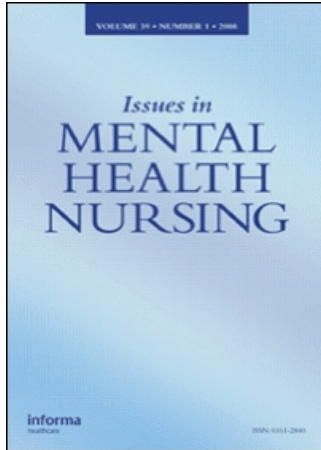


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On: 27 January 2008  
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Publisher: Informa Healthcare  
Informa Ltd Registered in England and Wales Registered Number: 1072954  
Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



## Issues in Mental Health Nursing

Publication details, including instructions for authors and subscription information:  
<http://www.informaworld.com/smpp/title~content=t713669522>

### HEALTH CARE PROVIDERS' PERSPECTIVE OF THE GENDER INFLUENCES ON IMMIGRANT WOMEN'S MENTAL HEALTH CARE EXPERIENCES

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Online Publication Date: 01 October 2007

To cite this Article: O'Mahony, Joyce M. and Donnelly, TamPhD T. (2007) 'HEALTH CARE PROVIDERS' PERSPECTIVE OF THE GENDER INFLUENCES ON IMMIGRANT WOMEN'S MENTAL HEALTH CARE EXPERIENCES', *Issues in Mental Health Nursing*, 28:10, 1171 - 1188

To link to this article: DOI: 10.1080/01612840701581289

URL: <http://dx.doi.org/10.1080/01612840701581289>

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## **HEALTH CARE PROVIDERS' PERSPECTIVE OF THE GENDER INFLUENCES ON IMMIGRANT WOMEN'S MENTAL HEALTH CARE EXPERIENCES**

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*The number of immigrants coming to Canada has increased in the last three decades. It is well documented that many immigrant women suffer from serious mental health problems such as depression, schizophrenia, and post migration stress disorders. Evidence has shown that immigrant women experience difficulties in accessing and using mental health services. Informed by the post-colonial feminist perspective, this qualitative exploratory study was conducted with seven health care providers who provide mental health services to immigrant women. In-depth interviews were used to obtain information about immigrant women's mental health care experiences. The primary goal was to explore how contextual factors intersect with race, gender, and class to influence the ways in which immigrant women seek help and to increase awareness and understanding of what would be helpful in meeting the*

We are grateful to all the health care providers who participated in this study. Special thanks go to Dr. Sandra Hirst, University of Calgary, Faculty of Nursing and Dr. Geertje Boschma, University of British Columbia, School of Nursing for their support and encouragement. We also extend special thanks to Ms. Barbara Colvin, University of Calgary for her editorial expertise.

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*mental health care needs of the immigrant women. The study's results reveal that (a) immigrant women face many difficulties accessing mental health care due to insufficient language skills, unfamiliarity/unawareness of services, and low socioeconomic status; (b) participants identified structural barriers and gender roles as barriers to accessing the available mental health services; (c) the health care relationship between health care providers and women had profound effects on whether or not immigrant women seek help for mental health problems.*

The number of immigrants coming to Canada has increased significantly over the past several decades. According to the 2001 Census of Canada, immigrants made up 15% of Alberta and 20.9% of Calgary's 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.

Many 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 is well documented that immigrant women suffer serious mental health problems such as depression, psychosis, and posttraumatic stress disorders (Cheung & Lin, 1999; Fox, Burns, Popwich, & Ilg, 2001; Li & Browne, 2000; Thurston & McGrath, 1993; Tracy & Mattar, 1999).

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; Donnelly, 2006; Goodridge, 2002; Morrow & Chapell, 1999). Factors influencing immigrant women's mental health care include language barriers, poverty, cultural and social stigma, unemployment, marginalization, discrimination, and gender roles (Beiser, Gill & Edwards, 1993; Browne et al., 2002; Dhooper & Tran, 1998). Other less visible barriers include 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 also have been reported (Masi, Mensah & McLeod, 1993; Morrow & Chappell, 1999). Beiser, Gill, and Edwards' (1993) study revealed that gender, age, socioeconomic position, unrecognized needs, ethno-cultural status, and availability of service do affect accessibility of health care. The researchers concluded that substantial barriers limit access to mental health care and compromise the equality of mental health care.

