. A participant observed that often the immigrant women would want to seek out a professional within their same culture. As well, she may prefer a female health care provider. To illustrate this observation Charlotte reflected on a past case of how one immigrant family was treated when they were newcomers to Canada. The client confided in her:

I look back now, even as a child seeing those physicians. We were not treated respectfully, not treated very well. [There was] some question around their competence.... My father was showing symptoms of... cancer, they kept telling him it was arthritis.

As the story unfolded, this immigrant family did not consider changing physicians or getting a second opinion because of the strong obligation and trust felt by the family towards the physician. She further verified:

They tolerated years of very disrespectful, incompetent care, simply for the trust in the physician.... the inherent trust you have in somebody who is from your own culture and understands you better than you think somebody else might, is sufficient enough to create the in access to other services when you really need them.

Charlotte maintained that some immigrant women only have access to one physician that is of the same culture and or speaks their language: "That's all they have.... So no matter

what...to acknowledge that they are not being treated well is sometimes not of choice for them... they live with it, it's an unfortunate situation." This example illustrated the strong cultural ties and the importance that is bestowed to the health care provider of the same culture. It also demonstrates the underlying power relations that are involved in this most significant health care relationship.

Summary

The goal of this chapter was to demonstrate the effects of the health care relationship between immigrant women and the health care provider on access to mental health care services. It was evident that the relationship had a profound effect on how the immigrant women would seek help.

Health care responsibility was illuminated as an important, complex and prevailing concept. Health care providers were mixed in their views on who should initiate initial contact for mental healthcare services. It was suggested that the immigrant women needed to be aware first. Strengthening outreach services to immigrant women and increasing awareness were critical steps to improved access for these women. Some providers felt that responsibility for seeking mental health care should be shared with the client.

Differing values and perspectives between health care provider and client were seen as barriers in the health care relationship. Misunderstandings precipitated breakdowns in communication and promoted negative feelings within the relationship.

Trust and faith in the health care relationship were found to be essential components to immigrant women's continued use of the service. Finding a health care provider from the same culture was very helpful in promoting trust and confidence.

Power distribution was acknowledged and the concept of empowerment for the immigrant women was seen as positive. However, health care providers were reminded to review the factors and recognize the many forces of race, class and gender that inform power. Knowledge alone could help to empower women, but their social circumstances need to be considered.

Participants believed that discriminating attitudes and biases occur in the health care encounter. They described differing forms of discrimination, both active and passive, and sometimes unintentional. Stereotypical views and generalizations were also recognized as inconspicuous forms of discrimination. From the health care provider's accounts, changes made in attitudes at an individual level would help to improve sensitivity and competence in the provision of services.

In the final chapter the exploration continues surrounding the experiences of immigrant women's access to mental health care services. To support the health care provider in meeting the mental health needs of these immigrant women, recommendations will be discussed. These intervention strategies are offered to provide information and important insight to health care and other service providers.

Chapter VII: Discussion and Recommendations

This section draws together all relevant information from preceding chapters. It also includes recommendations to the health care provider who wants to provide more culturally appropriate and accessible mental health care for immigrant women. Implications for practice and for research is also presented to bring forward a better understanding of what would be helpful in meeting the immigrant woman's future mental health needs.

Difficulties accessing Health Care Services

The health care providers in this study confirmed that immigrant women do have difficulties accessing mental health care. Language barriers have far-reaching effects and present challenges to both the health care provider and client. Factors preventing immigrant women from acquiring English skills were consistently reported in the health care providers' accounts. These factors included the demands and responsibilities of childcare, housework, an outside job and the expense of language classes. Furthermore it was of particular concern that although demand for ESL education was growing, funding was being reduced. In meeting the demands of the rising need to supply language training, continuous growth in funding is also necessary. The Calgary Board of Education reported that enrolment of ESL students has increased from 3,073 in 1991/92 to 8,836 in the year 2000/01. This reflects an increase of 187 % in the student population. These observations were confirmed in reports from other sources (Citizenship and Immigration Canada, 2003; City of Calgary, 2003). Even though the salience of learning English to enhance employment, daily activities and quality interactions within the health care system, language continues to be an access barrier for many immigrant women.

Alongside ESL needs was an emerging requirement for interpretive services. Health care provider participants had varying perceptions as to whether there were difficulties in obtaining interpretive services. Whether or not health care providers experienced difficulties in obtaining interpreter services depended upon whether one worked in a community service agency or worked within the Calgary Health Region (CHR). In the past several years CHR has taken great strides to improve their interpretive services. Within the CHR, interpretive based services are now provided for the most common languages based on Calgary's demographics such as Arabic, Punjabi, and Cantonese. Although these are welcome advancements, there difficulties remain within the smaller community based service agencies that rely on internal staff or contracting out for interpretive services. These immigrant-serving agencies have limited budgets and often rely on annual grants. These grants support non-profit immigrant serving agencies for the provision of settlement services, drop-in ESL and the assessment and referral of adult immigrants to ESL training. Even though grants for the year 2004/05 were increased by 4 % (Government of Alberta, 2004), for agencies that contract out for interpretive services, an increase in numbers of immigrants makes it difficult to maintain service levels. Some agencies rely on internal staff to provide interpretive services, however there are limited numbers of bilingual health care providers. Family members used as interpreters may limit or provide inaccurate information. Thus, it is clearly seen how these associated factors may present problems for the immigrant woman accessing health care.

The health care providers in this study recognized that not only there were a shortage of interpreters but also a lack of health care providers who spoke another language. It was

agreed by most participants that a stronger focus should be directed toward the recruitment and retention of bilingual health care providers. These recommendations are directed toward the CHR and Alberta Learning who are involved in attracting and promoting interest to engage in this type of career. Strategies suggested were to involve and promote interest within the immigrant youth population to pursue careers in those kinds of health care fields. This would help to expand and ensure competent, bilingual health care providers within our health care system. It was also suggested that more outreach was necessary toward the community and the youth to create and support interest in these health care fields, possibly in the form of career fairs in the community.

Also, noteworthy to mention was that the CHR has implemented a strategy to increase the awareness of bilingual health care providers who offer services in Calgary. Access to this collection of key people and areas with bilingual capacity would be available in the form of a booklet to all health care providers working with non-English speaking immigrants in the coming year.

