

# If I Was Going to Kill Myself, I Wouldn't Be Calling You. I am Asking for Help: Challenges Influencing Immigrant and Refugee Women's Mental Health

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**It is estimated that 37% of Canadians experience some types of mental health problem. As a result of the migration process, many immigrant and refugee women suffer serious mental illness such as depression, schizophrenia, posttraumatic stress disorder, suicide, and psychosis. The purpose of this exploratory qualitative study, informed by the ecological conceptual framework and postcolonial feminist perspectives, was to increase understanding of the mental health care experiences of immigrant and refugee women by acquiring information regarding factors that either support or inhibit coping. Ten women (five born in China and five born in Sudan) who were living with mental illness were interviewed. Analysis revealed that (a) women's personal experience with biomedicine, fear, and lack of awareness about mental health issues influences how they seek help to manage mental illness; (b) lack of appropriate services that suit their needs are barriers for these women to access mental health care; and (c) the women often draw upon informal support systems and practices and self-care strategies to cope with their mental illnesses and its related problems. The authors discuss implications for practice and make recommendations for intervention strategies that will facilitate women's mental health care and future research.**

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The number of immigrants and refugees coming to Canada from non-European countries has increased significantly over the past several decades. Immigrants and refugees represent one in five of the whole population in Canada; moreover, the admission of newcomers to the country in 2005 and 2006 reached its highest level since the 1980s (Statistics Canada, 2006). Mental health illness is a serious issue worldwide. It is estimated that one in four persons suffers a mental or neurological disorder at some point in their lives (World Health Organization [WHO], 2001) and as many as 37% of Canadians experience some type of mental health problems (Beiser, 2005). Studies reveal that as a result of the migration process, many immigrant and refugee women suffer serious mental health problems, such as depression, schizophrenia, posttraumatic stress disorder (PTSD), suicide, and psychosis (Beiser, 2005; Bhui et al., 2003; Grisaru, Irwin, & Kaplan, 2003; Li & Browne, 2000; Lin & Cheung, 1999; Shepherd, 1992; Thurston & McGrath, 1993). However, these women have difficulty getting their mental health care needs met (Donnelly, 2004; Morrow & Chappell, 1999; O'Mahony & Donnelly, 2007a, 2007b). Barriers influencing immigrant and refugee women's mental health care include low socioeconomic status (Chiu, Ganesan, Clark, & Morrow, 2005; Dhooper & Tran, 1998; Pilowsky, 1991; Zelkowitz et al., 2008), unemployment and underemployment (Beiser, Johnson, & Turner, 1993; Bhui et al., 2003; Thompson, 2000), marginalization,

discrimination, gender issues, language barriers (Chiu et al., 2005; Dhooper & Tran, 1998; O'Mahony & Donnelly, 2007b; Ziguras, Stankovska, & Minas, 1999), cultural differences (Anderson, 1987a; Dhooper & Tran, 1998; Li & Browne, 2000; O'Mahony & Donnelly, 2007a), social stigma, and lack of knowledge regarding available mental health care services (Chiu et al., 2005; O'Mahony & Donnelly, 2007a, 2007b). In this paper, the term "immigrants" refers to persons who seek lawful admission to Canada to live as permanent residents (Citizenship and Immigration Canada [CIC], 2000). The term "refugee" refers to persons in or outside Canada who fear returning to their country of nationality or habitual residence. These are persons needing protection. Canada, through its refugee protection system, provides safe haven to those with a well-founded fear of persecution, or are at risk of torture or cruel and unusual treatment or punishment (CIC, 2002).

Many health care providers have recognized that immigrants often have difficulty accessing health care services to deal with health problems because of the lack of cultural acceptance and appropriate health care services, a lack of social resources (Anderson, 1998; Chiu et al., 2005; Donnelly, 1998, 2004; Hirota, 1999; Stephenson, 1995), ethnic inequality, unequal health care provider-client power relations, and restructuring of the health care system with its emphasis on lowering health care costs (Anderson, 1998; Anderson, Blue, & Lau, 1991; Donnelly, 1998, 2004; Stingl & Wilson, 1996). It has been pointed out that to provide effective health care services to immigrant women, health care professionals 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).

It has been recognized that immigrants' conceptualization of health and illness, cultural beliefs, values, and expectations towards treatment influence the ways in which they view and use Western medicine and shape the ways in which individuals and families cope with illness (Chiu et al., 2005; Good, 1994; Kleinman, 1978, 1980; LaBun, 1988; Maltby, 1998; Stephenson, 1995). The different environments and circumstances from which immigrants come have created many health problems and barriers to accessing health care (Chiu et al., 2005; Stephenson, 1995). A study that investigated immigrant women's mental health care experiences from the health care providers' perspective (O'Mahony, 2005; O'Mahony & Donnelly, 2007a, 2007b) revealed that (a) immigrant women face many difficulties when accessing mental health care services due to insufficient language skills, cultural and social stigma, unfamiliarity with Western biomedicine, low socioeconomic status, gendered roles, and structural barriers, (b) the health care provider-client relationship exerts great influence on how immigrant women seek mental health care, and (c) cultural background exerts both positive and negative influences on how immigrant women seek mental health care.

