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THE INFLUENCE OF CULTURE ON IMMIGRANT WOMEN'S MENTAL HEALTH CARE EXPERIENCES FROM THE PERSPECTIVES OF HEALTH CARE PROVIDERS

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It is well documented that serious mental health problems such as depression, schizophrenia, and post migration stress disorders exist among immigrant women. Informed by Kleinman's explanatory model, this qualitative exploratory study was conducted with seven health care providers who provided mental health services to immigrant women.

Analysis of the data revealed that (a) immigrant women face many difficulties when accessing mental health care services due to cultural differences, social stigma, and unfamiliarity with Western biomedicine, (b) spiritual beliefs and practices that influence immigrant women's mental health care practices, and (c) the health care provider-client relationship, which exerts great influence on how immigrant women seek mental health care. The study also revealed that cultural background exerts both positive and negative

453

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influences on how immigrant women seek mental health care. We suggest that although cultural knowledge and practices influence immigrant women's coping choices and strategies, awareness of social and economic differences among diverse groups of immigrant women is necessary to improve the accessibility of mental health care for immigrant women.

Canada's immigrant population has steadily increased over many decades. It is estimated that 18% of the Canadian population are immigrants (Stats Canada, 2003). 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 (Beiser, Gill, & Edwards, 1993; Matuk, 1995; Meadows, Thurston, & Melton, 2001; Morrow & Chappell, 1999). Studies revealed that immigrant women suffer serious mental health problems such as depression, schizophrenia, and post migration stress disorders (Beiser, 1999; 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). Depression and anxiety are the most common mental health problems among immigrants (Beiser, 1999; Berry & Blondel, 1982; Cheung & Lin, 1999; Dhooper & Tran, 1998; Tracy & Mattar, 1999).

Evidence shows that although immigrant women suffer serious mental health problems they often do not receive the care that they need and have difficulties in accessing what appears to be a rich network of mental health services (Beiser et al. 1993; Meadows et al., 2001; Morrow & Chappell, 1999; Ten Have, 1999). Substantial barriers that limit access to mental health care and compromise the equality of mental health care services include language insufficiency, different knowledge and understanding about health care services, gender, age, socioeconomic position, unrecognized needs, ethno-cultural status, and availability of services (Beiser et al., 1993; Masi, Mensah & McLeod, 1993; Morrow & Chappell, 1999).

Li and Browne (2000) found that many Asian Canadian immigrants are hesitant to access and utilize available mental health care services due to their lack of understanding of the mainstream culture's health care system and their poor English language skills. Similarly, Bigby (2003) found that Asian Americans tended to underutilize mental health services and often were reluctant to seek help because of cultural and language barriers. Other reasons for this underutilization were cultural

inappropriateness of services, social stigma, lack of financial resources, use of folk healers, and concepts about mental health and treatments that differ from those of the West. In addition, Fox et al. (2001) suggested that because the decision to migrate is often viewed as a positive change for immigrant women, mental health problems might be under detected.

The role of social support has been well documented as a significant contributor to immigrants' mental health (Cheung & Lin, 1999; Kinnon, 1999; Li & Browne, 2000; Wu & Hart, 2002). Social support factors, 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 et al., 2001). Studies have found that the roles of informal social support within the family were highly regarded and the majority of Asian immigrants would seek help for mental health problems from family members and friends rather than from a health care provider (Cheung & Lin, 1999; Li & Browne, 2000).

Choudhry (1998) observed that immigrant women are reluctant to talk about family and personal problems with outsiders for fear of being judged. Some immigrant women feared that the health care provider would meddle in private family matters, thus creating more problems. As a result, many suffer quietly for they are watched closely by their community to maintain status quo cultural and gender roles. For many, cultural norms may dictate that traditions and family take precedence over personal necessities. This may further isolate and limit immigrants' ability to access health care services in the community.