There have been considerable improvements made in services, which cater to the ethno-cultural population, yet there is an ongoing need for translated materials. All participants strongly emphasized that there was a lack of translated information terms of written materials, audios or videos that could be helpful to the immigrant woman. Thus, information concerning mental illness and health care services are not reaching those immigrant women in the community. Translated materials are essential in providing information and increasing the awareness of what mental illness is and what mental health care services are available. There is need for health promotion materials to be developed for various dominant languages. However, at the present time it appeared that many health agencies rely on interpretive services rather than on translated materials. The

recommendation of increasing health promoting translation materials is directed toward the provincial and municipal sectors, i.e. - the Government of Alberta and the CHR for a stronger commitment in provision of these essential health promotion tools. This critical link of translated materials would help to bridge the information gap to reach the immigrant woman in providing adequate awareness of mental health care services.

It was recognized by several participants that mental health services such as counseling was unfamiliar to immigrant women. Thus, many immigrant women lacked understanding or trust in the approaches of Western style mental health care. Participants reported that “talk therapy” was sometimes intrusive and might not be an acceptable choice for the immigrant woman. Talking to someone about a mental health problem outside the family could be seen as dishonourable behaviour. Therefore the very process of mental health care in the West is a cultural leap that is difficult for many immigrant women to make, and impedes access.

Participants agreed that the structure of Canada’s health care system affects immigrant women’s everyday life and influences their health. The health care system cannot be separated from broader economic, social and political contexts (Jiwani, 2001). Systemic structural barriers influenced the immigrant women’s contacts with the mental health care system and may make it inaccessible for many women. For example scheduling of clinic hours, the need for interpretive services and the inability to take time off work exacerbated access barriers for the immigrant women. Some of the systemic struggles were reflective of the inadequate resources to do health promotion such as health fairs and provision of translated materials. Several health care providers identified that the fragmentation of health care delivery and the way the system was designed was partially responsible for the kind of treatment immigrant women experienced. Participants

recommended the following strategies to all health care providers involved with the provision of mental health care services to the immigrant woman. It was suggested that a reformation of case management surrounding complex cases would help the client to avoid starting all over again with another health care provider. To support complicated multifaceted cases a good coordination of multidisciplinary teams was necessary to ensure adequate care. Participants suggested that effective health care involved multiple players. Some participants felt that all health care players need to look at maximizing, collaborating and working together to discover solutions to unify the system, even in the face of limited resources. A further recommendation to health care policy planners was to design mental health care programs and health care programs collectively, rather than as separate entities, for this may strengthen and provide more seamless service for all clients.

Participants identified that some immigrant women have misunderstandings about health care services, and with the absence of services such as interpreters, a lack of knowledge would continue to exist. Two participants questioned whether lack of interpreter services or the health care provider choosing not to use these services was a form of systemic discrimination against these women. It was suggested non-provision of translation services is discriminating because women would then be receiving a different kind of service. If information is not explained clearly the outcome of treatment may not be any better than if the woman was denied service altogether. If the health care system does not allow the health care provider provision of translation and childcare then one can argue there is systemic discrimination. Strengthening outreach services to immigrant women and increasing awareness of mental health issues were critical steps to improved access for these women.

Despite the popular shared ideology of equality, inequality within the health care system was identified as a real difficulty. Clearly, most health care providers maintained that inequality does exist even though one would like to ascribe to the ideology that everyone is treated equally. Inequalities however subtle or disclosed continue to exist in Canadian society and conflict with the social values related to justice and equality. These inequalities may present in the form of negative and discriminating conditions or attitudes within the health care system. Although it may be unintentional, women who have had negative health care experiences are more reluctant to re-enter the health care system. Coupled with the unfamiliarity of the system and often lack of language skills, the immigrant woman has less access to health care services. Most participants felt that access to services was not equal and that it was necessary to explore how best to decrease barriers in the system.

Low socio-economic status was seen as a crippling influence in preventing access to mental health services for the immigrant women. Poverty and lack of resources impacted the women's abilities to access services in the mental health system, and the kind of care and treatment received. Social conditions such as economic insecurity, family responsibilities and experiences of violence may influence the women's ability to access and use appropriate services. The way health care providers respond to the women also affect quality of care. Several health care providers articulated concerns about the two-tiered system of public and private mental health care services. A two-tiered system in the broadest sense refers to two co-existing health care systems: public and private. This definition implies that there are differences in access to health services based on the ability to pay rather than on need. Evans, Barer, Lewis, Rachlis and Stoddart (2000) have

reported that those who can afford private care may have access to better quality care and or quicker care while the rest of the population continues to access through publicly funded systems.

In a recent review, Evans et al. (2000) also concluded that the rich gain and the poor and sick lose. Restructuring issues in health care such as two-tiered services directly affect the immigrant woman accessing health care services. This also may create inaccessibility to health care services for immigrant women who are often in the low income group. Access to counseling or alternative treatments was almost impossible for the impoverished immigrant woman to receive.

Some participants perceived that the level of education could be either a benefit or a barrier, in so far as education could affect the immigrant woman's level of awareness of certain world knowledge and the ability to problem solve. Some participants contended that those women with higher levels of education might look after their health better. However the immigrant woman in a lower echelon job with poor English skills may have limited or no access to mental health care services, even though there is an overwhelming need to obtain care. It was clearly evident that the immigrant women's mental health status and opportunity depended on a multitude of social conditions. These findings also correspond with research studies in the literature review (Cheung & Lin, 1999; Kinnon, 1999; Li & Browne, 2000; Meadows, Thurston & Melton, 2001).

Most participants elaborated upon social isolation and the associated problems within the immigrant population. This was thought to be most significant within both the senior population and newly immigrated women. Newly sponsored immigrant women entering through family class status may find themselves in a powerless and generally dependent

position. Immigrant women who may be dependent due to their second class status in relation to the labour force, government benefits and services. This may make them vulnerable to an unhealthy situation with serious conflicts. Senior women may become the most disenfranchised because of lack of knowledge, language insufficiency and core beliefs around their culture. Participants viewed the ethno cultural community as an important source for seniors, however not all seniors had the means to access their own communities. Thus, the influence of gender on the immigrant women's mental health was significant.