To assist health care providers in identifying effective health care strategies that both meet women's mental health needs and

could be applied to mental illness prevention and health promotion for different immigrant groups, we need to investigate cultural beliefs, values, patterns of relationship and communication, and social, political, and historical processes that impact health care behavior. We also need to know (a) what encourages or limits immigrants to seek health care, and from whom they seek help, (b) the accessibility and suitability of health care programs to these immigrants, and (c) the social support networks that they draw upon to foster their health care practices. The purpose of this study is to increase understanding of the mental health care experiences of immigrant and refugee women by acquiring information regarding factors that either support or inhibit their coping. The study addressed the following research questions from immigrant and refugee women's perspectives: (a) How do immigrant and refugee women access the available health care services and social support networks to cope with their mental health problems? and (b) What do immigrant and refugee women perceive as barriers for them to access mental health care services? This research took place in a western province of Canada. Ethical approval was obtained from the institution where the study was conducted. All participants' names used in this paper are pseudonyms. Participants were informed that they could withdraw from the study at any time without negative repercussions.

## METHODS

This descriptive exploratory qualitative research based its theoretical foundation on an ecological conceptual framework and postcolonial-feminist perspective. The ecological conceptual framework, which refers to the interaction between individuals and their physical and sociocultural environment (Glanz, Lewis, & Rimer, 2002), has its roots within the ecological perspective. This perspective has been used as a theoretical foundation that informs the Canadian health promotion framework as stated in the Ottawa Charter for Health Promotion (WHO, 1986) and several other documents such as Lalonde's (1974) report and Epp's (1986) framework. Based on the ecological model, individuals' health care behavior is seen as influenced by their physical environmental variables, intrapersonal characteristics, and other social determinants of health (Green & Kreuter, 1991; Green, Richard, & Potvin, 1996; Hamilton & Bhatti, 1996; Vollman, Anderson, & McFarlane, 2008). To facilitate the most healthful outcomes, health care interventions should address what is identified as the individual and population's needs, at multiple social, cultural, and environmental levels (Hamilton & Bhatti, 1996; Poland, Green, & Rootman, 2000). Furthermore, to promote and maintain health, we must (a) provide health information and life skills necessary for the individuals to make health care decisions, (b) offer economic and social conditions conducive to health and healthy lifestyles, and (c) increase individuals' accessibility to social goods and services (Green et al., 1996). Thus, in order to address the problems associated with mental health among immigrant and refugee women, we

investigated how environmental factors and other social determinants of health influence women's health care practices and the choices that they make.

Post-colonial feminist perspectives, generated through the convergence of post-colonial and black feminist scholarship, have informed nursing research in recent years (Anderson, 2002, 2006; Anderson & Kirkham, 2002; Anderson et al., 2003; Donnelly, 2004; Guruge & Khanlou, 2004; Racine, 2003). Post-colonial feminism aims to "shed light on the complex issues at the intersection of gender, race, class relations and culture, and further our understanding of how material existence . . . influences health and well-being" (Anderson, 2002, p. 11). Postcolonial feminism provides a theoretical lens through which issues of social stigma, discrimination, equity in health, and accessibility in health care services are examined and incorporated into the analysis of the research (Donnelly, 2004; Anderson, 2002, 2006; Anderson & Kirkham, 2002).

Adopting a post-colonial feminist perspective, this research exhibits several important characteristics. First, mental illness issues were identified and addressed from the perspective of women who have experienced the illness. This will help health care providers and policy makers address what patients, themselves, define as important issues and problems. Second, this project is policy driven in the sense that its aim is not only to generate an accurate account of women's health care activities in relation to mental health care, but also to find ways to improve the conditions in which they live and practice health care. Third, this research was committed to the examination of how race, gender, and class relations influence social, cultural, political, and economic factors, which, in turn, shape the lives of immigrant and refugee women living with mental health illness.

According to Anderson (2006), in a cross-cultural study where different language and cultural perspectives are prevalent, conducting in-depth interviews enables research participants to describe their experiences and the meaning they attribute to these experiences in their own words. Thus, ethnography methodology (Carspecken, 1996; Gillis & Jackson, 2004), with in-depth interviews, was used as the method of data gathering. Using this methodology we were able to investigate not only what the women do and the decisions that they make, but we were able to capture the complexity and diversity of reasons why they chose certain coping strategies to manage their mental illness.

In collaboration with health care and service providers who provide mental health care services to immigrant and refugee women, a maximum variation purposive sampling procedure, which is "the process of deliberately selecting a heterogeneous sample and observing commonalities in their experiences" (Morse, 1994, p. 229), was used to recruit participants. Potential participants who met the selection criteria were referred to and invited by the researchers to participate in the study. Participants' selection criteria include (a) immigrant and refugee women who are identified by a health care and service provider as living with mental illness, (b) were born in China or Sudan (which were two large groups of immigrant and refugee women

living in the city); and (c) live in the city where the study was conducted. Ten women (five women born in China and five women born in Sudan) who were living with mental illness volunteered to participate in the study. Although an effort was made to recruit more participants, recruitment of women living with mental illness proved a difficult process due to social stigma associated with mental illness and because many immigrant and refugee women were not familiar with the research process. In addition, many of the women have come from a country where political turmoil created a mistrust and fear of authority.

Data were collected using individual in-depth interviews. Each interview, conducted in the language and at the location that is preferred by the participants, lasted 1.5 to 2 hours. To meet the study's research questions, the participants were asked questions regarding the factors that affect how they seek help for mental illness, what prevents and what motivates them to seek help for their mental health problems, and whether or not available mental health care services are suitable and accessible to them. Interview questions also inquired about their health care knowledge, attitudes, beliefs, and practices about mental health care; the health care program and services that would best benefit them; and what they perceive as the best possible strategies to prevent mental illness among immigrant women. Prior to the interview, the study was explained to the participants, an opportunity to ask questions was given, and informed consent was obtained. All interviews were audio-taped and transcribed verbatim. Field notes were completed by the interviewers. Efforts were made to enable the participants to feel comfortable speaking about their experiences. The interviews were conducted by the first author of this paper and a graduate research assistant. Both are female, have foreign ethnocultural backgrounds, and were thought to be more likely to be viewed by the women as understanding of the immigrant experience, such as migration and adaptation processes and issues.