Although all immigrants are a higher risk population due to the physical and mental stresses of resettlement, women are at even greater risk for mental health problems (Morrow & Chapell, 1999; Thurston & McGrath, 1993). Women in particular may be prone to the stresses of isolation and childcare responsibilities, which may restrict their ability to acquire language skills and attend English classes (Kinnon, 1999). A recent study revealed that immigrant women's health care behavior is influenced by their cultural knowledge and values, their socioeconomic status, social support networks, and gender roles and expectations (Donnelly, 2004, 2006). To provide effective health care services to immigrant women, health care providers need to recognize that the women's social position and conditions in which they work and live could be major deterrents to the appropriate management of illness (Anderson, Blue, Holbrook, & Ng, 1993; Donnelly, 2004). Women and men have well-known physiological and social differences in relation to mental health issues (British Columbia Center of Excellence for Women's Health, 2003; Morrow & Chapell, 1999).

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, Botoroff, 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. The researchers concluded that racism and other forms of discrimination coexist and continue to conflict with Canadian values related to justice and equality.

Social conditions such as poverty, violence, and abuse all serve to influence the immigrant women's experiences in the mental health care system. Immigrant women are vulnerable to violence because of the

integrated nature of the race, class, and gender discrimination they experience (Jiwani, 2001). The connection 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 those who do not. She viewed the health care system as being deeply structured around hierarchies 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 impede 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.

There is a need for more gender analysis in order to fully understand immigrant women's values and experiences. Such understanding will enable those in 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. Attention also should be directed towards the strengths of immigrant women and their positive attributes (Kinnon, 1999).

## **PURPOSE OF THE STUDY**

This exploratory qualitative study explored how contextual factors intersect with race, gender, and class to influence the ways in which immigrant women seek help to manage their mental illness. In a previous paper we examined the cultural processes that exert positive and negative influences on how immigrant women seek mental health care (O'Mahony & Donnelly, 2007). Based on the same data set of the study, this paper, however, reports the impact of gender on immigrant women's mental health care experiences. Ethical approval for the study was obtained from the University of Calgary Ethics Board. All participants' names used in this paper are pseudonyms.

## **POST-COLONIAL FEMINIST PERSPECTIVE**

A post-colonial feminist perspective was used to investigate the experiences of immigrant women through a health care provider's

perspective. A primary aim of this perspective is to illuminate how social injustices and unequal social power relations contribute to the unequally distributed health care resources and inaccessibility of health care services for immigrant women. Post-colonial feminism is a theoretical lens that allows access to the everyday experiences of marginalization as structured by the macro dynamics of structural and historical natures and the micro politics of power. This lens raises analysis beyond the micro level to provide an enquiry into the multifaceted socioeconomic, historical, and political forces that shape the human experience. By viewing this population's situation within a larger social context and exposing social inequities, policies and practices may be fostered that result in better social justice (Anderson, 2001; Donnelly, 2004). 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).

## **RESEARCH DESIGN**

This exploratory qualitative study was conducted in several Calgary health care facilities that provided mental health care services to immigrant women. We do acknowledge and recognize the importance of both the immigrant and the health care provider's perspectives. Due to time and financial constraints a thorough investigation of both perspectives was not feasible for this project. Thus, in-depth interviews utilizing semi-structured questionnaires were carried out with health care providers who speak English and provided direct mental health care services to immigrant women.

### **Research Participants**

A purposive sample, "the process of deliberately selecting a heterogeneous sample and observing commonalties in their experiences" (Morse, 1994, p. 229), was used. Participants were carefully selected from various health care settings to illuminate diversity in perspectives and gain insight from individuals who practice on different levels of health care. An information letter about the study was sent to various agencies. Acute care and community-based health care providers who provide and

promote mental health care among immigrant women were chosen as potential participants. They were then invited to participate in the study by the researcher. Participants were selected from disciplines of nursing, medicine, and social work to explore possible diversity in views regarding the immigrant women's encounter of specific kinds of barriers and contextual factors. Seven health care providers (two Caucasians, two Chinese, and three South East Asian health care providers) volunteered to participate in the study. Both male and female participants were included in the sample.

## **DATA COLLECTION**

The method of data collection was in-depth interviewing using a semi-structured questionnaire. Interviews were conducted in English and open-ended questions were used to gather rich, descriptive narratives from participants (Morse & Field, 1995). The duration of these interviews was 30–50 minutes with the second interview being a member check. This member check involved returning the data to the participant along with analytic interpretations. This process enabled the researcher to clarify, expand, and discuss with the participants emergent themes and concepts. Interview questions involved exploring whether participants viewed immigrant women as having difficulties accessing mental health care services. These questions provided invaluable data on the health care provider's view of the difficulties and structural barriers immigrant women face. It also increased the researchers' awareness of the contextual factors that intersect and organize the woman's experience at any given time.