Participants suggested that lack of transportation and isolation from the ethnic community affected women's access to resources. Everyday experiences of immigrant women were affected by the social discourses of gender. The multiple roles of immigrant women situated the women in a vulnerable, high-risk position. For example, role overload may include the immigrant woman working outside the home for economic survival (sometimes with two jobs) as well as housekeeping and caring for the husband, children and extended family members. The traditional role was powerful and influenced the immigrant women's access to mental health care. The shifting of the gender roles was also a good example of the underlying power relations within the family. This role reversal also may undermine the husband's authority, which may lead to family conflicts and abuse. Situations of dependency and abuse are very real for some immigrant women. Lack of power and loss of autonomy by the immigrant women may affect their access to obtaining support for their mental health needs. This was very well supported by this study's data and corresponded with research studies in the literature review (British Columbia Centre of Excellence for Women's Health, 2003; Morrow & Chappell, 1999).

It was also important for the health care provider to be aware and recognize the kinds of structural barriers to which these immigrant women are subject to. Gender, class, ethnic biases and hierarchies continued to reflect the Canadian power structure. As cited in the literature review, Canadian immigration policy further contributed to the immigrant women's dependency and vulnerability (Citizenship & Immigration Canada, 2002).

Immigrant women right from the onset are admitted into the country on unequal terms and made subject to a lesser citizenship. This inequality and embedded power based on race, class, gender and social relations influence the immigrant women's experiences and the kind of treatment received. It is recommended that the health care provider develop more reflective practices so that awareness and the recognition of how power differentials, knowledge and privilege are shared in relation to other groups in society.

Economic insecurity, care-giving and family responsibilities, experiences of violence and abuse are examples of social conditions which might affect immigrant women's experience and access to health care. This can create unequal social relations between the sexes and put immigrant women in a socially disadvantaged position. In social conditions of inequity, and particularly with poverty, barriers are created to obtaining appropriate mental health care for immigrant women. That is, women without financial resources have fewer choices when it comes to mental health care treatment. Immigrant women are often scrutinized and labelled upon entering the mental health system. The social inequities such as racism, sexism and class relations do influence the mental health problems immigrant women develop, and impact on how these problems are understood and treated by health care providers and society. An increased understanding of access barriers can help in the implementation and planning of future mental health care for

immigrant women. It is recommended that a commitment by health care providers and policy makers is necessary to continue the advancement of increasing the gendered understanding of the specific mental health needs of immigrant women.

Cultural Influences

Culture was a strong determinant in shaping how the immigrant woman would access mental health service and respond to a mental health problem. The health care providers felt that cultural background exerted both positive and negative influences that contributed to the immigrant woman's choices in accessing services outside the family. Support of strong family ties combined with appropriate treatment was seen as an effective way to manage a mental health problem. These findings were consistent with Kleinman's (1978) explanatory model concept whereby much of the decision-making was made in the popular sector as to whether to seek help or comply with treatment. Kleinman's conceptual framework was particular helpful in understanding the woman's experiences in relation to the health care system. By recognizing meanings assigned to events within the context of immigrant woman's experiences, one can further understand why it is important to the woman and how her behaviours may be influenced. This recommendation is offered to all health care providers so that with increased understanding of the immigrant woman's contextual factors more appropriate mental health care can be negotiated within the relationship.

Health, illness and health care need to be understood in relation to each other as a cultural system. The three domains, the professional, the popular and the folk have their own explanation and understanding of health related problems. Kleinman (1978) proposed that by understanding the client's perspective in each sector, the health care

provider would be able to bridge gaps in understanding and therefore provide more effective care and guidance in clinical practice.

Several health care providers identified that power and control exerted over the immigrant woman by the family could jeopardize appropriate access and treatment of the mental health problem. Dominance and control by the partner or family were viewed as potential negative influences. The health care provider also expressed concerns that denial and desire to keep the illness a secret within the family would impact how effectively the mental health problem would be treated.

In the findings it was suggested that in many cultures significant negative feelings surrounded the concept of mental illness, as well as the forms of treatment such as counseling and medication. Mental illness was a taboo subject amongst some cultures. Because of this feeling, immigrant women can be hesitant to reach out for help unless it is a crisis situation. For some clients, it meant denial and being silent about their situation for fear that others in the community would censure them. Therefore even if resources such as counseling were available, access was limited because of powerful cultural beliefs. The stigma attached to mental illness and help seeking was an overpowering access barrier for the immigrant woman.

Fear of being isolated socially from the ethnic community was recognized as a powerful influence over the immigrant woman. It was suggested that some immigrant women kept quiet about a mental illness problem in order to keep peace within the family. The concealment of the mental health problem clearly outweighed the desire to access mental health services and risk public exposure. Shunning and stigma attached to mental illness by the ethnic community might have contributed to the access barriers for

the immigrant woman.

It was clearly identified that a reliance on traditional healing practices and spiritual beliefs provided a source of healing, strength and power for the immigrant woman. Important contributions towards promoting their mental health were done by spiritual and healing practices. This finding is also well supported within research studies of the literature review (Choudhry, 1998; Kinnon, 1999; Meadows, Thurston & Melton, 2001). For some it facilitated their acceptance of the mental health problem. It was suggested that these methods were more likely used because the religious beliefs and practices provided strength and guidance for the immigrant woman. Most health care providers in this study were well aware of how these culturally tied concepts such as Karma and astrology supported the immigrant woman's well being. Due to certain deep religious beliefs such as Karma and destiny, many times the woman would not even consider accessing services. Recommendations that were seen as effective were directed toward the CHR and community service agencies who are involved in the planning and implementation of outreach services. Some participants suggested that outreach services such as informal presentations or workshops could be held at common meeting places in the community. For example, this could include the temple, mosque and other spiritual domains where immigrant women congregate. Other participants suggested that targeting the spiritual places would be an effective strategy for the provision of outreach services. Links with spiritual leaders and community organizations would lead to a more visible outreach service for the immigrant women.

Religious and spiritual practices were viewed as positive and effective ways to cope with health challenges. It is of interest and should be noted that because spirituality and

religion are so pivotal in the immigrant woman's daily life, it would be worthwhile to illuminate this further in future research. Strong cultural beliefs do impact the way immigrant women solve their problems individually and within the family.

The present study finding suggests immigrant women have positive health attributes that contribute to improving mental health care service access. Positive attributes of the immigrant woman such as the strong family and community centred values and sharing within the cultural unit were identified by the health care providers as effective ways of coping with stress. The hard working ethic of the immigrant women and their intentions of improving their situation was recognized and praised by the health care providers. Resiliency of the immigrant woman was viewed as a positive characteristic in coping and problem solving during very difficult circumstances. However, in contrast this finding challenges some of the stereotypical assumptions that have made reference to the immigrant woman as being passive, non-compliant and unable to take responsibility for her own health matters. One study (Brown, et al., 2002) reported that generalizing and stereotypical views may be very damaging with negative consequences toward immigrant women attempting to gain access to health care services. The recommendation to health care providers is to challenge themselves to recognize and question how their own views and biases may be affecting their practice and how the immigrant woman accesses mental health services.