Data coding, analysis, and interpretation were conducted manually by the principal investigator and by two trained graduate student (a doctoral and a master degree student) research assistants. The manual data analysis involved line-by-line reading and recording comments in the transcript margins to identify, refine, add to, and categorize emerging ideas, concepts, and themes. Quotes and experiential examples were noted. To generate a higher level of data conceptualization and broader theoretical formulations, emerging themes and concepts were confirmed by comparing within and across data set transcripts, across research participants, and across the set of data analysis generated from the research team members. An outcome of the analysis was a set of interrelated concepts and themes that describe the mental health experiences of immigrant and refugee women, including the social processes and influencing factors and structures. Audit trails were established to ensure the rigor of the data analysis methods. The research team met regularly to review the processes used to conduct the interviews, personal reflections, analytic descriptions, and interpretations.

## RESULTS

Analysis of the data revealed that (a) immigrant and refugee women's personal experiences with biomedicine and their fear and lack of awareness about mental health issues influence how they seek help to manage mental health problems; (b) system-level factors, such as a lack of appropriate services that suit their needs, are barriers for them to access mental health care; and (c) the women often draw upon informal support systems and practices and self-care strategies to cope with their mental illnesses and its related problems.

### Personal Experience with Biomedicine, Fear, and Lack of Awareness

The women in this study brought diverse life experiences that shed light on their complex mental illness experiences in the mainstream Western society. Some of the participants suffered from unhappy childhoods, abusive marital relationships, physical trauma resulting from a traffic accident, postpartum depression, and devastating war experiences. In the participants' narratives, losses of happy childhoods, disappointment and difficulties in marital or familial relationships, difficulties finding rewarding and satisfying careers that correspond to educational backgrounds and previous work experiences, and losses of loved ones through wars prevailed as major contributors to their mental health problems. Most participants indicated that they suffered from mood disorders, anxiety disorders, and PTSD. Many of them complained of lack of sleep, fatigue, paranoid feelings, psychosis, and suicidal thoughts.

The majority of participants who accessed mental health care services did so through referrals made by family physicians and the local distress center, appointments arranged by employers, and recommendations made to health care professionals by their family members. These participants communicated that they trusted Western biomedicine and its effectiveness in treating mental illness. They acknowledged the importance of accepting being mentally ill, seeking medical assistance, and following the medical regimen. In addition, participants who took prescribed medications stated that medications helped them control a range of emotions, sleep better, and suppress impulsive, irrational, and suicidal thoughts. As stated by Carol:

I feel that taking medication helps me a lot. It's an illness. It's because of a lack of some element in your body and it causes this problem. . . . After I took the medicine, I was not tired like before. Then, I began to think about some issues. Prior to that, I always thought about unhappy things in the past. Now, I begin to question, "why do I always think like this?" I begin to change my mind.

Some immigrant and refugee women participants voluntarily sought assistance from professional health care providers. These are women who actively accessed health information and the available services, such as workshops and counselling. They were keenly aware of mental health issues and relatively knowledgeable about mental illnesses and the consequences of not treating them readily. Lena, a refugee woman from a war-torn

country who has been suffering from PTSD, shared the following view:

I attended lots of workshop about mental illness and all symptoms [they talk about] just fit right into me. Maybe I'm sick with one of those [illnesses]. So through all of that workshop and the training that I went through, it made me [realize] this is the symptom that I have. "I might have this, I better go seek help." Because from the training I [learned] its effects on your mental health and if you didn't seek help for the long period of time how worse it's gonna be. You have to find a solution.

However, not all participants accessed mental health care services in a timely manner. Some participants waited until their problems grew beyond their control before reaching out for help. Therefore, by the time they sought professional and medical help, it was usually in the crisis phase of the problem. Some of the individual factors that delayed their help-seeking included fear of discrimination and stigmatization, denial of mental illness, fear of the unknown consequences of being diagnosed with mental illnesses (i.e., deportation, separation from family, losing children), mistrust of Western biomedicine, and multiple roles and responsibilities as a woman and a mother to support family. Amongst these individual factors, fear of discrimination and stigmatization by their ethnic community members and health care providers were the biggest barriers to all participants.

Ly: It's the uncertainty of how people will treat me when I seek help . . . that's the most important things . . . I never [cared] seeing a doctor because I was always worried that when I tell the doctor, I don't know what they would do. Will they see me as totally crazy and put me away when I tell what I'm thinking and what I was going to do? I think the fear is the one most important thing. . . . I knew there's a Crisis Distress Center but I never called them because I didn't know what to say. How can I tell someone, "Oh, I'm going crazy right now." If I was going to kill myself, why would I pick up the phone and call you? That means I'm not really trying to kill myself. I'm asking for help.

