THE IMPACT OF GENDER AND ETHNICITY
ON THE USE OF MENTAL HEALTH SERVICES:
A CASE STUDY OF TWENTY IMMIGRANT AND REFUGEE WOMEN
by
M. AUDREY JOHNSON
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ABSTRACT

THE IMPACT OF GENDER AND ETHNICITY ON THE USE OF MENTAL HEALTH SERVICES

The voices and experiences of immigrant and refugee women in Canada have been conspicuously absent from policy issues, programme planning, and mental health literature. However, more immigrant and refugee women than men, from traditional cultures, are considered to have mental health needs, because of risk factors such as stress at the time of migration, and because of Canadian policies and programmes which disadvantage them. This study explores from the consumer's perspective the reasons for disparate mental health service utilization between South Asian and Latin American women in Vancouver.

Using a cross-sectional, exploratory, case study approach, and a feminist perspective, ten South Asian and ten Latin American women who have used mental health services were interviewed in depth. Sixty percent of the participants were survivors of violence and torture. Five Latin American women were survivors of pre-migration catastrophic stress. Their mental health needs were characterised by traumatic experiences, grieving and depression. Except for the three who were married, they had no traditional support networks. In contrast with the South Asian group they appeared to have less shame and covert behaviour.
Mental illness, considered a 'house secret', carries great stigma in the South Asian community, and has serious ramifications for the immediate as well as the extended family. Among South Asian participants seven had been subjected to wife battering, and four of their spouses had a substance abuse problem. Their mental health needs were also triggered by traumatic experiences, grieving and depression. The more established South Asian women had extended family living in Vancouver, yet social support was still lacking.

Having 'no one to turn to' was a pervasive theme across both groups of women; their experiences characterised by loss. Analysis of data exploring the decision to use services illustrates stages in a process of recovery from experienced violence.

Post migration domestic violence and pre-migration violence have devastating, life-shattering consequences which require culturally sensitive interventions by social workers and other health care professionals. An obligatory stage in the clinical intervention process is to explore the issue of violence. Finally, policy decisions which impact upon women from ethnocultural communities in Canada must embrace a philosophy which considers well-trained, culturally-sensitive, linguistically-competent workers a priority.
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HEALING AND WHOLENESS

Native People know that in telling our personal stories we become connected to the larger tale that the spirits are trying to bring into the world. Alone, each of us receives a small piece of the story, a piece essential to the whole. By telling, and listening, and putting together the fragments we hear, we get inklings of something larger. When we live in conscious acceptance of the whole story, personal matters will find their proper perspective, and we will be able to live with one another. Then I imagine, analysts will be obsolete. We will be able to activate the healing function in each other, as a natural and integral part of life.

Janet O. Dallett
When the Spirits Come Back
CHAPTER I
INTRODUCTION

This exploratory study sought to provide Latin American and South Asian women with an opportunity to explain for themselves how ethnicity and gender might impact upon utilization rates of mental health care services. Previous studies, for instance, have indicated that utilization of community mental health services varied by selected ethnocultural groups (Peters, 1988). Furthermore, findings from several studies carried out over a five year period in Vancouver, in which the consumer's voice was included (Anderson & Lynam, 1988), showed that many of the Indo-Canadian and Greek women who participated felt the impact of the migration itself over a long period of time, which in turn gave rise to related mental health issues. Otherwise, although researchers have published findings identifying immigrant women as a population at risk for developing health and social problems (Bodnar & Reimer, 1979; Estable & Holmes, 1985; Shearer, 1987), there is little documentation about the experiences of South Asian women with mental health services. Likewise, many immigrants arriving in Vancouver from Central
American countries who have refugee status are women with dependent children, and research studies which address the mental health care needs of these new arrivals have yet to be published. What is conspicuously absent from the literature is research which cites the opinions of immigrant and refugee women concerning their own mental health beliefs, needs and concerns. Until fairly recently, in fact, the consumer's perspective has not been defined as an important area of research (Martin, 1986).

The question: "What might account for differences in utilization rates of mental health services between South Asian and Latin American women in Vancouver?", has not been answered fully. Therefore, the purpose of this cross-sectional exploratory research was to study access issues, as well as to seek information concerning different use.

Given the paucity of literature concerning what the decisive variables might be in health-seeking behaviours for these two groups of women, an exploratory design seemed appropriate. Adoption of the case study approach allowed twenty Vancouver women to speak out of their own experience in response to a replicable standardized open-ended interview schedule. Interviews which began with an open-ended research question provided an opportunity for women to describe in their own words the social-environmental conditions which influenced their decision concerning the use of mental health services.
Given that qualitative research has been acknowledged as being particularly useful for portraying the world view of participants, as well as taking a holistic and sensitive approach to the phenomenon in question, (Goetz & Le Compte, 1984; Fuchs Ebaugh, 1988), the quality of the data which emerged was particularly rich.

The following analysis, summary of key research findings and appendix of four identified stages in a process of adaptation and recovery from experienced violence highlight pre- and post-migration challenges and dilemmas which these women encountered. This analysis of the social context illuminates parallel social-environmental problems for South Asian and Latin American women living in an urban environment, and demonstrates how cultural sensitivity of mental health personnel toward ethnicity and gender affect utilization rates of mental health care services.
CHAPTER II
LITERATURE REVIEW

Nature of the Problem

Although the prevailing theme regarding migrants and mental health services is one of under-utilization (Allodi & Fantini, 1985; Cheung & Dobkin de Rios, 1982), the 1987 data base compiled by Greater Vancouver Mental Health Services Society shows that the Latin American community have confounded this thesis (Peters, 1987). Since many Latin Americans are adult survivors of catastrophic stress, and since the available data show utilization rates of almost three to one compared to Anglo-Canadians, the Latin American community can therefore be considered a group at high-risk for developing emotional disorder (Peters, 1989). Second, despite high-risk factors identified for women from traditional cultures by the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988), the South Asian community in general were found to conform with the theme of under-utilization (Peters, 1987). Third, although more women than men from traditional cultures are considered to have mental health needs because of risk factors which increase stress at the time of migration (Health & Welfare Canada,
1988), the voices and experiences of immigrant and refugee women in Canada have been excluded from policy issues, programme planning, and mental health literature (Canadian Mental Health Association, 1987; Cummerton, 1986; Henry & Rees, 1983; McCannell, 1986; Martin, 1986). In addition, Dr. Merry Wood, Research Co-ordinator for the Canadian Task Force on the Mental Health of Immigrants and Refugees, and Dr. Morton Beiser, Chairperson of the same Task Force, have both identified immigrant and refugee women as being the least powerful, and most socially disenfranchised group in Canadian society. For example, at a 1989 Multicultural Health Symposium, citing lack of social structures which render these women powerless, Dr. Beiser stated: "They are in double jeopardy: the risks are higher for developing mental illness, and the chances for adequate treatment are low" (February 17, Richmond, B.C.).

Acceptance and accessibility are both issues of Human Rights, and the significance of access has been addressed in the problems which have been identified in previous studies carried out by graduate research students in the School of Social Work at the University of British Columbia (Jensen, 1988; Jensen & Pendakur, 1988; Pendakur, 1988), as well as the late Renate Shearer who was engaged by the Social Planning Department of the City of Vancouver and the Immigration Division, Employment and Immigration Canada to review immigrant and ethnic services (Shearer, 1987).
Researchers on the east coast of Canada (Bergin, 1988; Doyle & Visano, 1987) have also addressed the question of equality amongst Canadians, and directed their research goals and questions toward the issue of access. Two types of access were identified for the purposes of their studies: (1) minority ethnic client access to services, and (2) minority ethnic group access to service organizations. The former speaks to the question of whether people from minority ethnic backgrounds have the same access as other people to services provided by mainstream health and social service organizations. The latter addresses the issue of whether minority ethnic group members participate in the planning, development, administration, and delivery of services as board members, volunteers and employees of those organizations (Bergin, 1988). Both studies identified barriers which acted as impediments for members of minority ethnic groups when accessing mainstream health and social services. Jensen & Pendakur (1988), focused on minority ethnic group access to service organizations, and produced findings which identified obstacles to service access, as well as the need for the United Way of the Lower Mainland, its member agencies and other community-wide services to become more responsive to the increasing cultural pluralism of the Lower Mainland area.

Obstacles to service access identified by Jensen & Pendakur (1988) are particularly significant when considered in conjunction with findings from the 1989 Environmental Scan.
for the Lower Mainland area of British Columbia (Cleathero &
Levens, 1989), which showed that 28.8% of the total Lower
Mainland population are of British origin; 2.2% of French
origin, and the remaining 69% are neither French nor British.
This figure of 69% compares with 22% of the respondents in
1981 who declared they had a language other than English as
their mother tongue. One in every five persons, is now
considered a visible minority in Vancouver compared to one in
every six persons in Toronto (Pendakur, 1988). This striking
change in the population profile for Vancouver and the
surrounding areas has gradually come about over the last
thirty five years because of a dramatic decline in the numbers
of immigrants coming to Canada from the British Isles or
Northern European countries (Cleathero & Levens, 1989; Nann,
1986). Finally, not only can language present a barrier to
service access, because researchers have found there is a
positive correlation between the degree of fluency in the
language of the host country and successful adaptation
(Maingot, 1985; Nguyen, 1982).

This literature review consists of two main sections: the
first considers conditions of exodus and such variables as a)
pre-migration stress, b) composition of the migrating unit,
and c) expectations regarding the future. The second section
addresses post-migration variables which are embedded in the
research questions of the Standardized Open-Ended Interview
Schedule, i.e. immigration status, socio-economic status,
length of stay, and social support. But first, in order to proceed with clarity, explanations for terms which are used frequently throughout this study are necessary.

**Definition of Terms**

Whereas people migrating from India prefer to be referred to as Indo-Canadians, women participating in this study were from Fiji and Bangladesh, as well as India, so that it is more correct to use the term South Asian women. Second, people migrating from Latin America do not generally refer to themselves as Latino-Canadians, hence, the term Latin American is used here (Anderson, 1987). Third, because confusion often surrounds the use of the term 'ethnicity', and there are also many different opinions and definitions, a summary definition which follows that of Milton Gordon (1964) will be used to define ethnicity as an ethnic group set off from the rest of North American Society by race, religion, or national origin (Gelfand & Kutzik, 1979). Next, the term immigrant women refers to women who are landed immigrants in Canada. All of the women in this study were chosen because they were migrants to an English speaking region of Canada from a non-English speaking Latin American country or from South Asia. Further, as stated in the Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988), under the 1976 Immigration Act, one of three classes of admissible
immigrants includes anyone who fits the United Nations definition:

Any person who, by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion, (a) is outside the country of his nationality and is unable or, by reason of such fear, is unwilling to avail himself of the protection of that country, or, (b) not having a country of nationality, is outside the country of his former habitual residence and is unable, or by reason of such fear, is unwilling to return to that country. (85)

In addition, a refugee claimant is someone who sets foot in Canada and claims refugee status under the Geneva Convention (99).