The level of cultural understanding by the health care provider was viewed as a necessary part in improving access to mental health services for the immigrant woman. Although great strides have been taken in the past decade to increase cultural competency

it remains an ongoing educational process. It is recommended to health care providers that a better understanding of the culture would considerably improve the health care encounter, thereby providing more appropriate and quality mental health care. The findings of this study also identified that viewing the immigrant woman in a holistic manner would contribute to the health care providers understanding of the contextual factors influencing these women. Factors such as cultural, social, historical, political and economic differences do have impacts on the immigrant woman's situation. The awareness of these factors is necessary in determining what might help or mitigate against their treatment. The development of a holistic approach to health care within the ethno cultural community was strongly encouraged by most health care providers.

Health Care Provider and Client Relationship

The findings of this study also identified that the health care relationship between health care provider and immigrant women had a profound affect on how the immigrant women seek help. The question of health care responsibility emerged and there were conflicting ideas as to who should initiate contact first for mental health care services. Several health care providers advocated that education for immigrant women came first because it is especially difficult to take responsibility and be accountable for a mental health problem when one is unaware of what services are available. One participant believed it is a cultural expectation by clients of certain ethnic groups that the health care provider should initiate contact first. Apparently this was the norm in one of her client's country of origin.

Strengthening outreach services and increasing awareness were critical steps offered by the health care provider to improve access for immigrant women. In contrast, some

health care providers' opinions were that health care responsibility should be shared between professionals and clients.

The initial health care relationship was deemed a significant entry point into the system because that relationship greatly influenced how the immigrant women would seek health services elsewhere. Trust and confidence were essential in sustaining the relationship and maintaining continued contact.

The concept of empowerment within the relationship was seen as useful and was seen as a positive for immigrant women. Conversely though, it was also felt that some of these women wanted to be told what to do by the health care provider. The power distribution was asymmetrical between the health care provider and client. Studies from the literature have questioned whether the idea of empowering immigrant women might discount the underlying social and economic structural processes that perpetuated inequities in health care (Reimer Kirkham & Anderson, 1998; Anderson, 1996). Anderson stated that it was not clear how class and power differentials may be addressed or how marginalized women would acquire the resources to become empowered and assume greater responsibility for their health care.

Social and economic structures may perpetuate inequity and influence health and well being, yet the onus may still be on the individual and the processes by which that individual can assume greater responsibility for their health. Reimer Kirkham and Anderson (1998) further cautioned the health care provider that by focusing on empowering the immigrant women, there was risk of glossing over the institutionalized practices that perpetuated barriers and inequities to health care.

Findings suggest that client's expectations of the health care provider varied depending

on their situation. The recommendation to all health care providers is the need to consider other mediating factors in the immigrant women's life. For example, recognizing the multiple forces of class, gender, race and history, which all influence and impact the delivery of health care, was important. As well, the severity of the illness, age and availability of resources also influenced their needs. Knowledge would help to empower the immigrant woman, yet her socio-cultural milieu also needed to be considered.

Maintaining a site for exploration and negotiation within the health care encounter would help accommodate the evolving situation of the client. Strategies, which included the women's participation was viewed by several participants as an effective way to provide immigrant women with a sense of control over their mental health, support and treatment choices.

Between the health care provider and client, differing values and perspectives precipitated misunderstandings in the health care relationship. The immigrant women sometimes viewed, for example, differences in communication style and ideas of pride and honour as evidence of discrimination. Western modes of communication by the health care provider unintentionally caused negative feelings within the relationship. With differing values, there were additional distinct priorities between the health care provider and client. For immigrant women, day-to-day survival needs of the family were most important as it contributed to the well being of their families. Whereas, for the health care provider, it was to manage the current mental health problem. It was suggested in the findings that some health care providers had increased awareness of how these different perspectives and values in the relationship may create problems for the women. Furthermore, a sensitive and cautious view as to what was best for each

unique situation was recommended by some of the participants.

Discriminating attitudes and biases occur in the health care encounters, as reported in the findings. Discrimination was sometimes active, sometimes passive and sometimes unintentional. Discrimination in the form of stereotyping and denial of racist behaviour were recognized as harmful. Firstly, it was recommended that health care providers were recognized as harmful. Firstly, it was recommended that health care providers needed to be reflective about their assumptions and stereotypical views because they may be acting upon biases and generalizations. It was also necessary for the health care providers to be aware that their own life experiences might influence the care provided. Attitudes of apathy, being uninvolved and refuting accusations of racist behaviours were mentioned in the interviews. Findings suggest that health care providers sometimes remained passive and uninvolved with other co-worker's discriminating attitudes because it was safer and easier. As well, the health care provider's attitude may come across as racist even when this was unintended. Secondly, from the health care provider accounts, it was recommended changes in attitude made at the individual level would help to increase competence in provision of services for immigrant women.

Two participants also expressed that having a health care provider of the same culture made accessing service easier for immigrant women, fostering confidence and trust. However the findings revealed that there were limited numbers of bilingual ethno cultural health care providers. It is strongly recommended to the CHR to direct a stronger focus on recruitment and retention of bilingual health care providers in the provision of mental health care services for immigrant women.

Implications for Practice

Health care providers strive to provide appropriate and acceptable care to their clients

and at the same time provide a holistic approach to meet their needs. As health care providers, the attention must focus on attending to the total context in which states of illness and health are experienced. A greater discernment of the complex relationship between culture, environment and the interpretation of illness will guide the health care provider to re-think cultural implications by drawing away from individual characteristics and moving toward the experiences of immigrant woman within society. A shift is required away from understanding culture as a social characteristic of the client to one that recognizes culture as a dynamic process which is important to the every day situation of immigrant women. There is strong suggestion in the findings that the onus is on the health care provider to recognize the many forces that impinge on the immigrant woman's life. Factors such as social, cultural, political and economic differences have an impact on the immigrant woman's situation (Anderson, 2001; Donnelly, 2002).

Understanding the ways culture can shape the immigrant women's responses to health and illness will help health care providers to adapt and improve their service to immigrant women.