Lena: I experience a lot of trauma and anxiety and fear but I haven't gone to any specialist to treat that as a medical issue. It's just a fear of unknown [consequences]. In my culture, when you hear [that someone has] a mental illness, people fear you. Nobody wants to come close to you because [they think], "Oh, she's crazy." That's the word we use. "She's crazy don't go close to her, she will make you crazy," or something like that. Nobody wants to be mentally ill. Even [they] don't look. We all come from the war-torn countries. We are faced a lot of trouble and issues, especially those who come from refugee camps. Nobody wants to believe or admit that I have [mental illness] because of the cultural stigma. When I came to [Canada], I tried to live my normal life. [But if] your sickness is not treated, you will still be sick. It's still on you because it's not treated.

Several participants pointed out that immigrants and refugees might not access health care services or seek medical help because they are not familiar with the ideas of mental health/illness and are not aware that there are services and treatment for such illnesses. The lack of awareness and knowledge regarding mental health issues coupled with certain cultural beliefs and practices delayed some participants' decision to seek treatment. For example, a participant stated that people from her country in



Africa are not familiar with the idea of buying medication when ill. Instead, they treat their conditions in alternate ways, such as drinking boiled herbal leaves or rice porridge to treat conditions like diarrhea and dehydration. Some participants considered mental health issues to be family issues, thus not amenable to professional treatment. Some participants also refused to take medications or to tell their primary care physicians about their mental illness as they felt that the medications would only amplify the current problem by negatively affecting the brain.

Betty: I didn't tell him [family physician] because taking so many medications will affect my brain. After taking medications, I find myself cannot remember so many things. I am so easy to forget.

Lena: The more I read about medication it just makes me crazy. And any medication that deals with anything in my brain, I won't take it.

Carol, an immigrant woman with Asian background, shared similar perspective on the need for mental health education. She emphasized the importance of providing educational services to immigrant and refugee women who are at high risk of suffering mental illnesses:

The people from the developing countries . . . many people cannot realize it. Once the environment changes, the stress is big. If you are weak on it, it is easy to cause this [mental] problem. If some people don't have this idea, they will be hurt more. . . . I'm an educated woman. I have knowledge. If you're sick and you didn't treat it, this is the consequences. That's why I will seek help because I know how dangerous it is. But for some other people, they have very limited education or knowledge, they won't see the seriousness of the mental illness.

The participants' narratives also revealed that gender hierarchy and male domination affect women's mental health status and timely access to mental health services by situating them in a socially vulnerable and dependent situation. Lena shared her experience:

In most African and Middle Eastern families, men are meant to be the strong one. They think they know better. They are the head of the family. So when there's a problem, somebody who [has] higher [power] than her just put her down. . . . I'm not gonna generalize that every [ethnic group] men have this kind of behaviour. But most of them in general, yes they do. That's how they feel. "I just want to be in power." Just saying "no" makes them [feel that they are] very strong and powerful without even questioning further, "Why am I saying no to her [when] she just wants to go to the hospital? It's not a big deal. Let her go." But [they would say], "No, the hospital is not going [to] give you anything."

### System Barriers: Lack of Appropriate Mental Health Services

While the individual factors delayed the women's help-seeking behaviours from professional health care providers, most participants in the study consistently voiced a shared concern that the current health care system does not meet their health care needs. Several participants identified that they have benefitted from attending counselling services (i.e., learning

cognitive problem-solving skills and effective behavioural coping strategies to deal with anxiety and fears). However, limited English language skills and the lack of professional interpretation services in the health care system disabled most of the other participants from accessing or benefitting from available mental health counselling services, including many beneficial, community based health programs.

Carol: If someone who understands my situation can communicate with me, it will be great. . . . There are few institutions providing services in Chinese. Sometimes, there is some emotional counselling [in some languages]. Speaking in English is not enough.

Anne: If I [have] something like this [mental illness] in China [and if] I need others' help, I can talk to them. Here [in Canada], I have language barriers. So, I will not talk to others as much as possible. The values are different. I cannot express what I think and my feelings totally. . . . [I] really need someone from the community [who speaks] the same language, [who] can communicate with you and help you get rid of the fear in your heart.

Lena: First of all, the language barrier. If my language is limited, how could I [speak] a sentence in English and talking about medical terms? I wouldn't be able to do that. So, why should I bother? I will just stay. . . . Family Matters has program for postpartum depression [PPD] for moms. It is a very good program but there [are] no interpreters. When I have [immigrant or refugee] client, they're telling me [that], "I'm suicidal, this is how I'm feeling, this is how is going on. I wanna kill my baby, I wanna kill myself." Now according to my job if I screen mom positive [with PPD], I have to refer to Families Matters because this is where they're gonna get the right help. Now I refer her but is she going to benefit? She doesn't know the language, the program only offer it in English.

Some participants spoke about using family members as interpreters. However, family members often failed to translate the exact message or the whole and true meaning of messages as they were quite often too deeply involved in their family member's situation. Furthermore, family members, usually the women's children, are also limited in English literacy/communication skills. They lacked the ability to translate one language to another correctly in a timely manner. Several participants advocated for creating professional interpretation services to ensure confidentiality. Confidentiality was an issue of utmost importance to many participants because women often feared that their partners would use their mental health status against them to exert even more control and power over their marital relationships.

Ly: It is confidential. No one's going to put them away. No one is going to tell their husband. That's important because you're afraid that your husband will know. Especially if it's physical abuse then you don't want your husband to know. He can turn around and do more abuse to you. I'm sure they've been threatened enough with physical abuse.

Thus, a lack of professional interpretation services in various languages is a significant barrier for immigrant and refugee women to access the available mental health care services.