The researchers 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. Other interview questions were used to explore whether there were differing views of health and illness by the immigrant women as seen by the health care provider. The health care provider also was asked what would be helpful to meet the immigrant woman's mental health needs. This kind of question helped generate data concerning the importance of the health care provider-client relationship as well as the problems that arise when meanings assigned to events are not shared by both the health care provider and the client. Exploring negative attitudes and relationships between health care provider and client also provided important insight into how these factors contribute to mental health care issues. Prior to each interview a consent form was explained and obtained. Careful attention was taken to preserve

anonymity and confidentiality of the participants. The participants were aware they could withdraw from the study at any time.

### **Data Coding & Analysis**

The interview data and field notes were taped and transcribed verbatim following the interview. To ensure accuracy, transcripts were rechecked against the audiotapes, corrected, and a hard copy was obtained for preliminary analysis. A list of code categories were formulated for organizing incoming data. The outcome of this analysis was a set of complicated interrelated concepts and themes. This flexible, evolving process involved an intricate and rigorous development of code categories and subcategories. Themes and concepts were used for comparison within and across transcripts in the data set and across cases. We generated a higher level of data conceptualization and broader theoretical formulations from these themes. The second interview involved returning the preliminary data to the participants along with the researchers' analytic interpretations. The participants agreed on the themes and issues identified by researchers and provided additional insightful and reflective responses to the findings. As a result of this step, the researchers developed a deeper understanding of the data and gained insight to move the analysis from individual experiences to the exploration of the social processes and structures that organize experience.

## **FINDINGS**

Health care providers viewed gender as an important influence on how immigrant women would access mental health care. Data analysis revealed that (a) immigrant women face many difficulties accessing mental health care due to insufficient language skills, unfamiliarity/unawareness of services, and low socioeconomic status; (b) structural barriers and gender roles inhibited access to the available mental health services; (c) the health care relationship between health care providers and immigrant women had profound effects on whether or not these women would seek help for mental health problems.

### **Gender Roles as Barrier**

#### ***Conflicting Gender Roles***

Gender is a complex variable, inextricably tied to the dynamic and changeable nature of social and cultural systems (Brown et al., 2002;



Greaves, 1999). We found the notion of role change as documented in the literature as one of the defining stressors in immigrant women's lives (Jiwani, 2001). Immigrant women from Asia and Africa had very different roles compared to Western or Caucasian women. Often the traditional female role is subordinate and sacrificing. As Charles, one health care provider, phrased it:

A lot of their roles is subservient . . . homemaker, housekeeper . . . they have much stress. But of course they don't know where to go to deal with it. . . . You see a lot of conflict in terms of their role. Sometimes they feel rejected by not just their husband but also by their in-laws too.

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. Role overload and cultural conflicts make it almost impossible for immigrant women to consider reaching out for appropriate mental health care. These multiple roles and high expectations of immigrant women put them in a vulnerable, high-risk position for increasing levels of stress and stress related illnesses.

Also, due to the socioeconomic demands of being in a new country, immigrant women may have to take on a new role; one that may be very different from the traditional role that they were raised with. Charlotte, who has counseled 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 might be more traditional.

Charlotte maintained that the women don't necessarily want to give up that traditional role because it was a familiar role, one that may have power. With changes in role, confusion and feelings of powerlessness may take hold.

### ***Commitment to the Family***

Gender roles influenced whether or not mental health care services were accepted and accessed. For example, participants reported that immigrant women often have a strong commitment to home chores and childcare. The time frame of when mental health services were offered and the practicalities of getting to clinics could also be problematic for the women. Often if women need long-term psychiatric care the

family may not agree to it. Charlotte felt that although some cultural practices may be a barrier, there also was another very significant aspect to this gender role analysis. For many 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 continue to maintain honor within the family. This traditional role is so powerful that it impacts the choices these women make. For some women, accepting mental health care services or treatment may be viewed as betraying the family or abandoning their traditional role.

Ruby reflected on a past case where the immigrant woman was dealing with an abusive husband and depression. By helping the immigrant woman through this negative situation Ruby 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.

### ***Shifting of Roles***

For the low-income immigrant family, survival of the family necessitates the woman engage in paid work, as well as maintain the household and care of 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 or family violence if the husband attempts to reassert authority in the relationship.

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 woman 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 in Canada for a while. In some cases, 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 go through the grieving process of losing her own power and self-esteem.