This case study analysis, for instance, provides important insights into the lives of five Latin American women who believed that in order to survive they had to flee their homelands. These women will be referred to here as survivors of catastrophic stress. The Report of the Canadian Task Force gives the following definition of catastrophic stress:

People who have experienced catastrophic stress - whether natural disasters like earthquakes or floods or made-made assaults such as harassment, threats, warfare, rape or torture - bear wounds which require special compassion and understanding. Even if they have not experienced the catastrophe directly, families and children of someone who has been persecuted or tortured develop wounds of their own. (p.85)

Likewise, the American Psychiatric Association describes the symptoms of "post-traumatic stress disorder" as follows:

The essential features of this disorder include a re-experiencing of the event through painful, intrusive recollection, recurrent dreams or nightmares, feelings of being detached or estranged
from others, loss of the ability to become interested in things which a person had previously enjoyed and problems dealing with intimacy. Some survivors also display hyper-alertness, difficulty falling asleep and suspiciousness in their dealings with others. In some instances, the symptoms may emerge a short time after the trauma; but delays of months or even years are not uncommon. (Health and Welfare Canada: p.85)

Moreover, Linda MacLeod (1987), who synthesized over ten years of research on victims of crime and on women who are battered, developed the following definition of wife battering:

Wife battering is the loss of dignity, control, and safety as well as the feeling of powerlessness and entrapment experienced by women who are the direct victims of ongoing or repeated physical, psychological, economic, sexual and/or verbal violence or who are subjected to persistent threats or the witnessing of such violence against their children, other relatives, friends, pets and/or cherished possessions, by their boyfriends, husbands, live-in lovers, ex-husbands or ex-lovers, whether male or female. The term "wife battering" will also be understood to encompass the ramifications of the violence for the woman, her children, her friends and relatives, and for society as a whole. (16)

Finally, authors Eck and Devaki (1986) believe that some of the essential components of feminist research are, a) listening to the voices of women, b) advocating the participation of women, c) caring about the rights and concerns of women, d) working for the welfare of women, and e) transforming the world of women and men through the struggle of women for equality, and for a just and peaceful society. As Eck and Devaki have said, "The use of gender as a category of analysis has changed not only the results of the
research, but the methods of research, the questions asked and the shape of the field itself" (2).

Section One
Pre-Migration Variables

Conditions of Exodus: the Latin American Experience

Three variables which are reported to pose greater problems for refugees than immigrants are: a) sources of pre-migration stress, b) composition of the migrating unit, and c) expectations regarding the future (Health & Welfare Canada, 1988). Refugee women in Canada who are survivors of pre-migration social violence (have experienced traumatic life events such as harassment, threats, warfare, rape or torture), and/or have left a spouse or partner behind, are all considered sub-populations at risk for developing emotional disorder; this is especially true for victims of torture who are considered at special risk for developing mental disorder (Alley, 1982; Allodi & Rojas, 1983; Boman & Edwards, 1984; Duran, 1980; Hutchinson, 1985; Van Drunen, 1982). In addition, Hepworth & Larsen (1986), caution social work practitioners to pay special attention to political refugees, "who typically have urgent health care needs" (189). Although single migrants, married persons whose spouses have been left behind, and parents or children separated from one another have been found to be at particular risk for mental disorder (Bathien & Malapert, 1983; Burke, 1980; Miller, Chambers and
Coleman, 1981), no mention is made of single mothers in terms of the composition of the migrating unit. However, there can be no doubt that migrating single mothers would also comprise a sub-population at risk. Finally, although realistic expectations have been found to be central to successful adaptation (David, 1969; Murphy, 1977), generally speaking, women with refugee status are unprepared because they did not choose to leave their country - i.e., many believe they will return. Most often they do not possess realistic, accurate information about what to expect for their future when they resettle in Canada: as a result, they are often overly optimistic, and many believe they will return to their homeland at sometime in the future (Catholic Conference, 1985; Cohon, 1981; Salvendy, 1983).

**Conditions of Exodus: the South Asian Experience**

Many South Asian women are not expected to take part in discussions of major decisions even though they may have critical significance for the rest of her life (Papp, 1990; British Columbia Task Force on Family Violence, 1992). In the same manner as refugee women, migration for South Asian women is in some respects, an involuntary act. Traditionally absorbed in family networks, especially in close relationships with mothers and sisters, South Asian women who emigrate experience more stress than their male companions, when they leave their support system behind (Health & Welfare
Canada, 1988). Separation from her family of origin at the time of exodus, and the loss of her customary support network symbolize significant deprivation for a South Asian woman (Sell, 1983; Shuval, 1982; Sluzki, 1979). Research shows that lack of extended family support is associated with emotional problems and psychiatric disorder, particularly in women (Lynam, 1985; Rahim and Mukherjee, 1984; Williams and Carmichael, 1985). However, family pressures on women from traditional cultures to emigrate to Canada often carry more weight than personal opinions, especially when it is men or husbands-to-be who usually make the decision to leave the homeland (Health & Welfare Canada, 1988). Nevertheless, economic expectations and hopes regarding the future in the country of resettlement are usually high, if somewhat unrealistic (Yamamoto et al., 1976).
Section Two
Post-Migration Variables:
Sources of Post-migration Stress

The Implications of Immigration Status: the Latin American Experience

In the first place, most Latin American women in Canada are relatively recent arrivals from South America and the Central American countries of El Salvador, Guatemala and Nicaragua. In addition, many Central American women are refugee status immigrants (Employment and Immigration Canada, 1987). Second, aside from having no knowledge of either English or French, the main characteristic shared in common by many newly arrived immigrant and refugee women, is a high proportion of first generation immigrants who are relatively devoid of status, power, or class in the new society (Curtis, 1988). This is particularly true for those immigrant and refugee women who enter Canada in a position of economic dependency. Third, Latin American women with sponsored refugee status are dependent upon Federal and Provincial governments for financial assistance during the first year after their arrival, for the provision of English language programmes, and in some instances for employment training.

The Implications of Immigration Status: The South Asian Experience

Categorized as "assisted relative" or "family class", immigrant women from South Asia usually enter Canada as dependents: in this case, immigration policy implies economic
and social dependence upon the sponsor, although concerns have been expressed by immigrant women's groups who have pointed out that the implications of the policy are not fully understood until after women have arrived in this country. Immigrant women in particular do not receive sufficiently detailed information before they emigrate: they are not aware that two incomes are usually necessary to support a family in Canada, and they don't know how difficult it can be to find employment. As a sponsored immigrant they do not qualify for language and/or employment training programmes. The two key issues are access to basic language training allowances, and eligibility for social services (Estable, 1986; Seward & McDade, 1988). As stated in the Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, "Any dependent relationship is subject to abuse and the immigrant husband-wife relationship is no exception" (75). As Seward & McDade (1988), have pointed out, in a case of marriage breakdown because of wife battering, the onus rests on the immigrant woman to prove that the sponsored relationship has collapsed before she qualifies for assistance.

Socio-economic Status: the Latin American Experience

In the first place, because low socio-economic status is known to be a predictor of poor mental health (Dohrenwend et al., 1980; Korchin, 1980), it is not surprising that
satisfactory employment in the country of resettlement has been found to be more useful in predicting emotional well-being than either pre-migration stress or family separation (Minde & Minde, 1976; Starr & Roberts, 1982; Westermeyer, Vang & Neider, 1983a, 1983b; Yamamoto et al., 1976). Second, other researchers have found that what is more critical than absolute economic status to migrant mental health is the difference between the status perceived in the host country and that remembered from the homeland (Bowman & Edwards, 1984; Hopkins-Kavanagh & Sananikone, 1981; Vignes & Hall, 1979). Further findings are: a) that English language ability is positively associated with personal well-being; b) that satisfactory employment usually relates to the degree of language fluency; c) inability to speak the host language is associated with schizophrenia in men (Bland & Orn, 1981), and depression in women (Williams & Carmichael, 1985). Continued downward economic mobility several years after resettlement, and continued inability to speak the language of the host country are also linked to psychological distress (Lin, K.M., Inui, T.S., Kleinman, A.M. & Womack, W.M., 1982).

Socio-economic Status: the South Asian Experience

A number of researchers, (Bergin, 1988; Epstein, Ng & Trebble, 1979; Estable, 1986; Seward & McDade, 1988), have claimed that women in general are an economically disadvantaged group, and especially that a disproportionate
number of immigrant women are in the most economically disadvantaged groups within Canadian society. Furthermore, much of the research done from the standpoint of immigrant women (Ng, 1988; Ng & Ramirez, 1981) substantiates the perception that,

Immigration into an urban industrialized Canadian setting results in two clear changes in the situation of the working class immigrant housewife. The first is the qualitative change in her work in the home: it intensifies. The second is a concomitant increase in, and enforcement of her dependence on her immediate family, notably her husband. (113)

Economic dependency has been called a trap which many immigrant women find themselves in because household finances are completely controlled by their husbands (Epstein, Ng & Trebble, 1978). In one study, 67 of 100 South Asian respondents said they had absolutely no control over money (Papp, 1990).

Length of Stay: the Latin American Experience

Researchers have reached consensus concerning the resettlement phases which migrants experience, and that some phases have characteristically higher mental health risks than others (Health & Welfare Canada, 1988); they also agree that recent migrants are at greater risk for mental disorder (Grinberg & Grinberg, 1984). Recent migrants who experience higher levels of psychological distress are primarily those with lower levels of social support, and those living without
their spouses (Boman & Edwards, 1984; Nguyen, S.D., 1982; Rumbaut, 1985).

Length of Stay: the South Asian Experience

Of the two phases which researchers have consistently associated with elevated mental health risk for migrants - relatively recent arrivals and those settled for several years or more - elevated mental health risk is typically associated with the emergence of family problems several years after resettlement (Barwick, 1986; Sluzki, 1979). Roskies (1978), and Vignes & Hall (1979), for example, attribute these problems to marital conflict.