Cultural generalizations may not differ from stereotypical views and may lead to prejudice if one is not open to being corrected. Health care providers need to be aware of their own judgmental attitudes and blind spots. This will help to better understand the immigrant woman's situation. Through questioning one's own stereotypical views, one can recognize how such views may affect practice.

Health care providers need to recognize that the role of gender greatly influences the immigrant woman's everyday experiences and affects her access to mental health care services. A gender lens application will support the health care provider to understand

how social policy may create bias against immigrant women and increase awareness of barriers in access to services and cultural conflict that may arise when immigrating from countries with different expectations of roles.

Access to mental health care services may not be equal and it is necessary to explore how best to decrease barriers in the system. It is clearly depicted in the findings that situations of control, dependency and abuse are very real for some immigrant women. The health care provider needs to be aware and recognize the kinds of structural barriers that immigrant women face. An increased understanding of the specific mental health needs of immigrant women will help to implement and plan future mental health care. Comprehensive strategies are needed to educate health care providers on the impact of discriminating practices within the health care system. By developing an increased awareness and sensitivity of discriminating practices there is a greater chance to overcome individual and institutional barriers in provision of care.

In addition, health care providers need to be aware that the health care relationship significantly influences how immigrant women seek help for mental health problems. Barriers such as differing values and perspectives within the relationship may result in misunderstandings which precipitate breakdowns in communication and negative feelings. Although differing values and perspectives may occur, the negotiating process between health care provider and client is the most important issue (Kleinman, 1978). Health care providers need to be aware that their attitudes and behaviours affect the health care relationship and may indirectly create barriers to health care access thereby making it less likely for immigrant women to seek the appropriate care.

Limitations

In this qualitative study a small sample was selected to discover meaning and information richness. Therefore generalizability of the data will be limited (Polit Beck & Hungler, 2001). The scope of the investigation could have been broadened with the health care provider by using a larger sample.

This research study investigated immigrant women's mental health care issues from the health care provider's perspective. I acknowledge the critical importance of recognizing both the immigrant women's and health care provider's perspectives, but due to time and financial constraints it was not possible for this project. Therefore immigrant women's perspectives might be differing with the health care providers' views revealed in this research. The immigrant women's experiences also might be different and there may be other issues that exist. However, I would like to recommend in the future that in-depth inquiry with immigrant women be considered, as it will provide relevant information to future development of mental health services for immigrant women.

Implications for Research

A postcolonial feminist perspective lays the groundwork for analysis of gender, race and class relations as contextualized and historicized. Researchers require more inquiry aimed at overcoming barriers and inequities to provide a clearer picture of service usage. Research aimed at producing transformative knowledge means focusing attention on multiple experiences from different socio historical locations (Anderson, 2001). Doing research from praxis means consciously using our research to help immigrant women understand and change their situation (Lather, 1991). Information about how health reform affects women is minimal and information is key to understanding how reform

efforts are affecting the primary users and health care providers.

The application of gender-based analysis in immigrant research will provide comparative information between women and men and therefore would be useful in analyzing gender bias in programs and policies. A gender lens that recognizes the social determinants of mental health and the impact on immigrant women will contribute to an increased understanding in provision of mental health care services.

Further research aimed at the positive contributions that immigrant women have on Canadian society as well as exploring the strengths and positive health attributes of immigrant women would be beneficial in creating greater access for all.

Research that is explicit about the forces that influence women's health may be useful in providing a forum for articulation for the multiple strands of socio political contexts of illness and health. This heightened awareness may be implemented and used in collective strategies to advocate with policy makers locally and globally. Research conducted through a post-colonial feminist perspective is designed to be inclusive of community and policy makers right from the outset to ensure dissemination of research findings remain top priority.

Conclusion

The steady numbers of immigrants coming to Canada have increased in the last three decades. This has greatly changed societal structure and the health care system. This also has meant that health care providers need to recognize that providing effective and quality health care that is culturally acceptable is a most salient issue. In providing appropriate health care, health care providers need to be aware that social, cultural, political, economic and historical factors may shape the ways in which immigrant women

deal with their mental health problems and access services.

Immigrant women's health cannot be understood in isolation from the social conditions of their lives. The cultural and socio economic environment affects immigrant women's responses in accessing and using mental health services. Social inequities such as racism, sexism and class relations can influence the mental health problems women develop, and impact on how these problems are understood and treated by health care providers and society.

Health care providers need to consider other mediating factors in the immigrant women's life. Through examining the factors of race, gender and class, health care providers can better understand barriers and factors that shape and influence the way immigrant women access mental health services and the way the health care system operates. An understanding of access barriers through this research will help with implementing and planning more culturally sensitive mental health care for immigrant women.

It is suggested health care providers need to consider other mediating factors in the immigrant women's life, for example, the multiple forces of class, gender, race and history. These all influence and impact how the immigrant woman thinks and uses health care services. Furthermore, by paying attention to the immigrant woman's experiences and how they are shaped by historical positioning and social and economic inequities one sees more clearly the impacts on their health.

Recommendations that include increasing the gendered understanding of mental health by policy makers will help develop transformative knowledge that is constructed from the social location of those marginalized women. It gives direction for addressing

unequal power relations, both in practice and in the broader social context. Health care reform needs to better respond to the concerns and needs of immigrant women and at the same time advocate a paradigm that acknowledges the inadequacy of the biomedical explanations for understanding women's mental health. A continuous challenge to traditionally paradigms for understanding mental health issues and abuses are necessary within the health care system. It is important to move towards different understandings of mental health challenge and toward more holistic responses.

A post-colonial feminist scholarship offers a theoretical and methodological framework to analyze gender, race and class relations as contextualized and historicized. It calls for a health care system to be responsive to the varied social locations of its users. It is recommended that a postcolonial feminist scholarship be used in offering an alternative perspective on knowledge development that would help to address more thoughtfully issues of equity in health and health care reform (Anderson, 2001).

Kleinman's (1978) framework had particular emphasis on these explanations of health and illness that were constructed within the health care provider-client relationship. The meanings assigned to events within the context of the immigrant women's experiences provided an awareness and understanding of how immigrant women may develop their ideas about what is salient in relation to an event and how their ideas may influence their behaviours. The importance of negotiation in each health care provider-client encounter was stressed. As well, Kleinman's model facilitated the health care provider to understand and explore the immigrant women's mental health care experiences in relation to the health care system. These important insights will assist the health care provider to plan and implement more effective strategies to support immigrant

women's mental health care needs.