Another barrier voiced by the participants was the lack of information about the available mental health services provided

to the women. The majority of participants were unfamiliar with the Western health care system. They were not aware of what health services are available. Many were unable to access or struggled with finding needed resources. Even a participant who worked in the health care field remarked how difficult it was for her to locate appropriate services despite of her continuous search for medical assistance for her mother-in-law who also suffered severe mental illness.

Sarah: I do believe there are a lot of services that should be offered to anybody. But I always feel [that] my mother-in-law is not getting [any help]. I have struggled to find the information. With my work, I have knowledge about services that are available like assessment of health and all these kind of stuff. I would phone around and I would ask. . . . I do believe there is more support for mental health out there, but it's not offered to her.

Not surprisingly, other participants also revealed that they did not know where to seek help and find related information. The participants expressed the need for having written information, in the form of brochures, to advertise to the public a list of phone numbers of mental health services that are available.

The majority of participants voiced concern in regard to the health care provider-client relationship. Several participants perceived that their health care providers did not spend adequate time with them; this led to disappointment and distrust of the Western health care system. For example, one participant elaborated on how common clichés fail to offer support when substituted for concrete and practical advice.

Ly: It's not easy to find a doctor who gives you time. They just see you. "What's wrong? Oh, here, here, and you go." The doctor never has time. . . . She is trying to make me feel good. She says, "You should wear jewellery." But I have no jewellery. "Wear jewellery, your husband should give you more money." Then she said, "Next time you come see me you wear make-up." I say, "I don't wear make-up." She said, "Do something to your hair." But I've cut my hair already. She said, "Colour your hair." But I [do not] color my hair. She said, "Buy yourself some new clothes. It's time to take care of yourself." But I said, "Well, you know, my clothes are clean." I know she's trying to make me feel good, but it's. . . . So I stopped seeing a doctor.

Trust, rapport, and faith in health care relationships were found to be essential components to the participants' continued use of services. Having a health care provider who was genuinely concerned and interested in the women's narratives, and is also aware of the women's cultural background and the impact of the migration process was seen as a critical component for the women to continue accessing the available mental health care services.

Sarah, an African refugee woman, was suffering from a mood disorder. She was also the main caregiver of her mother-in-law who suffered from schizophrenia. Sarah articulated the importance of continuity in care, support for family caregivers, and the need for respite care. She believed that the lack of continuity in care, health care providers' lack of communication and interaction with family members, and the health care team's

over-reliance on family members for continued responsibilities of complex care resulted in repeated hospitalization of her mother-in-law and burn-out of family caregivers.

Sarah: Each nurse is doing [her] own thing, people fall into cracks . . . if they have one way of doing thing, then every patient will get the same information, every person will get the same level of care . . . I think [continuity of care] is not there, in the hospital, dealing with mental health. Each nurse is doing her own thing differently, every single person [each] time. Sometime, somebody will ask us, "She is going to be discharged. Is she still going to stay with you?" [Then we say,] "Yes, she is going to stay with us." [Then they just say,] "Ok, good. She is going to be discharged next week. See you!" and that's it. And the whole thing repeats over and over again.

Sarah further emphasised the importance of understanding and supporting the client's informal social networks by establishing a mutually supportive partnership and collaboration.

Sarah: [Families] are willing to take [her] in, it's not a problem, but I'm not prepared. It took me forever to understand schizophrenia and the symptoms. It's always not about one thing, it will be one thing plus this, this, and this. Sometimes I just have to figure out things on my own. But I think it would be easier if somebody explains it to me, and support me through understanding, and be willing to work with me. When they are in the hospital they have 24/7 care, but when they are outside, do they have the same care? . . . Support and advocate for the caregivers. . . . With mental health, if we don't look into the support system around them, we are not going to get anywhere. We are going to get frustrated caregivers like me. For immigrants, sooner or later, we are going to kick them [mentally ill family member] out of our homes because we cannot care for them. Caregivers are most important here. Patients are on medication. You cannot do much with them. But you can do more with the people who are around [to care for] them.

Moreover, Sarah identified different cultural characteristics of immigrant and refugee populations—from food through daily activities, socializing, and illness-coping patterns. She voiced her concern that the current Canadian health care system is not sensitive to the unique cultural needs of immigrants, thus resulting in further isolation of immigrant and refugee populations and readmissions of mentally ill clients.

All participants talked about raising awareness of mental health and well-being among immigrant and refugee women as the first important step towards making positive changes in the community. The participants consistently articulated the need for written resources in their own languages and making them available on the Internet or in public places where ethnic community groups congregate such as English as a Second Language (ESL) schools, churches, and community centres.

Carol: All kinds of information. You can give them some hand-outs about how to prevent depression, the information about the symptoms of depression, how to prevent, who are at high risk, and what kind of [consequences] it will bring. If someone doesn't have this idea, maybe they will realize when they read the handout. . . . It's [important] to have in different languages because some immigrants' English is not good enough.

In addition, some participants also articulated the need for careful follow-up and advocated for utilizing telephone consultation

for follow up, crisis-management, and confidentiality protection.

Carol: They have already told you, "You need to go somewhere, need to do this and this..." but sometimes, after a while, I ignore that. So, if they can push you to do something, that will be better because you have [mental] problem and you cannot control yourself sometimes. . . . [mental] illness is a little bit different from other illnesses . . . Use the different ways [telephone] to treat patients. It's not over after seeing doctor. The doctors need to keep in touch with these patients with psychological illnesses actively, and suggest them to do this or that.