The Health-Related Function of Social Support

Several authors (Cobb, 1976; Kaplan, 1983; Turner, 1983) have referred to the beneficial effects of social support and social support networks. Turner (1983) identifies several variables which are associated with the occurrence and prevalence of psychiatric distress and disorders, as well as on a wide range of somatic diseases; these variables speak to the social-environmental conditions which many immigrant and refugee women encounter - these are: "low socio-economic status, geographic mobility, social isolation, marital status, minority-group status or social marginality, and social disintegration" (106). It is Turner's (1983) belief that, "Variations in social support or social-support networks are
one factor that importantly influences susceptibility to psychological distress and illness" (106).

In conclusion the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees found that,

Migrants who experience a relative drop in socio-economic status after resettlement, live without members of his/her previous family, without a community of similar cultural background, and without supportive policies and attitudes from the host society is at higher risk than the migrant whose status remains constant, and who experiences familial, communal, and societal support. (10)

**Rationale and Function of the Research**

The issue of access to mainstream health and social services by minority ethnic group members is a relatively new area of research for social sciences because most studies in the past have emphasized a needs analysis, or have opted to focus on the availability of services (Doyle & Visano, 1987). Although a data base relating to utilization of services by various minority ethnic groups does exist, rich in-depth data, which qualitative methods of research can provide, are lacking. Consequently, the primary function of this exploratory research was to map the variables which apparently influence the decisions of Latin American and South Asian women to use, or not use, mental health services. Given the paucity of literature on the subject of the impact of ethnicity and gender on the use of mental health services, an exploratory study seemed most appropriate (Arkava & Lane,
1983). The twenty women who participated in this research were able to speak out of their own experience, in their own words, and thus take an active role. In other words, because a qualitative grounded theory approach attempts to generate, not verify, theory (Glaser & Strauss, 1967), qualitative interviewing provided a framework within which the intensity and complexities of individual perceptions could be captured (Patton, 1988). This study, therefore, will make a contribution to the inductive development of a theory of intervention with, and for the provision of culturally sensitive services to immigrant and refugee women.
CHAPTER III

METHOD

This chapter contains details of the research design, including sampling, source of referrals, as well as a discussion of the interview schedule, procedures for data collection, and the strategy of data analysis. Using a qualitative approach, this exploratory study seeks information about why Latin American women in Vancouver use mental health services more often than women who are from South Asian countries. These two groups of women are the focus of this study as there is a difference in their use of direct mental health treatment resources (see Table 3.1). The research questions in this study were:

1. What are the social-environmental factors to account for previously reported different mental health services utilization by women in the Latin American and South Asian communities in Vancouver?

2. How do cultural sensitivity of mental health personnel toward ethnicity, and gender impact upon the utilization rates of mental health care services?

3. How do stereotyping, prejudices, and social practices related to gender, race and/or ethnicity affect the mental health of Latin American and South Asian women?
Table 3.1 - Relative Utilization of Community Mental Health Services by Selected Ethnocultural Groups

<table>
<thead>
<tr>
<th>Ethnocultural Group</th>
<th>Percentage in Catchment</th>
<th>Percentage in Caseload</th>
<th>Utilization Rate</th>
<th>Relative Utilization by Minority Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latin American</td>
<td>0.27</td>
<td>0.93</td>
<td>344.4%</td>
<td>289.4%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>0.39</td>
<td>0.58</td>
<td>148.7%</td>
<td>125.0%</td>
</tr>
<tr>
<td>South Asian</td>
<td>3.66</td>
<td>2.03</td>
<td>54.5%</td>
<td>45.8%</td>
</tr>
<tr>
<td>Chinese</td>
<td>13.08</td>
<td>7.57</td>
<td>57.9%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Anglo-Canadian</td>
<td>68.00</td>
<td>81.00</td>
<td>119.0%</td>
<td>(100.00%)</td>
</tr>
</tbody>
</table>

After the Door has been Opened (Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988. Adapted from R. Peters, "The Interagency Mental Health Council's Committee on Multiculturalism and Mental Health: Progress Update," Greater Vancouver Mental Health Service Society, February, 1988.)
Design

The research design followed a cross-sectional exploratory model, and was based on a case study approach. In-depth interviews with ten South Asian and ten Latin American women were considered as twenty discrete units of analysis. A single case study design was chosen because it provided a social history of each woman's past experience and perceptions of traumatic life events which may have had adverse effects on her mental health. The case study design yielded more detailed material to the question of why South Asian women use direct treatment resources less than Latin American women (Hutchinson & McDaniel, 1986). The exclusion of non-English speaking women, as well as the presence of certain linguistic barriers between researcher and respondents inevitably created limitations and barriers for this small self-selected sample.

The feminist viewpoint which was brought to this research implied that the respondents' ideas and opinions were accepted and respected as important sources of information. Each respondent's perspective was welcomed as a valid source of knowledge for the researcher (Oakley, 1981; Stanley & Wise, 1983).

This study considered (1) Task Force documents provided by Greater Vancouver Mental Health Services; (2) data gathered during participant observations; and (3) data gathered from twenty individual interviews. During May of 1987, and January of 1989, GVMHS released reports of the Multiculturalism and
Mental Health Treatment and Education Committee: the Task Force Report on Indo-Canadians (Peters, 1987), and the Task Force Report on Latin American Canadians (Peters, 1989). A Report on Chinese Canadians was released in November of '87, and on Canadians from Southeast Asia during May of '88. All four documents contributed valuable information, as well as recommendations that "offer the possibility of increasing the utilization of community mental health services by local ethnic minority groups." (Peters, 1988). There was also the February '87 Brief submitted by GVMHS to the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. These documents provided background information which related to the questions proposed by this study, and were used as secondary sources of data to compare and contrast the primary source findings. These documents were used as a source of verification and elaboration required to supplement the specific information which the in-depth interviews with the participants provided.

Attendance at a number of conferences in April through November '89 concerning such immigrant settlement issues as racism, municipal race relations, family violence, access and equity in housing, policing, health and employment, provided opportunities for networking with cultural brokers who could facilitate participation in this research project. Conference notes and observations were incorporated into the researcher's daily log. This daily log was an important tool because it
enabled process identification, such as that described in the six step process embedded in snowball sampling. Observations of, and contact with professionals who make decisions and policies which impact upon services available to women from ethno-cultural communities in Vancouver were important for research of this nature which has implications for future policy decisions.

During the month of August the researcher taped an interview with a female agency worker not included in the interview sample: her opinion and perspective regarding underutilization of direct treatment resources by South Asian women were cross-referenced with those of the participants in the study, and broadened the primary data base. The researcher also viewed an NFB film, (No Longer Silent) recommended by one of the respondents: the content of the film had close parallels to some of the traumatic life events which South Asian participants in the study described, and was part of the process of this research. A transcription of an audio-tape from an April '89 CKNW radio talk show included an interview with Shashi Assanand, who at that time was a Family and Crisis Worker with O.A.S.I.S. (Orientation Adjustment Services for Immigrants Society), Dr. Godwin Eni, Director, Health Services Planning & Administration Program, U.B.C. Department of Health Care and Epidemiology, and one of the study participants. The purpose of these research activities was to enhance the quality and credibility of the study, and to add checks for
validity and reliability to the research findings.

**Sampling Design**

A snowball sampling technique was used to locate fifteen participants for this study (see Fig.3.1). Snowball sampling involved a six step process as follows: (1) made telephone contact with cultural broker: explained nature of study, and criteria for inclusion; (2) if cultural broker showed interest, sent information package which included introductory letter and informed consent form in English and either Spanish or Punjabi; (3) after a reasonable length of time had elapsed, called cultural broker again to 'jog' his/her memory; (4) cultural broker called back to confirm contact had been made with prospective participant; provided name and telephone number along with some basic background information; (5) made contact with prospective participant, set date/time/place for one-on-one in depth interview; (6) called participant day before planned interview to confirm that arrangements still stood. While the time consuming and lengthy process of snowball sampling was a major limitation of this research design, it also proved to be an asset because the six step process required contact with many cultural brokers who control much of the information and referrals to mental health care services (Green, 1982). The researcher was able to advise these community 'gatekeepers' about the study, as well as gain their support and blessing (Hammersley & Atkinson,
Figure 3.1 - Recruitment Strategy for Snowball Sampling

- OASIS
- Vancouver Society on Immigrant Women
- Vancouver Status of Women
- Vancouver Health Department
- India Mahila Association Representative
- Two V.S.B. Multicultural Home-School Workers
- MOSAIC
- Refugee Determination Board Member
- Family Services
- Equal Employment Opportunities, City Hall
- Researcher
1983). The key element of success in the six step process was consultation. The problem of access to this research population could not have been resolved without assistance and direction from cultural brokers. Cultural brokers negotiated participation in this research project, and were major links in a series of contacts which had to be made in order to gain access to these ethnocultural groups of women. A list of fifty-three Cultural Brokers and Preliminary Key Informants are included in Appendix A.

**Source of Referrals**

In total, seven of the South Asian, and four of the Latin American women were contacted through cultural brokers. Green (1982), describes the concept, and role of cultural brokers as follows:

They may be political activists, religious functionaries, or minority social workers. Most importantly, brokers function where there are significant gaps in the institutional arrangements of society. They handle problems where "official" organizations and their representatives are not active. Brokers commonly develop extensive interpersonal networks in both the dominant and dominated sectors of a society. The brokerage role in social services is an important and necessary response to the failure of established social service organizations to meet the legitimate needs of minority clients. Minority professionals are a resource to both the professional and the lay community. (21)
Access to Latin American Sample

The first of the snowball sample was a Latin American woman referred through a student advocate (also a Latin American woman) at King Edward Campus of Vancouver Community College. The second and third were referred by a member of the Immigration and Refugee Board; two were previously known to the researcher, and one was referred by a Family Services counsellor. Four Latin American women were referred by the Broadway Mental Health Team. Five of these ten women were born in El Salvador; two were from Brazil; two from Chile; and one from Nicaragua (see Table 3.2). Five entered the country as refugees. These Latin American women had lived in Canada anywhere from two to fifteen years, and their average age was 39 years when they participated in the research interview (see Table 4.1).