The application of gender based analysis to policy and program analysis will facilitate development of women-centred care. Woman-centred health care addresses the social determinants of mental health and gives the immigrant women choices about mental health care and equal access to mental health services. Strategies that are evidence based such as actively engaging women with mental illness and utilizing their experiences to create change and restructure is necessary. Participation will help ground both policy making and program delivery for all women's mental health.

Education of health care providers must include skills and knowledge in the use of research evidence in their practice. It is a professional responsibility for all health care providers to read and use research in their practices.

Communication of these research findings is a critical task of the researcher to ensure that new knowledge is addressed to correct inequities and past injustices. Dissemination of these findings is necessary if there is to be any differences made in the lives of immigrant women and how they access mental health care services in Canada.

References

- Abu Laban, Y. (1998). "Keeping' em out: Gender, race, class biases in Canadian immigration policy." In V. Strong Boag, S. Grace, A. Eisenberg & J. Anderson (Eds.), *Painting the maple: Essays on race, gender and the construction of Canada*. (pp. 69-84) Vancouver: UBC Press.
- Anderson, J. M. (1987). The cultural context of caring. *Canadian Critical Care Nursing Journal*, 7-13.
- Anderson, J. M. (1996). Empowering patients: Issues and strategies. *Social Science Medicine*. 43, 697-705.
- Anderson, J. M. (1998). Speaking of illness: Issues of first generation Canadian women: Implications for patient education and counseling. *Patient Education and Counseling*, 3,197-207.
- Anderson, J. M., & Reimer Kirkham, S. (1998). Constructing nation: The gendering and racializing of the Canadian health care system. In V. Strong-Boag, S. Grace, A. Eisenberg & J. Anderson (Eds.), *Painting the maple: Essays on race, gender and the construction of Canada*.(pp.243-261) Vancouver: UBC Press.
- Anderson, J. M., & Reimer Kirkham, S. (1999). Discourses on health: A critical perspective. In H. Coward & P. Ratanakul (Eds.), *A cross-cultural dialogue on health care ethics*. Waterloo ON: Wilfred Laurier University Press.
- Anderson, J. M. (2000a). Writing in subjugated knowledges: Towards a transformative agenda in nursing research and practice. Editorial. *Nursing Inquiry*, 7, 145.
- Anderson, J. M. (2000b). Gender, "race", poverty, health and discourses of health

reform in the context of globalization: A post-colonial feminist perspective in policy research. *Nursing Inquiry*, 7, 220-229.

Anderson, J. M. (2002). Toward a post-colonial feminist methodology in nursing research: Exploring the convergence of postcolonial and black feminist scholarship. *Nurse Researcher*, 9, 7-27.

Andrews, M., & Boyle, J. (2003). *Transcultural concepts in nursing care*. (4th ed). Lippincott.

Beiser, M., Gill, K., & Edwards, R. (1993). Mental Health Care in Canada: Is it accessible and equal? *Canada's Mental Health*. 2-6.

Beiser, M. (1999). *Strangers at the gate: The 'boat people's' first ten years in Canada*. Toronto: University of Toronto Press.

Berry, J., & Blondel, T. (1982). Psychological adaptation of Vietnamese refugees in Canada. *Canadian Journal of Community Mental Health*, 1(1), 81-88.

Bhabha, H. (1994). *The location of culture*. London: Routledge.

Bigby, J. (2003). *Cross cultural medicine*. American College of Physicians, Philadelphia: Versa Press.

Blehar, M., & Norquist, G. (2002). Mental health policy and women. In S. Kornstein & A. Clayton (Eds.), *Women's mental health*. (pp.613-625) New York: Guildford Press.

Bodner, A., & Reimer, M. (1979). The organization of social services and its implications for the mental health of immigrant women. *Resources for Feminist Research*, 63-65.

Boyd, M. (1998). *Migration, human rights and economic integration: Focus on Canada*.

- Centre for Refugee Studies. Toronto: York University.
- British Broadcasting Corporation News. (2003). Immigrants 'face higher health risks'. Retrieved Apr 22, 2004, BBC News Web. Site: <http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/3185643.stm>
- British Columbia Center of Excellence for Women's Health. (2003). *Mainstreaming Women's Mental Health: Building a Canadian Strategy*. (pp.1-13)
Vancouver: Author
- Browne, A., Johnson, J., Bottorff, J., Grewal, S., & Hilton, B. (2002). Recognizing discrimination in nursing practice. *Canadian Nurse*, 98, 24-27.
- Calgary Health Region. (2002). Ethno cultural external consultation project. Diversity Services.
- Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. (1988a). *After the Door has been opened: Mental health issues affecting immigrants and refugees*. Ottawa: Minister of Supply and Services.
- Carspecken, P. F. (1996). *Critical ethnography in educational research: A theoretical and practical guide*. London, England: Routledge.
- Cashmore, E. (1996). *Dictionary of race and ethnic relations*. (3rd ed.) London, England: Routledge.
- Cheung, F., & Lin, F. (1999). Mental health issues for Asian Americans. *Psychiatric Services*, 50, 774-780.
- Choudhry, U. K. (1998). Health promotion among immigrant women from India living in Canada. *Image: Journal of Nursing Scholarship*, 30, 269-274.
- Citizenship & Immigration Canada. (2002). *Canada's Immigration Law*. Minister of

- Public works & Government Services, Ottawa, 1-31.
- Citizenship & Immigration Canada. (2003). *The Monitor*. Spring, Ottawa, 1-7.
- City of Calgary. (2003). Calgary's shifting socio-economic landscape: A long term forecast of the economy and society 2003-2033: Author.
- Collins, P.H. (2000). *Black feminist thought: Knowledge, consciousness and the power of empowerment* (2nd ed.). New York: Routledge.
- Denzin, N., & Lincoln, Y. (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Denzin, N., & Lincoln, Y. (2000). *Handbook of qualitative research*. (2nd ed.) Thousand Oaks, CA: Sage.
- Dhooper, S., & Tran, T. (1998). Understanding and responding to the health and mental health needs of Asian refugees. *Social Work in Health Care*, 27, 65-81.
- Donnelly, T. (2002). Contextual analysis of coping: Implications for immigrant mental health care. *Issues in Mental Health Nursing*, 23, 715-731.
- Donnelly, T., & Long, B. (2003). Stress discourse and western biomedical ideology: Rewriting stress. *Issues in Mental Health Nursing*, 24, 397-408.
- Donnelly, T. (2004). *Vietnamese women living in Canada: Contextual factors affecting Vietnamese women's breast cancer and cervical cancer screening practices*. Unpublished doctoral dissertation, University of British Columbia, Vancouver.
- Dyck, I. (1995). Putting chronic illness "in place": Women immigrant's accounts of their health care. *Geoforum* 26, 247-260.
- Dyck, I., & Lynam, J. & Anderson, J. (1995). Women talking: Creating knowledge through difference in cross cultural research. *Women's Studies International*