### Informal Support Systems and Self-Care Practices

For all the immigrant and refugee women participating in this study, social support was identified to be the most important component in coping with mental illnesses. The participants mentioned that they often drew upon informal support systems, such as family, friends, and their ethnic community. However, the loss of family and community support, loneliness, isolation, powerlessness, dependency, and lack of support systems were still commonly raised as dominant issues during each interview. Amongst all strength factors, family was identified to be the most crucial, powerful, and protective factor for emotional health and well-being. For example, positive marital relationship and spousal support were represented as ruling factors that either supported or hindered the women's ability to cope with mental illnesses and related problems.

Carol: The family is very important. If the family members [especially your husband] cannot understand you, it's really hard. If others talk about you, you can ignore it because they are outsiders. However your family members [don't understand you, it will] give you too much stress. You live together, so the stress is so huge.

The participants spoke in concert that conversing with family and friends about their issues was therapeutic as it helped them release emotional burdens and find inner peace; by the same token, being ignored, invalidated, and laughed at were huge barriers to reaching out for help.

Ly: I mention it to my two girlfriends. I mentioned about death. And they laughed and made a joke out of it because they didn't think it was [serious]. It's hard though when you know, you tell people things, they don't know how to deal with it because they're not professionals . . . and they don't know what I was talking about. So I never told anyone again. . . . Of course, I avoided seeing my friends, too.

Even though family support was viewed as very important, most participants would only seek informal support when they were overwhelmed and felt helpless. Several participants expressed resentment about their experiences of not being accepted and understood by their own families and friends whom they thought to be the most important people in their lives. Some participants reported that they were emotionally and sexually abused by their spouses. Those participants identified that knowledge and awareness of mental illness by their family members were important components in continuing to access proper

treatments and professional interventions, making education of family members imperative.

Betty: Your family needs to understand you, and other people around you need to help you as well. My kids want to help me, but I feel that they don't know how to help me. For them, it is difficult to acknowledge that my mom is a person living with mental health problems. Therefore, every time, when I take the medications, they dissuaded me from taking the medications, they said, "More medications you take, worse your mental status, and then your brain will have problems."

The participants articulated the importance of expanding their social support networks to stay connected with others and to improve mental well-being as most of them lived in a limited social boundary. One participant mentioned that having friends of different cultural backgrounds has helped her find different sources of support.

Lena: So having variety helps me a lot because I know that there are some sensitive issues that I cannot discuss with Sudanese friends. But if I talk to my co-worker who is Canadian, she understands why I'm talking to her about this. And she could support me better because Canadian when talking about mental issues, they are very supportive because they know how terrible or how it's affected ability to cope or to work. But when coming to marriage stuff or marriage conflict, I could talk to my Sudanese co-workers because we know our men. And they could give me very good support through their experience, but I cannot talk about my marriage conflict with Canadian women because their beliefs of being a wife or being a husband are different than mine.

Notably, participants with an African background spoke of having strong ethnic community support. They have big monthly gatherings where members of the community would cook, eat together, and converse about their lives. In the narratives of other participants with Asian backgrounds, this kind of communal support was also described as a positive factor in maintaining emotional well-being.

The participants in this study demonstrated strong personal determination. Many participants believed that they had the willpower to change their situations and emotional status. They emphasized that mental illness depended on the person's personality and the level of self-acceptance of the illness, because this in turn determined how much the person would be willing to take care of herself and reach out for help. Effective self-care strategies that were identified by the participants in dealing with mental illness experiences included, engaging in positive self-talk such as, "Don't be anxious, be patient. By doing step-by-step, you will get better and better," not holding onto sour memories, solving problems that directly affect mental health status, keeping busy, and being physically active. Some participants also talked about relaxation techniques, such as taking a warm bath, visiting friends, changing hair styles, singing happy songs, and listening to quiet prayers. Moreover, several participants mentioned the powerful influence of religious beliefs and its healing power. Faith and spirituality were positive factors that not only assisted them to reduce anger and cope with

traumas and emotional sufferings, but also helped them to think positively, clear their minds, and regain peace.

Carol: I believe in Buddhism. Buddhism has many theories, such as chain of cause and effect, etc. When you are suffering during the tough period, you can pray and get support from Buddha. I think it helps me a lot. . . . When you think about something in terms of chain of cause and effect, you will easily understand it and not be angry anymore.

It is important to note that while spiritual practices were identified as sources of strength and hope, such beliefs can also deter women from accessing Western biomedicine treatment.

Lena: I seek religious healing. I believe in healing through prayer. So when I was suffering from the, the trauma and the anxiety, and lack of sleep and all of that and when I seek medical help my doctor told me I'm going to prescribe medication for you. But I said, "No, I don't need medication." . . . And until today I didn't take any medication. And I'm doing fine. I know it's taking longer, but I'm just taking it slowly. Whenever I feel I'm losing control or my heartbeat is just start to raise, I know that I'm not okay, then I will just break into prayer.

## DISCUSSION AND CONCLUSION

The purpose of this exploratory qualitative study is to increase understanding of the mental health care experiences of immigrant and refugee women by answering the following research questions from the immigrant and refugee women's perspectives (a) How do immigrant and refugee women access the available health care services and social support networks to cope with their mental health problems? and (b) What do immigrant and refugee women perceive as barriers for them to access mental health care services? In the following sections, we discuss implications for practice and make recommendations for future research.