Access to South Asian Sample

Five of the ten South Asian women who participated in this study were referred through three active women's organizations: two by Vancouver Status of Women, two by India Mahila Society, and one by the Vancouver Society on Immigrant Women. Two were referred by intermediaries at the municipal level (Vancouver Health Department, and Equal Employment Opportunities staff, City Hall); one by an immigrant serving agency, and one by the researcher's daughter. The nine respondents listed above were all located through the snowball
Table 3.2 - Countries of Origin

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<td>Chile</td>
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sampling technique. Four of the nine women in the snowball sample were using, or had used, GVMHS services: two required services for themselves, and two for members of their immediate family. Three of the four were referred by workers other than staff at any one of the eight Mental Health Care Teams located throughout Vancouver and Richmond. The tenth South Asian participant was referred by the South Vancouver Mental Health Team. Six of the ten South Asian women who participated in this study were born in India; three were from Fiji, and one from Bangladesh (see Table 3.2). The majority came either as new brides or planned to be married here. Their average age when they participated in the study was also 39 years, and they had lived in Canada anywhere from seven months to twenty five years (see Table 4.2).

Access to GVMHS Sample

The Executive Director of Greater Vancouver Mental Health Services Society gave permission for access to a sample of women who were of Latin American and South Asian origin (Appendix B). As mentioned earlier, four Latin American women were referred by the Broadway Mental Health Team. South Vancouver Mental Health Team referred one South Asian woman. This response appears to mirror the results of the 1988 survey compiled by staff of GVMHS in terms of proportion.
Sample Description

At the time of the interview, eight of the Latin American and six of the South Asian participants were receiving counselling or therapy. Four Latin American and four South Asian women were currently using services provided by GVMHS; three Latin American and one South Asian woman were using the services of psychiatrists in private practice; one Latin American woman was using the services of a Family Services Counsellor, and one South Asian woman was receiving counselling from staff of the Vancouver Health Department programme: Healthiest Babies Possible. Two of the Latin American and four of the South Asian women were not using any kind of mental health counselling or therapy when they participated in the study, but had consulted a psychologist, a psychiatrist, or belonged to a self-help group during the five years prior to the interview. When interviewed, five Latin American and four South Asian women were using, or had used services provided by GVMHS.

Standardized Open-Ended Interview Schedule

This cross-sectional exploratory research design replicated an existing data collection instrument developed by the research team for an Ottawa-Carleton study (Appendix C). A copy of the Interview Guide and Score Sheet for Consumer Survey was received during October 1988, from John Macdonald, Research Director for the Social Planning Council.
of Ottawa–Carleton. Several initial modifications were made to the original instrument before the pre-test. First, the title of the instrument was changed to Standardized Open-Ended Interview Schedule (see Appendix D). Second, a number of additions were made to Client Characteristics (Section A): this Section was then placed at the end of the modified Interview Schedule. Third, the "What-Would-You-Do?" Scenarios (Section I) were removed. Chiefly because the participants were all to be female, other modifications were made. Gender specific issues relating to the role of professional staff, a question which asks whether or not the women would choose to talk with a professional who speaks their preferred language, and a section concerning family and community attitudes toward mental health issues were added. Following the pre-test with staff of the Broadway and South Vancouver Mental Health Teams, a question asking how participants felt about being referred to a mental health agency was added, and the number of questions relating to whether or not the participants had been asked by the receptionist to complete any forms were reduced because this is not general practice at Mental Health Teams. This was verified during actual interviews.

In order to provide an active and responsive role for the women being interviewed and to effectively capture their concerns, modifications were also made to the original data gathering instrument which could facilitate the expression
of negative responses (Martin, 1986). This was achieved by adding two complementary questions: "What did you like best?" and "What did you like least about the services you received?" An open-ended question with an encouraging tone was also introduced: "If you had to obtain the same services again, what improvements can you suggest?" (Martin, 1986).

Procedures for Data Collection

The interviews were conducted in two phases. Seven Latin American and three South Asian women were interviewed during Phase I: February through March, 1989. Notes were taken during the first three interviews: the notes reflected English language usage and sentence construction, and did not necessarily capture the manner of speaking or the meaning intended by the participants. After the first three interviews, two changes were made to the interview protocol. First, permission was sought to audio-tape the interview: all agreed. Subsequently, a tape recorder was used, and additional notes were taken. Secondly, interviews concluded with: "After this long discussion is there maybe something else you'd like to add, to ask, or to have clarified?" These probes elicited many rich, 'door knob' comments which would have remained unspoken otherwise. Examples of 'door knob' comments are given in Chapter IV.
Phase II began during the month of July and continued through mid-December, 1989. During this time-frame, seven South Asian and three Latin American women agreed to be interviewed. A third modification to the interview protocol was introduced at that time. Question one was reworded: "Please tell me about the events which led to your decision to use the services of .......?"

Thirteen of the twenty field interviews took place in the participants' homes; four in the researcher's home; two in the Community Health Team offices, and one at King Edward Campus of Vancouver Community College. All interviews were preceded by signing of the consent form. Informed consent forms and introductory letters were provided to each participant in English and either Spanish or Punjabi (Appendices E, F,). The ethical considerations delineated in the introductory letter were discussed, and the reasons for conducting the study were carefully articulated. Confidentiality was a major concern for many of these women. Reassurances were given that their identity and that of family members, especially their children, would be protected at all times. A second commitment was given: each participant will be provided with a copy of the research findings.

Prior to the commencement of each interview the following instructions were given: "If at any time during the interview you would like to turn the tape recorder off,
all you have to do is press this button on the microphone, and no record will be made of what is said." Two of the participants used this option. This instruction conveyed respect for individual dignity, and provided an opportunity for control over the interview.

All twenty interviews were conducted in English, and most lasted from ninety minutes to two hours, but some extended beyond, especially if the participant had a great need to tell her story. This variation in length of time spent with each participant was a limitation of the study, but was offset by ethical considerations. For instance, asking a woman to discuss some of the most painful experiences of her life precluded shutting her down because time kept slipping by. The collection of some very rich descriptive data, often at the expense of long interviews, and more emotional involvement with respondents was a challenge to more traditional information interview training (Fuchs Ebaugh, 1988). The researcher also found it useful to move away from the systematized interview schedule at points during the interview when it was apparent that a particular comment by the participant was central to her experience (Patton, 1988).

At the end of each interview, the researcher gave translated resource materials, as well as programme information for the activities of the Young Mothers' Group organized by M.O.S.A.I.C. (Multilingual Orientation Services
Association for Immigrant Communities), for Latin American women and their children. Time was usually spent explaining that this practical help was an exchange for the information, time, and knowledge which had been shared: this acknowledged that the research was an interactive, reciprocal process of exchange (Barnsley & Ellis, 1987; Crane, 1988; Hessler, Kong-Ming New, & May, 1979). In some cases, further information was provided at the participant's request, either through a follow-up 'phone call, or mail-out. Several participants expressed appreciation for the therapeutic impact of the interview.

**Data Analysis Strategy**

Each tape was listened to following every interview. Unfortunately, there were tapes with poor quality sound, and sound was lost for twenty percent of the interviews. However, six tapes were completely transcribed from each group of women. These twelve complete and five incomplete transcriptions, plus the accompanying hand-written notes from the first three interviews were then coded. The third task was to compare and contrast themes which surfaced across both groups of women. Data were selectively coded by sentence or paragraph as it related to three themes embedded in the research questions: (1) cultural sensitivity; (2) social-environmental factors; and (3) discrimination, gender bias, and racism. Two emergent analytic categories were
identified during the coding of data: pre-migration political violence and post-migration domestic violence, as well as a theme of 'no one to turn to' (Silverman, 1985). The emergent categories were serendipitous findings (Miles & Huberman, 1984). The significance of these analytic categories as they relate to gender and ethnicity will be explored in Chapter V.

The first goal was to reconstruct the specific categories that participants used to conceptualize their own experiences and world view (Goetz & Le Compte, 1984). At this inductive stage the words of the participants became the first-order codes. This was a subjective rather than objective approach, and has been described by Strauss (1987) as "in vivo" coding. Using "the constant comparative method" developed by Glaser and Strauss (1967) and Glaser (1978), the first codes to emerge were sorted and categorized. The second-order coding at a more abstract level were constructs developed from related literature. These were then compared with each other to discover any common patterns or themes. The patterns or themes are known as core categories. Data systematically obtained and analyzed in this manner is called "grounded theory" (Barnsley & Ellis, 1987; Patton, 1988; Pennington, 1988). This was done for comparative purposes, not only because the two groups were reported to differ so dramatically in their utilization of mental health services, but because the
interview was an opportunity for each participant to tell her own story, as well as an opportunity for the researcher to identify similarities and differences.

In summary, multiple data collection strategies, and an intensive study of a small number of cases, were central to the methodology of this research. One-on-one in-depth field interviews in non-stigmatizing confidential surroundings were instrumental for bridging the gap between the English speaking academic researcher and vulnerable women for whom English is not a first language.

However, this research is especially susceptible to replication difficulties because it occurred in natural settings. The primary safeguard against unreliability is the integration and analysis of data within a theoretical framework (Goetz & Le Compte, 1984). The effects of bias between female researcher and female participants was another limitation as was the naturalistic design of the study, and the fact that only women have been involved in this research: the interviewees, the researcher, the psychiatric social workers, and the front-line ethnic community workers who made referrals to the researcher have all been women. The only male involved in a somewhat peripheral way has been the Unit Director of the South Vancouver Mental Health Team. Snowball sampling precludes any claim to statistical representativeness. Nevertheless, even with these limitations, this qualitative investigation
may provide a rich description of twenty Vancouver immigrant women's experiences (Reid & Smith, 1981).

The major benefit of this particular research design was the collection of data from the perspective of women who were consumers of mental health services, and who had not previously been asked to comment: consumers are a source of essential data (Martin, 1986).
CHAPTER IV
FINDINGS

In this exploratory study two groups of ten first-generation immigrant and refugee women agreed to speak about their experience with mental illness. The main goal was to understand and explore from the consumers' perspective the reasons for previously reported differences in utilization rates of mental health care services by South Asian and Latin American women in Vancouver. For instance, staff of Greater Vancouver Mental Health Services have reported 'under-utilization' and 'over-utilization' patterns for South Asian and Latin American clients respectively (Peters, 1987). However, in this small study, almost equal numbers of women in each ethnocultural group were using or had used services provided by GVMHS for either themselves or a family member.