- Forum*, 18, 611-626.
- Evans, R., Barer, M., Lewis, S., Rachlis, M. & Stoddart, G. (2000). *Private Highway, One Way Street: The Decline and Fall of Canadian Medicare?* Health policy research unit discussion paper series, Center for Health Sciences and Policy Research, Vancouver, University of British Columbia.
- Fowler, N. (1998). Providing primary health care to immigrants and refugees: The North Hamilton experience. *Canadian Medical Association Journal*, 159, 1-6.
- Fox-Keller, E. (1985). *Reflections on Gender and Science*. New Haven, CT: Yale University Press.
- Fox, P., Burns, K., Popvich, J., & Ilg, M. (2001). Depression among immigrant Mexican women and Southeast Asian refugee women in the U.S. *International Journal of Psychiatric Nursing Research*, 7, 778-792.
- Ghandi, I. (1998). *Post colonial theory: A critical introduction*. New York: Columbia University Press.
- Good, B. (1994). *Medicine, rationality and experience: An anthropological perspective*. Cambridge: England, Cambridge University Press.
- Goodridge, E. (2002). Meeting the health needs of refugees and immigrants. *Journal of American Academy of Physician Assistants*, 1, 20-32.
- Government of Alberta. (2004). Immigration Settlement and Support Services. (Retrieved Nov 12, 2004), Web site: <http://www.gov.ab.ca>
- Greaves, L. (1999). Canadian Institute of Health Research (2002) Written submission to the commission on the future of health care in Canada. *Gender, Sex and Health Care*. Institute of Gender and Health, Vancouver.

- Health Canada. (1986). *Achieving health for all: A framework of health promotion*. Ottawa: Minister of Supply & Services, Canada.
- Health Canada. (1999). *The Canadian Health Care System*. Ottawa: Minister of Supply & Services, Canada.
- Helman, C. (1985). *Culture, health and illness*. (2nd ed.) Toronto: Wright.
- Jiwani, Y. (2001). *Intersecting inequalities: Immigrant women of colour, violence and health care*. Feminist Research Education Development and Action Centre. Vancouver.
- Kalinowski, C., & Penney, D. (1998). Empowerment and women's mental health Services. In B. Lubotsky-Levin, A. Blanch & A. Jennings (Eds.) *Women's mental health services: A public health perspective*. (pp. 127-153). Thousand Oaks, CA: Sage.
- Kinnon, D. (1999). *Canadian research on immigration and health: An overview*. Ottawa: Health Canada.
- Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural system. *Social Science and Medicine*, 12, 85-93.
- Kleinman, A. (1980). *Patients and the healer in the context of culture*. London: University of California Press.
- Kleinman, A. (1988). What is a psychiatric diagnosis? In: Author, *Rethinking psychiatry: From cultural category to personal experience*. (pp. 5-17). New York: The Free Press and Macmillan.
- Laroche, M. (2000). Health status and health services utilization of Canada's immigrant and non-immigrant populations. *Canadian Public Policy*, 26, 51-73.

- Lather, P. (1991). *Getting smart: Feminist research and pedagogy within the postmodern*. New York: Routledge.
- Legault, G., Gravel, S., Fortin, S., Heneman, B., & Cardinal, M. (1997). Adaptation of services to new immigrant families: Perceptions of families and practitioners. *Canadian Journal of Community Mental Health, 16*, 67-85.
- Li, P. (1988). *Ethnic inequality in a class society*. Toronto: Thompson Educational.
- Li, H., & Browne, A. (2000). Defining mental illness and accessing mental health services: Perspectives of Asian Canadians. *Canadian Journal of Community Mental Health, 9*, 143-159.
- Manzankowski, D. (2001). *A framework for reform*, Report of the Premier's Advisory Council on Health, Alberta.
- Masi, R., Mensah, L., & McLeod, A. (1993). *Health and cultures: Exploring the relationships: Policies, professional practice and education*. Oakville-New York London: Mosaic Press.
- Matuk, L.C. (1995). Health promotion surveys of multicultural clients. In M. J. Stewart (Ed.) *Community Nursing*. (pp 266-283), Toronto: W. B. Saunders.
- Meadows, L., Thurston, W., & Melton, C. (2001). Immigrant women's health. *Social Science & Medicine, 52*, 1451-1458.
- Morrow, M., & Chappell, M. (1999). *Hearing women's voices: Mental health for women*. Vancouver: British Columbia Centre of Excellence for Women's Health.
- Morse, J., & Field, P. (1995). *Qualitative research methods for health professionals*. (2nd ed.). Thousand Oaks, CA: Sage.
- Ng, R. & Strout, J. (1977). *Services for immigrant women: Report and evaluation of a*

- series of four workshops*. Vancouver: Women's Research Centre.
- Peters, R. (1988). Gender differences among adult mental health team clients. *Women's Mental Health*. Vancouver: Greater Vancouver Mental Health Service.
- Polit, D., Beck, C., & Hungler, B. (2001). *Essentials of nursing research: Methods, appraisals and utilization*, (5th ed.) Philadelphia: J. B. Lippincott: Raven.
- Quayson, A. (2000). *Post-colonialism: Theory, practice or process*. Cambridge: Polity Press.
- Ralston, H. (1988). Ethnicity, class and gender among South Asian women in metro Halifax. *Canadian Ethnic Studies*, 20, 63-83.
- Reimer Kirkham, S., Anderson, J. (2002). Postcolonial nursing scholarship: From epistemology to method. *Advanced Nursing Science*, 25, 1-17.
- Romanow, R. (2002). Building on values: The future of health care in Canada, Final report, Saskatoon: Commission on the future of health care in Canada.
- Sandelowski, M. (1995). Focus on qualitative methods, qualitative analysis: What it is and how to begin. *Research in Nursing & Health*, 18, 371-375.
- Stats Canada. (2003). *Census of Canada*. Ottawa: Canada. Minister of Supply & Services.
- Steele, L., Lemieux-Charles, L., Clark, J., & Glazier, R. (2002). The impact of policy changes on the health of recent immigrants and refugees in the inner city. *Canadian Journal of Public Health*, 93, 118-122.
- Strachan, J., Johansen, H., & Nair, C. (1990). Canadian suicide mortality rates: First generation immigrants versus Canadian-born. *Health Reports*, 2(4), 327-341.
- Ten Have, M. (1999). Inequalities in mental health care and social services utilization