### Implications for Practice

This study is consistent with previous research (Anderson, Blue, & Lau, 1991; Li & Browne, 2000) that suggests that language is a strong determinant in accessing available mental health services and responding to mental health issues for women within a multicultural context. In an earlier study, O'Mahony and Donnelly (2007a) found that health care providers perceived that "counselling could be viewed as intrusive and might not be a suitable treatment modality for some immigrant women" due to a cultural belief of "keeping honor within the family" (p. 466). However, in this study we found that immigrant and refugee women participants who accessed mental health services benefitted from these services if culturally sensitive, professional interpretation services were available. A study has shown that Asian immigrant patients are often receptive and likely to benefit from psychotherapeutic interventions (Lin & Cheung, 1999). Other research studies have also suggested that community-based services and ethnically matched health care providers were perceived as the most accessible to immigrant population; however, when ethnic matching is not

possible, mental health services were perceived to be most effective when an interpreter was available to attend to the language needs of the client (Sadavoy, Meier, & Ong, 2004; Wu, Kviz, & Miller, 2009). In many instances, the participants of this study left health care encounters without clearly communicating their concerns and having their questions answered. Thus, to provide effective mental health care to immigrant and refugee women, it is imperative to have professional interpreter services that are appropriate and affordable for women who need to access various mental health services and community based health promotion programs.

This study shows that confidentiality is a huge barrier in accessing mental health services for immigrant and refugee women because of the social stigma associated with mental illness. The participants often articulated the fear of censure from ethnic community members, family, and friends, and physical and emotional abuse from their partners as consequences of disclosing their mental health status and reaching out for help. This finding is evident in other studies (Amankwaa, 2003; Holopainen, 2002; O'Mahony & Donnelly, 2007b; Teng, Blackmore, & Stewart, 2007). This study demonstrated a possibility for better patient care when immigrant and refugee women are provided with appropriate and adequate resources in a safe and confidential environment.

Congruent with health care providers' perspectives (O'Mahony & Donnelly, 2007a, 2007b) and other literature (Sadavoy et al., 2004), not knowing about mental health issues, available health services, and how to access these services were major barriers for women to seek help. The participants consistently identified a need for written, translated materials about mental illness and health care services. They also recognized that development and active dissemination of mental health information are essential not only in increasing awareness of mental health issues in the society but also in reducing social stigma and discrimination towards mental illnesses. Educational campaigns that place emphasis on increasing awareness for the whole community would foster an environment that is conducive to women's mental health and well-being.

Congruent with literature, this study's findings also reflect under-utilization of available mental health services by people of different ethnocultural backgrounds (Cheung & Snowden, 1990; Lin & Cheung, 1999; Zигuras et al., 1999). The findings of the study demonstrate various individual and system-level factors that delay the women's help-seeking behaviours until their symptoms became severe. The majority of the participants in this study accessed mental health services through a family physician. Therefore, primary health care providers, including family physicians and nurses who are in close contact with patients, could play a crucial role in identifying and treating immigrant and refugee clients who present with mental health problems (Fenta, Hyman, & Noh, 2007). Moreover, a recent study suggests that not only are there barriers to accessing services for marginalized women, but it can also be challenging for health care professionals to deliver the needed care and to



be culturally sensitive to a wide range of multi-cultural clientele (Teng et al., 2007). Therefore, health care providers must recognize and understand their own barriers and challenges as a first step to overcoming barriers in building partnerships and working effectively with immigrant and refugee women.

Trust, understanding, and cultural sensitivity from health care providers were often identified as essential components that facilitated the participants' help-seeking, participation in care, and compliance with treatment. Barriers such as differing cultural values and perspectives, enforcement of dominant values onto clients, common clichés that only offer short-sighted help, and lack of sufficient time spent with clients may result in mistrust that hinders development of the therapeutic relationship between health care providers and clients. Although tension may arise from differing values and discrepancies between cultural views and the dominant biomedical perspective on health and wellness, negotiation and collaboration are crucial to build partnerships in care (Kleinman, 1978; Weerasinghe & Mitchell, 2007). Health care providers need to be aware that "both health care provider and woman are engaged in producing culture, a new knowledge is produced in reciprocal relations between them" (Anderson, 1998, p. 205). Because practitioner-client relationships significantly influence how immigrant women seek help, health care providers must constantly reflect on their own values, attitudes, and behaviours that may affect helping relationships and can directly and indirectly create barriers to mental health care (Anderson, 1998; Donnelly, 2002; Yukushko & Chronister, 2005).

Furthermore, continuity in care was identified as an area that needs careful attention from health care providers. Many participants in this study indicated that they needed more support and attention after locating and accessing mental health services to manage their mental illness symptoms such as fatigue and lack of motivation that impedes their abilities to follow a medical regimen. Therefore, the participants recommended careful follow-up of clients' progress and continued encouragement via phone contact. Moreover, the findings suggest that the client's social support systems must be readily recognized, acknowledged, and supported throughout the whole treatment process, even after discharge. An illness impacts the whole family, not only the client, and often family members are not prepared to provide a complex level of care to their ill family member (Lin & Cheung, 1999; Wright & Leahey, 2005). Anderson (1986) suggests that the ideological and cultural disjuncture between health care practices often leads to noncompliance and ineffective treatment and argues that noncompliance and poor patient outcome should be viewed and understood in terms of institutional practices that exclude families from reciprocal, collaborative participating in caretaking. The literature and the research findings signify the importance of a family-centered care approach to mental health issues (i.e., involving family members in making decisions in care, educating family members, supporting family caregivers, and providing respite care).