Traditional healing practices and spiritual beliefs are important contributors to immigrant women's mental health (Choudhry, 1998; Kinnon, 1999; Meadows et al., 2001). It was identified that spirituality was very much a part of the immigrant women's culture and way of life. For some immigrant women, utilizing these practices was a normal and accepted way to manage their health concerns. Spiritual and religious practices such as daily prayer and attending church were seen as sources of strength, comfort, and part of the context of their health practices (Meadows et al., 2001).

Legault et al. (1997) found that there were multiple perceptual differences between families and practitioners. Families gave priority to their children's problems; practitioners identified the mother's mental health problems as first priority. Both practitioners and families ranked unemployment and financial problems as dominant concerns. Families rated isolation as the major problem; in contrast, practitioners viewed

couple relationships as the main concern. Families preferred to seek
help for a socio-cultural adaptation problem from the informal net-
work. Interestingly, difficulties related to accessibility and compatibil-
ity of services was seen to be more serious by practitioners than by
families.

The prevalence of mental health illness among immigrant women
and their underutilization of mental health services put this population
in danger of exacerbation of mental health symptoms with associated
physical illnesses and social problems. How to provide culturally ap-
propriate and acceptable mental health care to immigrant women to
decrease the severity of mental illness and its consequences has been
an important issue for health care providers and policy makers (Beiser,
1999).

PURPOSE OF THE STUDY

The overall aim of this qualitative research was to explore with the
health care providers their concerns about immigrant women's mental
health and how women access mental health care. Through the health
care provider's perspective, barriers were identified concerning the ac-
cessibility of mental health care services that are available to immigrant
women. The ultimate goal was to illuminate and disseminate awareness
of immigrant women's mental health care experiences in order to pro-
vide important insight that might help with planning and implementing
more effective and culturally sensitive mental health care for immigrant
women. Three research questions were addressed: (1) What are the ex-
periences of health care providers regarding immigrant women's men-
tal health concerns? (2) From the health care providers' perspective,
what are the contextual factors that influence immigrant women ac-
cessing mental health services? (3) What intervention strategies would
help health care providers meet the mental health needs of immigrant
women?

This paper illuminates the cultural processes that exert both positive
and negative influences on immigrant women's mental health care. The
topic is addressed from the health care providers' perspective. Other
findings will be reported in subsequent papers. In this paper, the re-
searchers will describe the theoretical framework guiding the explo-
ration of how cultural processes influence immigrant women's lives and
their health care practices. This is followed by the research design, find-
ings of the study, and a discussion and recommendations to all health
care providers. Ethical approval for the study was obtained from the

University of Calgary Ethics Board. All participants' names used in this paper are pseudonyms.

KLEINMAN'S EXPLANATORY MODEL

Arthur Kleinman (1978) viewed culture as a system of symbolic meanings that may influence experience and social reality of individuals. He conceptualized that medical systems could be compared to cultural systems. He maintained that health, illness, and health care were parts of a cultural system and need to be understood in relation to each other. Kleinman's explanatory model is composed of three sectors: professional, popular, and folk. The popular sector was made up of the family, social network, and community. To a large extent decision making as to whether to seek aid or comply with treatment was made in this sector. This explanatory model of illness guides patient and health care professional choices about treatment. Generally biomedical explanatory models focus on disease (malfunctioning of decreased psychological and biological processes) while patients focus on illness (the experience), psycho-cultural construction of disease, and the societal reaction to it. Kleinman concluded that different perspectives and views would occur, but the most salient issue is the negotiating process between patient and health care professional in providing acceptable and effective care.

The experience of health and illness is linked to the environment in which one lives as well as to culture. To understand the immigrant woman's health care behavior, there is a need to understand their conceptualizations of health, illness, and disease, as well as how their cultural values and knowledge may shape health care experience. This is key in recognizing that different views of health and illness may be brought to the health care provider-client encounter.