The Greater Vancouver Mental Health Service Society is a not-for-profit society registered under the B.C. Society Act. Eight Community Mental Health Teams provide services for clients in Vancouver and Richmond who are in need of a comprehensive programme of treatment and rehabilitation because they are seriously mentally ill; this includes services for children ranging in ages from pre-school to
adolescents and their families. GVMHS also provides emergency mental health services; a mental health boarding home placement service; two residences which operate in conjunction with GVMHS programmes, and a counselling service known as S.A.F.E.R. for individuals who have attempted suicide (Suicide Attempt, Education and Research).

This chapter, which is divided into four major sections, begins with anecdotal descriptions given by participants from each ethnocultural group about their personal conception of mental disorder; prior knowledge, if any, of mental health care services, and their initial expectations of such services. These descriptions are followed by anecdotes which illustrate the importance of English language fluency, the women's experience of the counselling relationship, and their perception of help provided by mental health care professionals. Section two is devoted to social-environmental factors which may help to illuminate the patterns of 'over' and 'under-utilization' previously referred to. Case studies which chronicle problems of transition from one culture to another, pre-migration political/structural violence, and post-migration domestic violence are presented. Issues of fear and shame, as well as expressions of marginality, loneliness, loss, grief, and depression are also introduced. The differences and similarities of experience for both groups of women are presented. Section three deals with illustrations of systemic racism, sexism and gender bias in
terms of discriminatory responses from social institutions toward the needs of these women; the significance and impact of these incidents for the mental and emotional well-being of those who were victimized are considered. Section four gives the participants' recommendations for improvements in the delivery of services.

The herstories and case studies which follow are taken from verbatim transcripts of seventeen tape recordings, and three hand-recorded interviews. No names are used, and other identifying factors have been changed to ensure the confidentiality and anonymity of the participants and their families.

Section One
Anecdotal Descriptions

Cultural Conceptions of Mental Disorder

Given that the ideology of culturally sensitive services has already been established as an ethical imperative (Draguns, 1981; Sartorius, Pedersen and Marsella, 1984), and as stated in the Review of the Literature on Migrant Mental Health, "Interest now lies in identifying and implementing specific means to that end" (20). The direct quotes which follow are intended as practical tools which will make a contribution toward the identification and implementation process, and also provide some answers to the research question: How does cultural sensitivity toward ethnicity, race
and gender impact upon the utilization rates of mental health care services?

The women who participated in this study spoke frankly when given the opportunity to discuss their initial response to the advice that they attend a mental health agency. It was also apparent this was the first time they had been asked to comment as consumers of health care services. For instance, women in each ethnic group described how they felt a great deal of reluctance, apprehension, suspicion, and ambivalence when first advised to consult a mental health practitioner. Some of them believed that mental health services were provided "only for people who have mental problems - not for emotional problems." As a matter of fact, compared to four of the ten Latin American women who were self-referrals to psychiatrists in private practice or other mental health agencies, the data show that only two of the ten South Asian women sought referrals to either a psychologist or a psychiatrist.

There were women in each group who shared a fear of being labelled crazy; they also shared a fear of the shame, social stigma, and ostracism which they associated with mental illness; they feared losing their children; they shared a fear of the unknown; a fear of the stigma of therapy; and some were ashamed and angry, that their spoken English was not adequate enough to enable them to express their difficulties to health
and social service professionals who did not speak their preferred language.

The Meaning of Mental Health Therapy for Latin American Women

A Latin American woman spoke about her fears: fear of the unknown, and the fear of being labelled "crazy":

"I told the counsellor through an interpreter that I wasn't crazy. Because it is my belief that I am not crazy. How come I have to see the psychiatrist? I didn't want to go. And he (college counsellor) explained many things to me. But by that time I didn't want to understand. And then I saw the psychiatrist for the first time. At my time of life it was kind of shock for me. And even though I tried to be clear enough of what psychiatry means - I couldn't. I couldn't. I mean I didn't want to. I didn't want to go. I didn't even want to believe that I had to see a psychiatrist, you know. But I did."

Although unwilling to see a psychiatrist who she believed cared only for 'crazy people', this woman recognized her overwhelming need for help:

"I was feeling as if I was really a crazy woman with mental control problems. I was feeling like that. I was afraid even to get the elevator, you know. To take the elevator to the third floor, I was so afraid. So afraid. But then I realized that I really needed help. So I went there."

She recalled the warm welcome she received at the Broadway Mental Health Team, but again emphasized her fear:

"There is a lady who is so friendly. I mean, at the time she was friendly with a smile. Trying to tell you "you are
welcome." The receptionist, M. (psychiatric social worker) and the doctor, they all made me feel welcome, you know. I felt like as if I were at home. They are good people, you know. But my main point was I was scared to go to see the psychiatrist.

A second Latin American woman who told a Crisis Line counsellor she was "screaming inside", described her fears concerning her children:

"When you don't have family in Canada you have to rely on your friends. I took the advice because I was crumbling. I held myself together on a previous occasion because they wanted to put my kids in care. I didn't want my kids to go to a Receiving Home, and they wouldn't like it either. But my friend said: "Don't worry about anything. Go see your doctor. I'll take care of the kids." So I was able to go to the hospital because my friend was there to take care of my kids. And I could take care of myself."

'Holding herself together' may well have been a response to the unspeakable fear that she might lose her children if they were admitted into the care of social services.

Frightened by self-destructive suicidal thoughts, aware of the social stigma and cultural beliefs associated with mental illness, but concerned about what might happen to her children if she didn't find help, a third Latin American woman explained:

"There wasn't anyone I could talk to because most people are thinking that you are crazy people if you are thinking about suicide. But I don't feel some special bad or good thing about going to this kind of place (SAFER) because I think I need it. I need to talk to somebody about this. I felt suicidal. I feel at least I
could talk to somebody. And this person
to who I talk, she understood me. And by
understanding me she helped me. Because I
was thinking, you know, that really I
didn't want to live any more. But for the
other side, I have these kids, that they
need me. So that's why the thing I was
very worried. Because I was thinking the
way I was going to suicide me. A lot of
times. And thinking and thinking about
very violent. What I'm going to write.
All those things. So I started to worry a
lot about that, and to think I will be
going crazy, and what is going to happen
to me. So that's why I went there."

Prior socialization, and fear of the intense social
stigma associated with mental illness could have led these
Latin American women to conceal or somatize their emotional
and psychological problems, but instead they chose either to
seek help for themselves, or followed the referral advice they
were given. They recognized their need for help; a need to
talk with someone who would understand them, and their need to
nurture themselves. As a fourth woman said:

"I decided myself to go to a psychiatrist.
I told him (the general practitioner): I
need a psychiatrist."

Nevertheless, fear, anger, shame, and a certain degree of
ambivalence seem to have been the predominant emotions.
Doubtless the negative stereotypes which the women associated
with mental illness, as well as the fear they would be
labelled "crazy" or marginalized, together with the fear of
losing their children, were all directly related to their
reluctance to become users of mental health care services.
When interviewed, three of these four Latin American women were single mothers.

The Meaning of Mental Health Therapy for South Asian Women

South Asian women were also extremely fearful of being labelled "crazy", and one of them echoed the sentiments of the first Latin American woman quoted above:

"So I had a talk with my family doctor. But this doctor he was pushing me to go for mental health counselling. I didn't like! I told the doctor: I am not crazy. I was not willing to go even. Who wants to go there? Because in India we hate mental hospitals. Who wants to go? Only crazy people go there."

But, contrary to all of her previous beliefs, she decided:

"What the hell, I should go. I said: O.K., doctor's forcing me, let me go and see. Anyway, she's not going to eat me!"

A second South Asian woman spoke about having to overcome her reluctance to attend a community mental health team:

"My family doctor and my social worker was referring me long time, but I never went. And finally, I did went."

In each of these cases a child was involved, and the triggering factor seems to have been love and concern for the child. In the same manner, a third South Asian woman also motivated by concern for a loved one, said:

"I felt okay. The doctors and teachers said I had to go for counselling."
This woman chose to flee the family home with teenage children because of an abusive spouse. It is worthy of note that she had not previously sought any kind of help for herself, but school counsellors intervened when one of her teenagers subsequently attempted suicide.

Fear and reluctance to use mental health services for South Asian women appears to have been directly related to the intense social stigma which they too associated with mental illness. As a fourth South Asian woman explained:

"In my culture there is a lot of shame about mental illness, so they never speak. They try to cover it up."

Nonetheless, this woman who referred several times to feeling no shame about her mother's mental illness, said:

"It hurt me so much to have to take my mother to that building, but I didn't feel badly because I thought I would get some help for her. I didn't feel bad about it because if I didn't speak I wouldn't have had help."

This woman's partner was Canadian born; familiar with Western medicine and the health care system, he was initially responsible for instigating the search for appropriate services, although later it was the woman who assumed the entire responsibility of daily care for her chronically ill parent:

"My husband 'phoned everywhere, and said: I'm going to make something happen."

Another South Asian woman felt much the same relief and comfort as the previous participant:
"I welcomed the idea of a referral to the psychiatrist who was treating my husband. I was reassured: "You don’t have a problem."

Despite fear and reluctance to disclose what others in their ethnocultural community might have considered shameful secrets, these women were able to overcome such social pressures. By discussing mental illness with non-family members they broke a cultural taboo. In addition, they also acknowledged and accepted the need for professional help from outside the family circle, as well as outside their ethnocultural community. This too was risky behaviour because prior to this they were more likely to visit a general practitioner than to access more appropriate services. At the time these five women were interviewed four were single mothers.

A sixth South Asian woman referred specifically to the need for outside help; she was not a recent immigrant and further education had broadened her world view. But she knew traditional community attitudes had not changed:

"I felt good about being referred. I really felt helpless that time because we needed the outside help. We could not handle the situation ourself. At the same time, I could not just go to any Indo-Canadian friend to talk because they would not understand my feelings, because they are more conservative."

However, her help-seeking behaviour was determined by more than just individual choice. In her particular case, economic factors played a decisive role.
"Same time, if you go to a private practice psychologist they are so expensive. Not everybody can afford that. I went when I was desperate. I went to once, and paid $75. I could not dare to pay another one. Even realizing that could help us (with a marriage problem)."

This woman emigrated from India, divorced after an arranged marriage, and married for a second time. The second marriage was not arranged. Her comments identify economic factors which can serve to discourage help-seeking behaviours. On the other hand, she had not limited herself by thinking all of the family's needs could be met only within the ethnic community: she was eventually able to locate universal services such as those provided by the Vancouver Health Department. Once again, this particular anecdote provides an illustration of a woman breaking a cultural taboo. Her willingness to discuss husband/wife relations with someone who was not a family member runs counter to the general behaviour of many immigrant women who are reluctant to discuss family relationships with outsiders in any great detail.