- by immigrant women. *European Journal of Public Health*, 9, 45-51.
- Thobani, S. (1999). Sponsoring immigrant women's inequalities. *Canadian Women Studies*, 19, 11-16.
- Thurston, W., & McGrath, A. (1993). "With two pennies in my pocket, I just feel not so helpless". A report on the mental occupational health promotion needs of immigrants in Calgary: Canada. University of Calgary, Canadian Mental Health Association.
- Tousignant, M. (1997). "Refugees and immigrants in Quebec". In I. Al-issa & M. Tousignant (Eds.), *Ethnicity, immigration and psychopathology*. (pp. 57-70), N. Y: Plenum Press.
- Tracy, L. C., & Mattar, S. (1999). Depression and anxiety disorders. In E. J. Kramer, S. L. Ivey & Y. Ying (Eds.), *Immigrant women's health: Problems and solutions*. (pp. 205-219). San Francisco: Jossey-Bass.
- Wenger, A. (1995). Classic article: Cultural context and decision-making. *Journal of Transcultural Nursing*, 7, 3-14.
- Westermeyer, J. (1989). *Mental health for refugees and other migrants: Social and preventative approaches*. Springfield, Il: C.C. Thomas Press.
- Wood, G., & Haber, J. (2005). *Nursing research in Canada: Methods, critical appraisal and utilization*. Toronto: Elsevier.
- Wu, Z., & Hart, R. (2002). Social and health factors associated with support among elderly immigrants in Canada. *Research on Aging*, 24, 391-412.

Appendix A: Interview Questionnaire

- 1) In your opinion, do you see immigrant women having difficulties accessing mental health care services?
- 2) In your view do you think underutilization is a problem for immigrant women?
- 3) In your view, do you think gender issues affect immigrant women's mental health care experiences?
- 4) There is suggestion in the literature review that racism and discrimination may affect immigrant women's mental health care: What is your view?
- 5) What do you think immigrant women should do to access mental health care services?
- 6) In your perspective what do you see are the strengths and positive health attributes of immigrant women that contribute toward improving their mental health care access?

Appendix D: Consent Form

TITLE:

Exploring Immigrant Women's Mental Health Care Experience
From a Post-Colonial Feminist Perspective :Implications for Practice

INVESTIGATOR:

Principal Investigator: Tam Donnelly BScN PhD. (c) Assistant Professor
Co-Investigator: Joyce O'Mahony RN BN Master of Nursing student

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND:

New immigrants that arrived to Canada in 2002 were reported at a total of 228,575. Alberta has had 14,672 immigrants settle in 2002, with Calgary claiming 61% or 8,997 immigrants from these totals. Statistics reveal Calgary is the fourth largest city in Canada to receive increasing numbers of new immigrants (Stats Canada, 2003). In 1996 the population of Calgary was 768,082, with the proportion of foreign-born population being 20.9 %. Five years later the population of Calgary was reported at 878,866 with the foreign born population remaining steady at 20.9 % (Stats Canada, 2003).

Immigrant women suffer from serious mental health problems and often do not receive the care that they need. Women's mental health care needs are not being met in the current system, despite what appears to be a rich network of services (Morrow & Chapell, 2001; Beiser, Gill & Edwards, 1993). The prevalence of mental health among immigrant women and the underutilization of mental health services will lead to increases in the seriousness of mental health problems experienced. Barriers to accessing mental health services are language, cultural beliefs and practices, stigma of mental illness and racial discrimination. It has been reported through many studies that immigrant women suffer from mental health problems such as depression, schizophrenia and post migration stress disorders (Thurston, 1993; Li & Browne, 2000; Beiser & Wood, 1988; Legault, G., Gravel, S., Fortin, S., Heneman, B., & Cardinal, M., 1997; Fox, P., Burns, K., Popvich, J., & Ilg, M., 2001).

To decrease the severity of problems and prevent secondary problems we must address these problems. Through examining the factors of race, gender and class we can better understand barriers and factors that shape and influence the way immigrant women access mental health services and the way our health care system operates. An

understanding of access barriers through this research will help with implementing and planning more culturally appropriate and acceptable mental health care for immigrant women.

In this study six health care providers will be interviewed. Through semi-structured interviews we will investigate and explore how immigrant women experience and access mental health care services from a health care provider's perspective.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this exploratory study is to investigate and describe how immigrant women access mental health services from a health care provider's perspective.

WHAT WOULD I HAVE TO DO?

Potential participants must meet the inclusion criteria. Each participant will have two interviews (a month apart) with duration of 30-40 minutes. The interviews will be audio taped and transcribed. They will be kept confidential and in a secure environment. After seven years from project completion they will be destroyed. Questionnaires with open-ended questions will be utilized. These interviews will be conducted in May and June/2004. Data analysis will be ongoing with completion of the thesis project by December/2004.

WHAT ARE THE RISKS?

There are no risks anticipated with this study.

WILL I BENEFIT IF I TAKE PART?

Additional research addressing barriers and facilitator factors would be beneficial in providing a clearer picture of service usage by immigrant women with mental health problems. The reason for underutilization of mental health services by immigrant women is not clear. We need to investigate whether or not under use of services reflect societal, cultural barriers or that there is not a need to seek help as perceived by the immigrant women. Investigating the reasons for differences in health care utilization may prove useful for developing mental health care programs that are culturally acceptable and appropriate to immigrant women.

We also need to recognize that difficulties immigrant women face in accessing and utilizing mental health services may not be due to culture but historical processes that have produced systemic inequities and oppression. A better understanding of how race, gender and class influence immigrant women's mental health care experiences is necessary in order to provide more appropriate and accessible mental health care to these women. There will be no direct benefits to you, yet you may enjoy contributing your expertise and experience to this research, as the eventual results will inform practice. You also may request a copy of the final report that includes suggestions for practice.