### ***Domination and Control of Women***

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. 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 create unequal social relations between the sexes and place the immigrant women in a socially disadvantaged position (Abu Laban, 1998; Anderson & Reimer Kirkham, 1998).

The shifting of the gender roles may disrupt 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 well demonstrated in this study's data and corresponded with research studies in the literature review (British Columbia Center of Excellence for Women's Health, 2003; Morrow & Chappell, 1999). Charles, a participant, 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 woman 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. . . . 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.

Another participant reflected on how historical factors have influenced his Chinese clients, women who are from the mainland, but have lived here for 50 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.

Most of the health care providers reported that even though some 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, the impact of change is limited when they go home. One health care provider revealed that over time controlling and dominating behavior 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 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 had told the woman that she would like to speak to the woman alone. The woman's husband angrily replied, "Well what for? If you want to meet my wife, meet my wife with me . . . I am the interpreter." As the story unfolds this client ended up with severe postpartum depression and there were allegations of family violence and child apprehension. Another participant, 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."

### **Construction of the Canadian Health Care System**

The construction of Canada's health care system also may 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 (Anderson & Reimer Kirkham, 1998). 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 advocates 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, class, gender, social background, and sexuality. The structure of the health care system may make it inaccessible for many immigrant women. Several of the health care providers agreed that immigrant women might be aware of the 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.

### ***Systemic Discrimination***

Although the commonly held view of Canadian society is that the health care system is equitable and non-discriminating, there is evidence that racism is enacted within institutional organizations and is embedded in the structures and value systems of society (Browne 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 37 years of 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."

This woman maintained that change needed to come at various levels, both the individual level and 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 said: "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 belief that some immigrant women were vulnerable targets for systemic discrimination. Characteristics of some immigrant women, such as 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 women as they may have jobs with long hours and no sick time benefits, or they may have childcare responsibilities and no one to care for the children. She also pointed out that health care providers experience barriers to care as well. Many are women and have their own family responsibilities. They might not commit themselves to work on weekends or evenings.

One health care provider questioned whether lack of interpreter services or in some cases health care providers choosing not to use these services was a form of discrimination against immigrant 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, although 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*

The past few decades have seen huge 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 a picture of an open society where everyone has equal rights/opportunities and failure or success reflects self-efforts. However, health care providers confirmed that inequality does exist.

Charlotte, who has helped immigrant women for years, would like to think discrimination is unintentional, but acknowledges: "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. 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 those women 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 . . . 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.

## **DISCUSSION AND RECOMMENDATIONS**

Gender role influenced immigrant women's everyday experiences and in turn limited or made it impossible to consider accessing help for mental health needs. The multiple changing roles of immigrant women situated them in a vulnerable, high-risk position. The shifting of the gender roles and the underlying power relations within the family greatly influenced how some immigrant women accessed the available mental health care services. It is well supported both in the data and literature review that some immigrant women may have strong commitments to home chores and childcare. For these women there was a core belief that they are the holders of all family stabilities and of the caregiving role. This strong commitment, coupled with the time frame of when mental health services were offered and the practicalities of getting there, were problematic for some women in their efforts to seek help. Often if the women need long-term psychiatric care the family would not agree to it.

Most of the health care providers reported cases when immigrant women wanted to seek support, but access was either limited or forbidden if the male partner found out about counseling. Furthermore, if there was any continued involvement with treatment, the women's restrictions and abuse could escalate. It was found that due to male domination and the disapproval of counseling in some instances, it was very difficult for these women to seek help. Canadian immigration policy further contributed to immigrant women's dependency and vulnerability.

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. Access to mental health care services may not be equal and it is necessary to explore how best to create equity to care in the health care system. Health care providers need to recognize and facilitate the removal of structural barriers that immigrant women face when seeking care.

The application of gender-based analysis to policy and program analysis will facilitate development of women-centered care. Woman-centered health care addresses the social determinants of mental health, gives the immigrant women choices about mental health care, and equal access to mental health services. Strategies that are community based that actively engage women with mental illness and utilize their experiences to create change and restructure are necessary.



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**ERRATA**

The publisher regrets that both e-mail addresses provided in the correspondence section of Joyce Maureen O'Mahony and Tam Truong Donnelly's previous *Issues in Mental Health Nursing* article ("The Influence of Culture on Immigrant Women's Mental Health Care Experiences from the Perspectives of Health Care Providers," published in Vol. 28, No. 5, pp. 453—471) were incorrect. The following are the correct e-mail addresses:

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We are sorry for any inconvenience this may have caused.