In summary, the South Asian women who were willing to participate in this exploratory study, spoke about culturally taboo topics: mental illness and marital relationships. In addition, motivated by love and concern for loved ones, they were willing to seek help from professionals outside the family and ethnic community. In seeking help, they acted contrary to all previously held health-related beliefs and practices.
Knowledge of Services

Of the ten Latin American women who contributed to this study only one referred herself to SAFER. She read a notice board flyer:

"I thought: I find out about this agency with counselling services for people in danger of suicide. Somebody there asked me what language I spoke, so somebody gave me an appointment to going and talk with the people who speak Spanish there. In that moment, I was thinking a lot that I don't want to live any more because of my life here. I was feeling very depressed."

This woman was doubly fortunate: when her situation was critical she just happened to find desperately needed information. In addition, there was a practitioner on staff at the agency who spoke Spanish. In the first place, her English language skills led to the knowledge that services were available and second, she had the opportunity to communicate with the clinician in her first language.

Unlike this particular woman, and prior to their first visit, many of the women were unaware such services existed. One uninformed Latin American woman, said:

"I had very little expectations because where I came from we have no health care. What came to me was very helpful. I could have asked for help sooner had I known the services were there to use. I had no knowledge of what to expect. New Canadians should be more informed about what services are available to them."

This woman had lived in Canada for almost eight years when she shared her experiences with the researcher. Her
experience was comparable to that of a South Asian woman who also arrived in Canada during the early eighties:

"I wasn't expecting anything. I thought there was nothing like that. I never thought there was any services like that. I didn't know about them, but through the social worker at Broadway Mental Health Team, everything moved for me."

Interestingly enough, a second South Asian woman in Canada for twenty-five years, and working within the health care system herself remarked:

"Actually, I wasn't aware of the psychology services in Public Health so my expectations wasn't that high as much as I received. So it was a pleasant surprise, but the services didn't come on a silver platter. I really had to work on it. It isn't easily accessible as it should be for the public. And I wasn't even aware whether we have psychologists or other professionals in the public health besides the nurses."

In other words, the length of residency in Canada does not appear to have been the critical factor for these women. What did seem significant was that women from both ethnocultural groups lacked information about the types of services available in the community. Lack of information about available services, together with low expectations for help they may have received for emotional and psychological distress, also applied to help with problems of physical and sexual abuse.
Expectations

Generally speaking, the women appeared surprised when asked to comment on their expectations of mental health care services. This could have been because a) they had not anticipated such a question, b) they were not consciously aware of having expectations, or c) they had not previously been asked to comment. Nevertheless, given the opportunity to comment, expectations about the nature of the mental health care services these twenty women were going to receive ranged from one end to the other of the continuum: from no expectations or poor expectations, to very high expectations. There were six women in each group who were virtually given no choice about whether or not they would use mental health care services because an acute transitional crisis had demanded decisive crisis intervention by the referring practitioner. Of the four remaining Latin American participants, two described non-existent services, a medieval system, or only expensive private clinics for the rich in their countries of origin, and said they had no prior expectations about services in Canada. Both spoke of their subsequent surprise and satisfaction. As one said:

"The services were much more comprehensive than I had expected. The Canadian system does not have many parallels around the world. Except maybe Sweden."

On the other hand, a woman from Central America who referred herself to SAFER said her chief expectation was to be
understood:

"I just thought that it was going to be somebody to talk. Somebody to give some counselling. Okay, the expectation is being understood. If not, I wouldn't go there."

In summary, the data show that the circumstances of six Latin American women were so critical they had little or no choice about using mental health services. Lack of services in their countries of origin or availability for three others led to surprise and pleasure when they did discover the range of available services. The chief expectation of the tenth woman was for understanding.

None of the South Asian women said they expected to be understood. These non-expectations are significant because this particular aspect of the findings parallels similar findings based on data gathered during twenty-seven interviews with Indo-Canadian and nineteen Greek immigrant women. Anderson (1987) reports,

The Indo-Canadian women, in particular, continually repeated that health professionals did not understand their concerns, so in other words there was no point in trying to communicate with them. Discussions over time with women revealed that these perceptions were based on their actual experiences. (426)

Neither expectations nor knowledge of services, but rather love and concern for a parent in one case, and for their children in three other cases overcame all cultural traditions and taboos about seeking and using mental health services for four South Asian women. A fifth woman expected
she would be completely returned to good health after receiving treatment for a chronic condition. Her comment was: "I always come and follow the advice."

As Waxler-Morrison, Anderson and Richardson (1990), have stated,

Many members of cultural minorities feel that health professionals do not understand them, but instead simply assume that they feel and believe just as other Canadians do. (8)

On the other hand, Assanand, Dias, Richardson and Waxler-Morrison (1990) also describe a significant social distance between South Asian doctors and most patients, resulting in a relationship which is overly formal, with patients taking a passive role. Although some traditional South Asian patients may expect this "bio-medical approach", such hierarchical relationships do not necessarily promote mutual understanding nor do they adequately address patients' psychosocial concerns. The barrier identified in such a situation is one of class rather than race.

In summary, the data show that the circumstances of six South Asian women were so critical they had no choice but to use services. Love and concern for their children or a close family member tipped the balance in favour of using services for four others. Finally, if the South Asian women who participated in this study can be considered typical, most do not have the expectation of being understood if the health care professional is from the majority caucasian culture.
Communicating with Health Care Providers

Without doubt, the most obvious problem (aside from cultural differences) facing the majority of immigrant and refugee women using health or social service agencies is the linguistic barrier. However, none of the participants in this study had been asked during their first visit if they would have preferred to have a counsellor and/or doctor who could speak their mother tongue (Appendix D:9). Although this was a self-selected sample of women who all spoke English well enough to participate in the study, some reported linguistic barriers, and feelings of frustration and embarrassment during those occasions when they were unable to express themselves as fully as they would have liked. A Latin American woman described her previous difficulties:

"They have a doctor here at this community college (King Edward Campus), and when I was in this crisis some people here referred me to him. And I was talking to him several times about this thing (her suicidal thoughts). But it is entirely different talking in Spanish, you know. My English for talking deep feelings is very difficult."

Interviewer: "Do you feel you haven't got the English words to talk about deep feelings?"

"Yes. I could read a lot of that, but it is different expressing it, and the poor doctor was trying with all of his will to understand me, but it's not the same."

This woman obviously felt handicapped by her inability to express psychological concepts in English (Milne, 1990), and
was unable to overcome the cultural and language barrier between herself and the campus doctor. It is not difficult to appreciate the additional stressors inherent in such situations. The inability to communicate fully must have posed a major treatment dilemma for the practitioner and client. The barrier of inadequate communication, in fact, may have led to a delay in diagnosis and treatment. Conversely, her experience at SAFER had been most encouraging:

"They asked me when I called the first time if I would like an interpreter, but then she said she was going to look for an appointment with a person who could talk my language. We started talking, and of course she asked me why I was there? What was bothering me? And everything. And I started to talk to her, and I think it was good for me going to talk to her. It really was. At least I could talk with somebody who I could talk free(ly) with."

It is highly probable that the ability to represent her symptoms in appropriate linguistic and cultural terms led to germane treatment, and played a key role in this woman's subsequent recovery from symptoms of a painfully acute depression. This woman had been in Canada for three years, and her comments make an interesting comparison with those of a South Asian woman (see page 45) who had spent more than half of her life in Canada.

The opportunity to talk freely in one's own language was an affirming, and empowering experience for a second woman who felt so frightened and humiliated in her situation she simply cried and cried.
"And then M. came, and she introduced herself, and I went to her office. She wanted me to explain everything. I think I was pretty upset. Well yes! Sure I did (feel good to speak in Spanish), because in my own language I can explain you very well. I talked to her, but I was only crying and crying, and crying. But it wasn't me because I was so upset. Yes, then we talk. I told her everything. Everything, and everything. And then I saw the doctor (psychiatrist) the same day. He gave me some pills. Thirty pills of diazepam (valium) which I thought were oh too many. He explained to me about the pills. I suppose to take only one or two a day. He explained that the pills could help me to control all my nerves. To get at least a sleep. Not a good sleep, but at least try to get to sleep. He (the psychiatrist) spoke in English, but I was with M. who was the translator. I didn't have any problems. I was lucky to find M. there."

As Prather (1984) reports, "More women than men are prescribed psychotropic drugs, especially minor tranquilizers such as diazepam (valium)" (2).

Several other Latin American women felt fortunate to have the opportunity to speak their mother tongue. A supportive, knowledgeable friend had prepared a third Latin American woman for the quality of care she could expect to receive at the Broadway Mental Health Team:

"I have a friend who is a nurse, and she talked to me because she knows M. (psychiatric social worker). And so she said she may be help to me because M. speaks Spanish. And I say: For sure she is no Communist? Because I no go. I no like her speak. I explain to my friend when she talked to me about M. Yes, because I know that too many Chilean people here is communist people. My
family has problems on that people you know."

Obviously, the political factor was a major consideration for this woman (Estable, 1986). Fortunately, the Spanish speaking worker understood her depth of fear and concern. Reassured M. was not a Communist, she decided she would go to the clinic after all. A family member who accompanied her made it somewhat easier for her to overcome previous fears and misgivings, although not completely:

"Yes, I going to because in the second level I going to for the elevator, and open to the door, and nervous. Very nervous. And she kissed me - my daughter. My daughter is going with me at that time, and she talk. I can't talk. She took in front desk, and ask for M. I am so nervous, I can't talk! But me understand English, you know. Yes, because is in my experience when I go to the clinic, I know is M. no? But my doctor, he say: Mrs. X you understand English, you talk me. And I am your doctor, is my obligation to understand you, to the communication. But about when the people is sick, is scary you know. And so in that time me saying: He is rude. But no, he is right; but me is confused, you know. Yes, because I try me to speak, but my sound. Maybe my pronunciation is not clear, you know. And my doctor don't understand."

Feeling nervous and fearful had obviously served to compound this woman's difficulties with the English language. On the other hand, prior knowledge that there was someone on staff who spoke her mother tongue, and did not subscribe to a Communist ideology provided positive expectations:
"It's okay because I know I needed the help, you know. And so only see that it's good because M. is speaking Spanish. It's help for me you know, because I see to the psychiatrist too, and she is my interpreter. And she is from Chile too."