Culture can shape individual responses to health and illness. Cultural background has a significant influence on people's lives, including their perceptions, emotions, languages, diet, dress, body image, behaviors, family structures, concept of space and time, and attitudes toward illness and pain. However, culture must be seen in its particular context in relation to historical, economic, political, and geographic elements (Donnelly, 2006; 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 economical differences influence immigrant women's situations and shape their mental health experiences. To provide holistic health care, health care

providers must strive to recognize cultural differences in perspectives and the complex interplay of factors that influence immigrant women's mental health care practices.

RESEARCH DESIGN

This qualitative research was conducted in several health care facilities that provided mental health care services to immigrant women. In-depth interviews were conducted in English with health care providers who provided direct mental health care services to immigrant women.

Participants

Both male and female participants were included in the sample. They were carefully selected from different health care settings to allow for diversity in perspectives and gain insight from individuals who practice various levels of health care. Acute care and community based health care providers who provide and promote mental health care to immigrant women were chosen. Participants were selected from disciplines of medicine, nursing, and social work to explore possible multiplicity in views regarding the immigrant women's encounter with specific kinds of barriers and contextual factors. Two Chinese, three South East Asian, and two Caucasian health care providers participated in the study.

Data Collection

The method of data collection was in-depth interviewing using a semi-structured questionnaire. Each participant had two interviews, each 30–50 minutes long. Interviews were conducted in English, and open-ended questions were used to gather rich, descriptive narratives from participants (Morse & Field, 1995). Interview questions explored whether participants viewed immigrant women as having difficulties accessing mental health care services. This question provided data on the health care providers' view of the difficulties and structural barriers immigrant women face. This, in turn, helped increase the researcher's awareness of the contextual factors that organize the women's mental health care experience. 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 providers. Health care providers also were asked what they thought 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 meanings assigned to events within the context of the immigrant women's experience were illuminated and gave researchers an understanding of what is important to an event and how it may influence women's behavior. Relevant information as to how the health care provider encounter could influence the immigrant woman seeking help was obtained.

Consent forms were signed prior to the first interview. Careful attention was given to preserve anonymity and protect the privacy and confidentiality of the participants. The participants were assured that they could withdraw at any time.

Data Coding and Analysis

Interview data and field notes were taped and transcribed verbatim following the interviews. As data were obtained to ensure accuracy, transcripts were rechecked against the audiotapes, corrected, and a hard copy was obtained for preliminary analysis. In the early stages of analysis, transcripts were coded to identify preliminary themes from the data and a list of code categories was formulated for organizing incoming data. The outcome of this analysis was a set of complicated interrelated concepts and themes. This process involved a systematic and rigorous development of categories and subcategories and was flexible and evolving. 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. At the second interview, preliminary data was reviewed with the participant along with the researchers' analytic interpretations. This step in the process enabled researchers to develop a deeper understanding of the data and gain insight that helped move the analysis from individual experiences to the exploration of the social processes and structures that organize experience.

FINDINGS

Analysis of the data revealed that (a) immigrant women face many difficulties when accessing mental health care services due to cultural and social stigma, and due to their unfamiliarity with Western biomedicine; (b) spiritual beliefs and practices influence immigrant women's mental health care practices, and (c) the health care provider-client relationship

exerts great influence on the ways in which immigrant women seek mental health care.

Difficulty Accessing Mental Health Care Services

Cultural and Social Stigma

All health care providers viewed the cultural and social stigma attached to mental illness and help seeking as a strong barrier to accessing mental health services for immigrant women. Participants felt that in many cultures there were significant negative feelings towards mental illness and the taking of medication. Participants clearly articulated that dealing with the diagnosis of being mentally ill for some clients meant denying and not accepting their situation. Some participants found that a woman's family might try to conceal the illness. Therefore, by the time the woman was diagnosed with mental illness, it was usually in the crisis intervention phase of the problem. In some situations the immigrant woman would isolate herself because of fears of community backlash. It was noted that even when mental health services were available for these women, the stigma and shunning from family and community exerted stronger influence over the women's mental health care behavior. Marie, who counsels immigrant women, spoke 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 reach out because of the taboo that they have placed on the condition.