We found that the immigrant and refugee women in our study were resilient, strong, and determined. The participants all understood the importance of looking after themselves and

actively sought assistance and employed self-care strategies to deal with mental health problems within the given context of limited resources. This finding challenges some of the stereotypical assumptions that immigrant and refugee women are problematic, non-compliant, difficult to deal with, and unable to take responsibility for their own health. Such generalizations, stigmatization, and labelling not only reflects and enforces the dominant cultures' ideologies and values (Aldwin, 1994; Anderson et al., 1991; Filipp & Klauer, 1990), but also denigrates the client's culture-specific values and beliefs. Such generalizations may be very damaging to the therapeutic relationship (Browne, Johnson, Bottorff, Grewal, & Hilton, 2002) by creating misconceptions and tensions even before the initial contact with the client. Health care providers are therefore encouraged to challenge their own biases and pre-assumptions that they bring to the care of immigrant women populations and endeavour to be open to exploring the culture of immigrant women in Canada and the broader socio-political-cultural context in which they are situated in the new host society (Anderson, 1987b). In this way, health care providers can provide holistic health care that focuses on the total context in which states of illness and health are experienced.

Religion and spiritual beliefs were an important support for some participants in coping with mental health problems. The significance of spirituality has been recognized in the social science literature (Chiu et al., 2005; George, Ellison, & Larson, 2002; Sirois & Gick, 2002). Spiritual healing and self-dialogue through prayers provided the participants with a source of hope, reconciliation, and strength, thereby promoting mental well-being. On the other hand, spiritual healing and deep religious beliefs in destiny prevented some participants from accessing mental health services and considering biomedical treatment modalities. Not surprisingly, we found that some immigrants were more likely to consult ethnic group leaders and informal support systems than medical professionals for emotional and mental problems. Similar findings were reported in other studies of health care utilization by immigrants and refugees in other geographical areas (Brown, 2001; Chiu et al., 2005; Fenta et al., 2007; Lin & Cheung, 1999; Sheikh & Furnham, 2000; Soonthornchaiya & Dancy, 2006). As literature indicates (Chiu et al., 2005; George, Larson, Koenig, & McCullough, 2000; Lin & Cheung, 1999; Nash & Stewart, 2002), it is important for health care providers to recognize the powerful influence of religion and spirituality on health care decisions that some immigrant and refugee women make, especially for those who do not have strong support systems. Health care providers can promote health by collaborating with the women to go through available treatment options and yet not contest or intervene with their clients' religious beliefs and value systems.

### Implications for Future Research

More research is needed to examine the subcultures of immigrant and refugee women in the host society. In order to create a more comprehensive picture of women's health and illness

experiences, it is necessary to examine and analyze carefully various contextual factors and social determinants of health that shape the ways in which marginalized women access existing mental health services. Active engagement with marginalized women is essential for developing culturally sensitive and congruent care models and health care policies that recognize the cultural diversity of women. This engagement will inform the development of services that are appropriate, accessible, and affordable for the context of the target population.

Furthermore, combining participatory research with health promotion interventions would open opportunities for active engagement and be a vehicle for outreach services (Meyer, Torres, Cermeno, MacLean, & Monzon, 2003). Understanding health needs and barriers in accessing care and services would provide health care professionals and researchers with deepened insights, contributing to collective empowerment of both health care providers and clients. This research generates more questions to explore and answer within the current restructuring and reform of the Canadian health care system. It also calls for further research opportunities that examine social equity and promote the empowerment of those who have been disempowered and disenfranchised within the social organization of the dominant health care system. In order to promote and maintain population health, providing health information, skills, and resources necessary for the individual to make the best health care decision is a requisite (Green et al., 1996). It is important to recognize that the solutions to mental health problems will be derived from people who suffer the illness. Therefore, it is important to listen carefully to what they have to say about current health care services.

Providing effective health care services that address immigrant and refugee women's mental health care needs will result in effective mental health care and overall cost savings. Cost studies show a decrease in total health care dollars following appropriate mental health intervention even when the cost of the intervention is included (Canadian Psychological Association, 2005). Using the ecological model (Glanz et al., 2002; Green et al., 1996) and the framework developed by Edwards, Mill, and Kothari (2004), the findings of this study could be used as a first step in a multiple interventions program of research on mental illness amongst immigrant women. The subsequent studies could aim at (a) implementing intervention options in the communities, (b) maximizing potential impact among the implemented interventions, and (c) monitoring and evaluating program impact, spin-offs, and sustainability (Edwards et al., 2004; Mill & Edwards, 2003).

## CONCLUSION

The number of immigrants and refugees coming to Canada has increased significantly over the past several decades. As the result of migration and pre-migration traumas and hardships experienced in their mother countries, many immigrant and refugee women suffer various mental health problems. Historically, however, the construction of Canada's health services and

treatment regimens have been centered on the Western biomedical model and disease model, limiting health care providers' ability to integrate contextual factors in promoting the women's health. The participants noted how difficult it was for them to meet their mental health care needs. The results of this study reveal (1) how immigrant and refugee women seek health care to manage their mental illness; and (2) what encourages or limits them to seek help, the accessibility and suitability of health care services, and the social support networks that they utilize to foster their health and well-being.

Although the findings of this study cannot be generalized to all immigrant and refugee women due to the small sample size and nature of qualitative research, the results reveal major challenges that immigrant and refugee women encounter when seeking mental health care services. Policymakers and health care providers working with these women need to recognize how not only cultural beliefs and traditional health behaviors, but also environmental factors and other social determinants of health influence immigrant and refugee women's illness coping and health promoting strategies and choices.

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