All of the Latin American women using services at the Broadway Team echoed the same theme. They felt truly understood and accepted in the unfamiliar cultural milieu of a mainstream mental health clinic because there was a psychiatric social worker on staff who not only spoke Spanish, but who also understood the differences in their cultural values and communication patterns. But not all of the Latin American women felt comfortable with a psychiatrist who did not speak Spanish. The woman least proficient in English expressed her concerns when asked if she would have preferred to have a counsellor or doctor who could speak her own language:

"I would prefer a doctor who speaks Spanish because it's very important for me to tell him everything I would like to tell him. I wouldn't need an interpreter if the doctor spoke Spanish. I would prefer to speak one to one with the doctor."

Having to depend on an interpreter in this case, appears to have created an additional stressor for an already anxious patient. The woman who found she couldn't speak to the receptionist because she was so nervous said:

"It's no problem for me now the communication to my doctor because now I understand English. But in the beginning I needed it (a Spanish speaking
professional). Yes. It is important for the patient to speak in English you know, for the communication. For the new immigrant you cannot speak English, you need an interpreter. Because when the patient not speaking English you know, is a confusion. Is not for sure to the interpreter say the truth.

This particular example illustrates how having to depend on an interpreter (who may or may not have the skill to interpret fully what is meant during the exchanges), may be responsible for increased feelings of insecurity, confusion and frustration, which can create additional stress, as well as functioning as a barrier to the provision of good health care.

The preference to communicate with a psychiatrist in their mother tongue was voiced by women in each group, although none of the participants had been asked if they would have preferred to have a counsellor and/or doctor who could speak their mother tongue.

A second South Asian woman, using the services of South Vancouver Mental Health Team, voiced her concern for those Indo-Canadians who, like herself, were born in the Punjab region of India:

"That's very nice if they have Punjabi speaking doctor or something like that. It's very good for non-English speaking people from India. Most of the people are from Punjab so it's helpful for them. It depends on the population. It depends on the patients. Population means sometimes in this area lot of Punjabi people live here, so it's nice to have Punjabi speaking doctor or some other person who
is involved in these things. The similar with other ethnic groups too. They also have similar kinds of problems."

Prior to this statement, she had only words of praise for the staff of the community care team:

"But here I can speak English, no problem. My social worker she can understand me very well. She's very helpful. Whenever I in need of anything I go her, and I tell her: now I have this problem. Or, I need this kind of papers, and she always do that at the same time."

Although she did appear to feel strongly about the need to have someone on staff who could speak Punjabi, she seemed reluctant to speak out:

"Sometimes you want to speak Punjabi when you don't have English words to explain. Sometimes you can talk with that person, but the staff members are very good here."

Her personal regard and feelings of loyalty toward the South team were quite apparent when asked what she liked best about the services she received: "All are best." In response to what she liked least: "There is nothing least."

A third South Asian woman was careful to make a distinction between the English speaking participants contributing to this study and the majority of Indo-Canadian women in Vancouver:

"The language will not make a difference to me because being here for twenty five years somehow I find it very difficult to speak just solely in Punjabi. I can't express myself. But I think the majority of Indo-Canadian women would like to have a doctor or counsellor who does speak Punjabi so they can express. Punjabi wasn't my first language there so I transferred from one language to
another, and now I become just too accustomed to speaking, to expressing my feelings. Maybe particularly my English wouldn't be as accurate as somebody educated here, but I can express more freely. I cannot limit myself in one language and express. I have to mingle with both to express... And I can fight better in English than in Punjabi!"

Her comments are particularly interesting in view of the comments made by a Latin American woman who after three years in Canada did not feel she had enough words in English to express psychological concepts (see p.39).

Although very familiar with Western medicine herself, and the way of doing things in the Canadian health care system, nevertheless, this woman had very real concerns for other immigrant women. Once again, she pointed out the major differences between herself and the majority of Indo-Canadian women in the Lower Mainland area of British Columbia:

"At the same time, I think because I am working with medical services, and that helped me a lot because I am more exposed to all the facilities around, and then I have no language problem so I could just go and get help. Like I could make my own approach.

But how would the people - how does the mothers, women who does have a language problem, who are at home, on Social Assistance, or just working? Unaware because they don't have much contact with the people who are aware of these services. How would they get help?"

At this point it is important to mention that amongst those women contributing to this study there were less South Asian women registered in upgrading English classes, or
employment training courses (one compared to four). Consequently, the Latin American women had more contact with educators who were aware of agencies to refer to should their students have a particular need. In addition, because English-as-a-second language teachers are usually readily available to their students as a helpful resource, they can play an important role in the integration of their students into the social and economic fabric of Canadian society (Malatest, 1991). Availability and accessibility of services are only one aspect of help-seeking behaviours. First-generation immigrant and refugee women are unlikely to use services if they have no understanding or knowledge of the Canadian health care system.

Unlike the Latin Americans, none of the South Asian women referred to having had contact with a psychiatric social worker who could speak their mother tongue. And as one woman pointed out:

"Even some women, they are well educated in India, but when they come here there is still this problem in communication because of accent."

Although reference to difficulties with "accent" was not mentioned by the Latin American participants, one woman did allude to difficulties which she attributed to her pronunciation (see page 42). In other words, an unfamiliar accent has very real potential to act as a communication barrier between clients, health care and social service
workers.

Finally, when a Latin American woman was asked if she would have preferred a doctor or counsellor who could speak Spanish, she replied:

"Yes, definitely! That's a great asset. There's no doubt about it. But it's not just the language, it's the culture. Language is culture. Cultural background speaks about you, so it's very important data."

Cultural Sensitivity and the Counselling Relationship

The reference to culture was restated by a South Asian woman who said: "It's not just language. It's how you're used to doing things."

Respect for how others do things is of paramount importance for mental health practitioners who are effective in their interactions with consumers of health care in cross-cultural settings. Respect from mental health professionals, and supportive relationships were also identified by the participants. A South Asian woman raised the issue of cultural sensitivity in the counselling relationship:

"Definitely it helps to be able to communicate with someone who understands the language, but what I'm saying is that it doesn't matter about the language. The comment that I made is actually applicable to everyone. What I'm saying is what one looks for is a cultural sensitivity. You know, one has to be sensitive in understanding the context and the background. And be sensitive to the feelings of the person. What I'm saying is that when they look at these coloured women they either decide that: aha! she
probably doesn't speak English, and they concentrate on asking the woman whether or not she understands English, you know."

This highly educated woman was able to communicate in English fluently, yet felt completely alienated by the attitudes she encountered. She felt put down by health care professionals, even though language was not a problem or a barrier for her. Her comments are an indication of why focusing exclusively on whether the patient understands English is insufficient: the caregiver must be aware and try to understand the total circumstances of the woman's life.

Research by Bodnar and Reimer (1979), Epstein et al. (1978), Ng and Ramirez (1981), found that immigrant women from many different ethnocultural groups were in agreement about their main problems. These were primarily those of being visible minority women living in industrialized urban settings within a racially stratified society, aggravated at times for many simply because their first language was assumed to be one other than English.

As previously noted by immigrant aid workers (Bergin, 1988), "It is important for immigrants to have a professional who speaks their language and understands their culture, especially their cultural values" (75). Bergin (1988) defines culturally appropriate services as "services adapted to meet the culturally determined dimensions of clients' individual needs" (xv). Sensitivity to cultural differences, plus a knowledge and awareness of concerns which are critical
to basic survival needs for many first-generation immigrant and refugee women, have much to do with how they are used to doing things, or the culturally determined dimensions of clients' individual needs.

**How Latin American Women Experienced the Counselling Relationship**

Counseled by a SAFER staff person, a Latin American woman described her experience of an 'optimal connection':

"I remember it was friendly. It was this woman who was a really warm person, and I remember that she don't look like that. I remember particularly that she was so warm with me. I especially remember that the three times I was there she hugged me when I was coming, and when I was leaving she hugged me. And I really felt something reassuring; something really warm. From this woman I liked her understanding and her warmth. In that moment that was really, really important."

This woman was provided with a feeling she was lacking at that time: that someone was interested in her, cared for her, and was ready to help. When asked by the researcher if it was her impression the SAFER counsellor really understood what her problems were, she replied:

"Yes, I think she understood because she is also a Latin American. So even if Brazilian and El Salvadorians are very different, they have that understanding of Latin American people."

Asked what gave her this impression (Appendix D:8), she replied:

"The way she talked. The things she asked me. Her body language also, that helped."
And I felt like I had told her everything that I wanted to."

Interviewer: "Can you explain?"

"O.K. It always happened for me particularly. I feel pressure here in this country because all of the people is always in a rush. Every people is always in a rush. And they have some time for this. And some time for the other. And for me this is one of the things that I call the cultural shock. But I feel this woman has time. She wasn't in a pressure. Yes, I hate when these people, especially counsellors, are so pressured that they are watching at the time. I understand that because they have to have enough time. But it's terrible. Even if they are not watching the watch, you can feel that they are with the time, and that they are expecting going soon. Yes, I have felt that. Some are always in a hurry. It's terrible. I have been in MOSAIC (Multilingual Orientation Service Association for Immigrant Communities) several times. Every people here is always in a rush. Some people is in a rush in every place I believe. But I think it is much more here."

Interviewer: "So you believe the pace of life in Canada is quicker?"

"Oh yes, it's much quicker. Much quicker than in our country. Yes, because people here say that time is gold, you know. Time is money. That is one of the reasons I believe. And also the system."

Interviewer: "What do you mean 'the system'?"

"The cultural system. Because they want to have the better time. I don't know the word."

Interviewer: "Efficiently? Is that what you mean? People here want to use their time efficiently?"
"Yes. Maybe the difference is in the matter of quantity. Of course people in El Salvador like doing the money, and having use of the time, and all these things. Especially if you are working, you have to do that. That's true. But it's not such a cultural thing as here, I think. Yes, more emphasis on making money. More emphasis in using the time. A lot."

Interviewer: "So time is viewed quite differently?"

"Time is important, and I think that how time is used here is different to how time is used in El Salvador."