Several health care providers in this study believed that the ethnic community had a very definite impact on how the immigrant woman and her family dealt with mental health problems. Marie noticed:

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

Due to the strong desire to keep peace within the family and within the members of the community, women might cope with mental illness by

seeking help among family members. Furthermore, the stigma of having a family member with mental illness can outweigh the desire to access mental health services for fear that the ethnic community would find out. Thus, the lack of community support and high stigma regarding mental health might be other barriers to seeking mental health care services for some immigrant women.

The health care providers' accounts noted that informal support from family was a critical influence over whether immigrant women sought help for mental health problems. The participant observations were consistent with Kleinman's theoretical framework, in that the family was described as a strong, controlling influence over the immigrant woman's health as well as her source of support. All participants agreed that having the strong support of family was an important factor influencing women's coping behaviors. The family's role in providing emotional support during the illness experience was acknowledged. As Ruby commented:

> 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.

Although dealing with mental health problems within the family was seen as a positive notion, some participants voiced concern about the power and control exerted over the immigrant women by the women's 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 woman's chances of obtaining appropriate treatment for mental health problems. Many immigrant women have commitments to maintain honor and pride within their family. Therefore, creating shame and dishonor within the family by acknowledging mental illness could complicate the situation. As noticed by Marie, "The mind set is that they can solve their problems on their own ... back home it is dealt with differently." Similarly, Charlotte stated:

> Keeping it within the family ... there is a lot of pressure ... that social pressure is real. So even if [the immigrant woman] chooses to make choices around accessing services and engaging services, staying with the service is highly impacted by the woman's perceptions and pressures from home.

Unfamiliarity with Western Biomedicine

The participants often mentioned that immigrant women's misunderstandings of Western biomedicine and their unfamiliarity with mental health care service affected how these women sought help. Many immigrant women lacked understanding or trust in the approaches of Western style mental health care. Often the mistrust centered on not understanding or trusting medications prescribed for their mental illness. Many immigrant women used alternative medicine and preferred to use their own traditional medications. Charles attested:

> 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 [Western] medication as much.

Lisa shared this view:

> 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.

Another difficulty voiced was the immigrant women's unfamiliarity with the mental health services. Most participants agreed that there was a lack of awareness of what resources were available to these women; and, more importantly, women think that they are not able to afford the services. As Charles saw 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.

The Influence of Spiritual Beliefs and Practices

Some health care provider participants identified that spiritual beliefs and reliance on traditional health practices can provide a source of mental health management for the immigrant woman. Traditional healing practices were commonly used to manage health care. Charlotte, who has 20 years of counseling experience, observed that some immigrant women were more likely to turn to those methods first if they are experiencing a mental health problem:

> For example in the South Asian culture . . . older women 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 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.

Several participants mentioned the powerful influence of religious beliefs. It was recognized that a strong sense of religious and spiritual beliefs were important to these women for maintaining good health. They emphasized that although spiritual beliefs offer a real source of strength and wisdom, they also could present barriers to seek mental health care. Christie, an immigrant counselor, shared the following concerning her Chinese clients:

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

It is of interest to note that most of the health care provider partici- pants had an awareness of these culturally tied concepts such as believ- ing in Karma or astrology among the immigrant women. As stated by Charlotte:

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 what they have to do and bring some control back or to manage it through that time.

She, however, recognized that access to mental health services might 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 women 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.

Several participants identified that immigrant women's spiritual well being is a part of the women's culture and way of life. Spiritual and religious practices were identified as sources of strength and hope, and as ways to possibly facilitate immigrant women accepting their mental

health problem. These findings are consistent with another study (Donnelly, 2006) in which it was noted that due to deep religious beliefs, such as destiny, some women might think it was not beneficial for them to consider accessing Western biomedicine services.

Although faith and religious practices were identified as having strong influences on everyday activities of the immigrant woman, there is recognition that immigrant women have many survival and adaptation strengths. As Lisa notes:

> 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.

It should be noted that some participants were keenly aware and proud of the hard working qualities that many immigrant women had displayed. Even with minimal resources, limited English skills, and coping with 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 on 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 life situations:

> 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 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 at home. They want to contribute to the family and look after their family's 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.

Cultural Understanding of the Health Care Provider-Client Relationship

Participants consistently voiced the opinion that an understanding and familiarity of the women's culture would considerably improve the mental health care therapeutic relationship. Hannah, a counselor for 25 years 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.

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. Some participants found it was related mainly to communication style differences. Different styles of communication might be perceived as discrimination, however unintentional. Immigrant women may perceive communication differences as discriminatory because the health care provider's style could be very confrontational. One participant believed that, for example, in Asian and South-Asian cultures communication could be very indirect and non-confrontational. Marie 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."

Trust and faith in the health care relationship were found to be essential components to the immigrant women's continued use of the service. Having a health care provider who understood or was aware of the woman's culture was seen as a very helpful component in promoting trust and confidence.

There was much feedback from the participants concerning a holistic attitude that not only attends to the mental and physical aspects, but also the immigrant woman's life circumstances. The health care providers strongly recommended that to effectively serve the mental health needs of different ethno-cultural communities, a holistic approach to care is a must. Lisa 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.

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

DISCUSSION AND RECOMMENDATIONS

Culture was seen as a strong determinant in shaping how the immigrant woman would access mental health service and respond to a mental health problem. The participants felt that cultural background exerted both positive and negative influences on the immigrant woman's choices in accessing services outside the family. The findings of this study also revealed that the family of the immigrant woman plays a powerful role in her decision to seek help. These findings were consistent with Kleinman's (1978) explanatory model which states that much of the decision-making process for immigrants was made in the popular lay sector regarding whether to seek help or to comply with treatment.

The study revealed that immigrant women's reluctance to access available mental health services may have been the result of keeping honor within the family unit. Counselling or "talk therapy" can be viewed as intrusive and might not be an acceptable treatment modality for some immigrant women. Talking to someone about a mental health problem outside the family could be seen as a dishonorable behavior. Thus adopting Western biomedicine mental health care approaches is a cultural leap that is difficult for some immigrant women to make. Health care practitioners' supporting the family and providing culturally appropriate explanations and treatment might be an effective way to manage a mental health problem and increase access to available health care services among immigrant women.

Congruent to Kleinman's (1978) theory it was found that the explanatory models of illness and disease used by the immigrant women influenced their perspectives and ability to seek mental health care services. By recognizing meanings assigned to events within the context of immigrant woman's experiences, one can further understand why the events are important to the woman and how her behaviors 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 therapeutic relationship. Factors such as social, cultural, political, and economic differences have an impact on the immigrant woman's situation (Anderson, 2001; Donnelly, 2002). Understanding how these factors operate to shape immigrant women's responses to health and illness will help health care providers to negotiate and improve services to immigrant women.

The results from this study suggest that the social stigma attached to mental illness and help seeking is a significant barrier to accessing mental health care for an immigrant woman. In some cultures, mental illness is a taboo subject and revealing it generates significant negative feelings within the ethnic community. Therefore, some immigrant women might be hesitant to reach out for help unless they are in a crisis situation. For some clients, this stigma means denying and being silent about their conditions. Powerful cultural beliefs and social stigma towards mental illness combined with unfamiliarity and misunderstandings of mental health care services impede access to available health care services.

Participants identified that although there have been considerable improvements made in services that cater to the ethno-cultural population, there is an ongoing need for translated materials about mental illness and mental health care to reach immigrant women. All participants strongly emphasized that there was a lack of translated information in terms of written materials, audiotapes, or videos that could be helpful to immigrant women. Thus, information concerning mental illness and health care services is not reaching these women in the community.

Participants recognized that translated materials are essential in providing information and increasing the awareness of what mental illness is and what mental health care services are available. Strengthening outreach services and increasing awareness should be provided in the language that is most understandable and accessible to the immigrant women. Thus, mental health promotion and mental health care materials need to be translated into various different languages and distributed widely within ethnic communities.

Although deep beliefs in destiny might pose as a barrier for some immigrant women to seek help, it was identified by the participants of this study that a reliance on traditional healing practices and spiritual beliefs can provide a source of hope, healing, and strength. Spiritual and traditional healing practices can make important contributions toward promoting immigrant women's mental health. This finding is also well supported by other research studies (Choudhry, 1998; Kinnon, 1999;

Meadows et al., 2001). Some participants suggested 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 sites where immigrant women congregate. The participants also suggested that collaborating with spiritual leaders and community organizations would lead to a more visible and effective outreach service for reaching immigrant women.

The health care provider participants acknowledged that the resiliency of immigrant women is a positive characteristic in coping and problem solving during difficult circumstances. The hard work ethic of the immigrant women and their intentions of improving their situation were recognized and praised by the health care providers. This finding challenges some of the stereotypical assumptions that reference the immigrant woman as being passive, non-compliant, and unable to take responsibility for her own health. Browne, Johnson, Bottorff, Grewal, and Hilton (2002) reported that generalizing and stereotypical views may be very damaging and have negative consequences toward immigrant women attempting to gain access to health care services. Thus, health care providers need to be constantly challenging themselves to recognize and question how their own views and biases affect both their practice and the ways in which the immigrant woman accesses mental health services.

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 that 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 behaviors affect the health care relationship and may indirectly and directly create barriers to health care thereby making immigrant women less likely to seek the appropriate care.

To provide holistic health care that is appropriate and acceptable care to immigrant clients, health care providers must focus their attention on the total context in which states of illness and health are experienced. A greater discernment of the complex relationships among 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 to consider culture not only as a social characteristic of the client, but also as a dynamic process

that impacts everyday experiences of immigrant women and their health care behaviors. Furthermore, health care providers need to recognize the many forces that impinge on the immigrant woman's life and health.

Much more research is needed to examine immigrant women's differing social experiences and how these experiences impact on their mental health. Active engagement with immigrant women to explore their experiences is needed for further development of women-centered research models, that recognize the diversity of women and the importance of developing appropriate mental health care services for them. We also need more cross-cultural, cross-sectorial research—research that utilizes the understanding that is derived from women's personal experience of mental illness and through the work of health care providers and researchers. Because spirituality and religion are so pivotal in the immigrant woman's daily life, it would be worthwhile to further explore its impact on immigrant women's mental health care in future research. Finally, immigrant women's resiliency contributes positively to how immigrant women successfully solve their problems individually, within the family, and community. More research is needed to illuminate how resiliency impacts immigrant women's mental health and well-being.

CONCLUSION

The number of immigrants coming to Canada has steadily increased in the last three decades. This has greatly changed societal structure and the health care system. In providing appropriate health care, health care providers need to be aware that not only culture, but also other contextual factors may shape the ways in which immigrant women deal with their mental health problems and access services. Historically, mental health services and treatment regimes have been centered on the Western biomedical model.

There is great debate about the utility of using a disease model for understanding women's mental health problems (Morrow & Chappell, 1999). Dominant biomedical ideologies are not easily integrated into social and cultural phenomena approaches. There may be neglect of the holistic approaches for these women and little attention paid to the complex interrelationship between their subjective experience and sociocultural contexts. These same women who may not have 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. This may mean that

the immigrant women's needs and concerns are neither fully understood nor taken seriously. Although the findings of this study cannot be generalized to all immigrant women due to the small sample size and nature of qualitative research, the results do reveal that barriers to access mental health services may be due to other factors beside the women's traditional beliefs and health care practices. Health care providers working with immigrant women need to recognize that cultural differences do influence the immigrant women's coping choices and strategies. However, contextual factors such as social, economic, and political differences also may be a part of the barriers these immigrant women face.

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