After three years in Canada, this woman was still experiencing the difficulties inherent in making the adjustment from one culture to another, and learning to cope with the non-stop atmosphere of immigrant serving agencies was also a new experience for her. She had apparently, had to learn to cope with feelings of embarrassment, disappointment, frustration and anxiety when confronted with this very unfamiliar sub-culture. As a refugee claimant, she had on a number of occasions felt insecure and humiliated, especially during interactions with representatives of major Canadian institutions. These data compare with those of Bhagavatula's (1989:) study:

Women found time-bound contact with front-line workers (only at appointed times during office hours) could be a major cultural difference. A difference which will take time to come to terms with. (21)

Although she didn't describe it as 'the cultural shock,' a second Latin American woman expressed her disappointment
concerning the lack of time she was given for explaining the details of her crisis situation to hospital staff. The time constraints imposed on one-to-one encounters with health practitioners left her feeling critical because group sessions didn't seem particularly relevant to her situation:

"In a limited time-frame, thirty minutes whatever. Open the tap, but close it down, because I have another appointment."

The first of these women to identify cultural differences in the use of time, as well as lack of time, also zeroed in on characteristics she shared in common with the SAFER counsellor from Brazil. These were cultural similarities relating to interpersonal space and touching ("she hugged me when I was coming and when I was going"). The display of emotions and expression of feelings ("the way she talked, warmth, understanding"); gestures, facial expressions and body movements ("her body language also, that helped") (Casse, 1981; Hall, 1976; Weaver, 1978).

A third Latin American woman talked about her experience as a volunteer at a health clinic on Commercial Street, and identified what she perceived were positive, appropriate attributes for culturally sensitive services:

"I know because when I talk to them about the people, about immigrants and refugees, they are compassionate, you know. They share with you."

Her appreciation of compassion had been acquired through difficult and trying times: a nurse in El Salvador she and her
husband had to flee the country when threats were made against their lives. Her husband returned to El Salvador where he "disappeared": she feels sure he was murdered by the Guardia Nationale. Isolated and lonely in Canada, she suffers from depression. It would appear that contact with compassionate sharing people was one of the unforeseen benefits of her volunteer work.

A fourth woman was satisfied with the counselling services she received because:

"I talk about my problem. They listen. They answer. They help me about my problem. They give me advice about my family in Chile. They worry about me. They care about me."

Another example of the informal, familiar relationship Latin American clients expect. Afflicted with a chronic illness, it seems that over a period of several years clinic staff have become this woman's surrogate family. Responding to what she liked best about the services she received, she replied:

"To see my doctor and M. (psychiatric social worker) and talk about my problem. Every month I come here to get my medicine and to talk. Everybody looks nice. They say: "Hello. How are you?" Now I feel good. I feel better than before. I am happy to be here to share my problems with the doctor."

A fifth woman identified sincerity, and helpful explanations as necessary components for effective cross-cultural counselling:
"But I lucky. I say me is lucky because my doctor, my psychiatrist, my family doctor is in English too, and is very sincere and help to me, and explain for me. And is good communication."

A survivor of catastrophic stress, this woman and her family were persecuted for their political beliefs, forcing them to flee Latin America. Several family members had developed emotional disorders. Initially suspicious of agencies such as mental health clinics, there was a major shift in her attitude regarding helping professionals.

Latin American Women's Counsellor Preference

Although stating she had no preference for either a male or female therapist, a Latin American woman said:

"But I felt quite good at the first time when I met M. Maybe because she was a Spanish speaker, and because she was a woman. Maybe for that."

A second woman replied:

"They didn't ask, but I was really pleased that it was a woman. I wouldn't like a man counsellor."

Interviewer: "So your preference is for a woman?"

"Of course! I think that I would like talking to woman more."

In all, there were three Latin American women who preferred a female counsellor; three had no preference; two didn't mind talking with either a male or female; one preferred a man because she said, "they have more experience."
Data on gender preference was missing for the tenth Latin American participant. In sum, recurring themes related to the counselling relationship were understanding, body language, warmth, friendliness, compassion and sincerity.

How South Asian Women Experienced the Counselling Relationship

When asked what they liked best about the services they received, a number of South Asian women focused on their relationship with a mental health counsellor. From their comments it would appear that these were professionals who did not individualize problems - that is, it seemed apparent they did not subscribe to a 'blaming the victim' ideology (Ryan, 1971). In addition, it would seem that they were cognizant of how the impact of various structural and socio-economic forces could undermine the mental health of their clients. Granted that such knowledge is important, a significant number of participants seemed to have been touched by the quality of the relationship with their caregiver: for these women empathy was paramount.

A South Asian woman, responsible for the on-going daily care of her mother with a chronic mental illness, had only words of praise for the staff of St. Vincent's hospital where the first assessment was made:

"Food, religion, background, everything. I was encouraged to tell all those things. I don't feel ashamed about anything. Where I am born. And where I am brought up. I don't feel bad about it. The social worker and the nurses they ask.
They like to know people's religion, and what kinds of foods my mother eats. I told them she doesn't eat beef or pork. They said when they know the background they can work better. They were so helpful, and so kind. Yes, they did understand what my problems were. I felt like the burden was taken off."

Coping with a major family adjustment, it would seem this woman was empowered by the understanding of the staff she encountered at St. Vincent's Hospital. This is a clear illustration of how awareness equates with the knowledge which is necessary to provide quality health care services which are culturally appropriate and sensitive.

Mental illness is a condition not openly discussed in South Asian families. This woman felt quite isolated in this respect. Fortunately, over time she developed trust and confidence in a psychiatric social worker at the Broadway Mental Health Team who became her confidant:

"Sometimes I talk with her on the 'phone. I open up my heart to her. She is such a nice lady."

A second South Asian woman was very specific about the factors which appear to have played a part in the development of trust and confidence in a mental health social worker who was accommodating and flexible:

"This counsellor was really good. Supportive. Even she will help me if I have a welfare problem. She will deal with that problem. She will phone them. She will talk to them. Just to lessen my burden. Just to give me relief."
In other words, the counsellor's role as mediator and advocate was important in this relationship. In the meantime, the discussion of counsellor qualities continued:

"Yes, and like I don't have money to buy vitamins, and she will give me vitamins from there free. Yes, she used to give me free passes for my child's swim. And then she used to give free passes for the P.N.E. (Pacific National Exhibition), for Play Land. So little, little things matters. Everything matters in our lives, no? They were very much supportive."

This anecdote clearly illustrates a response to each of three major problems. First, the social worker bridged the gap in socio-cultural backgrounds which typically exists between social service-providers and clients. Second, the social worker had the language skills which are necessary to make progress with any system of government: assisting with the rhetoric of bureaucracy which inevitably presents major barriers for many needy women, she successfully bridged the communication gap for her client. And third, she was able to provide some of the small pleasures of life without detracting from feelings of dignity and self-worth. In short, the services were culturally appropriate for this particular woman's needs.

This woman was not a recent immigrant, but this particular example does serve to illustrate three universal problems experienced by many immigrant and refugee women during their early days in Canada: (1) insufficient English language skills; (2) lack of money; and (3) difficulties
understanding and utilizing the health and social services bureaucracy (Waxler-Morrison, Anderson, and Richardson, 1990).

Following an arranged marriage in India, this woman emigrated to join her husband in Canada. A single parent now, she lived on Social Assistance for a while. She fled the family home because her spouse battered her. When asked what she liked least about the services she received, she replied:

"I liked everything except, as I told you, the second counsellor came (after a four year relationship with the first), and she was indifferent. She was not bad, but she was really indifferent. She was not taking real interest the way W. (the previous social worker) used to take. Yes, changed appointments, and even she will not listen thoroughly the way W. used to listen. Patiently, no? There was lots of difference. She was not really listening properly, if there is any trouble or something like that. And so I stopped. And then I said: I don't have time. She is not listening; I don't have time now just to go and waste time for nothing. So I said it is better to stop, and I will try to deal with my child if there is any problem."

When asked to elaborate on these comments, she gave the impression of becoming uncomfortable and cautious:

"I cannot say anything because maybe it's because shortage of staff. It's like one counsellor has so many patients. It is difficult for her. I can't say anything about her, no? So there is no complaints. I should not complain. You never know, governments cut back programmes!"

It would seem that the second counsellor was perceived as having an uncaring attitude because she was not paying
attention to what was being said. Furthermore, lack of respect for cultural differences can reveal itself in subtle ways: the impatience, indifference (the very opposite of sensitivity), and lack of concern shown in this particular instance seem to have been glaringly obvious. Time was also a major concern for this woman who was the sole provider for herself and child. Time lost from work in order to travel on public transit to and from counselling sessions, not to mention child care and transportation costs, was precious to her in more ways than one. The perception that her concerns were not adequately addressed because the mental health counsellor was not listening properly, and did not appear to be as patient as the first counsellor, led her to terminate the sessions. She re-framed her feelings about the quality of the counselling relationship by explaining she did not have time to waste. This particular anecdote clearly illustrates how insensitivity toward both ethnicity and gender impact upon utilization rates of mental health care services.

This South Asian woman's comments are similar to those made by other immigrant women in a study which was carried out in Vancouver to investigate the connections between migration and health (Anderson, 1987), "Some women felt health professionals did not take enough time to listen to the problems they were trying to discuss" (427). Time appeared to be construed by these women as having respect and concern for them as individuals.
Most of the women contributing to this study were obviously reluctant to be openly critical of the health care system or professionals within the system. This woman was no exception, although very willing to speak about positive aspects of services. After all, she did have a very satisfying four year relationship with the first counsellor. Had it not been for this positive encounter, the latter experience may have left her feeling alienated. However, this did not appear to have happened. Conversely, this behaviour could well be related to the level of her self-esteem at that particular time, as well as her perception of the devalued status she held. A single mother, in receipt of financial assistance from the Ministry of Social Services, she was assigned a dependent and devalued status. As a divorced woman and a single mother, she had no status either in the eyes of her ex-husband's family, or the larger community because without the family she had no place in her ethnocultural community. In other words, she was devalued by the family, the community, as well as social services: in this manner, she can be considered to be triply disadvantaged. Nevertheless, Bergin (1988) has also reported, "Mainstream health and social service providers indicate that minority ethnic group clients rarely or never complain" (72).

Divorced after an arranged marriage, then abandoned by her common-law spouse, a third South Asian woman talked about
her relationship with a health care worker from the Vancouver Health Department's Healthiest Babies Possible programme:

"Then she came, thank God! She was like a mother to me, and like a God to me. She came to me. She talked to me. She helped me so much. And all this help was going, and it passed another month."

A nurturing woman, the front-line worker introduced a rare component of preventive care to this single mother in the sense that a future crisis may well have been prevented by such a direct, localized service. Other than this one relationship, this young woman had previously felt there was no one with whom she could share her grief and anguish. The health care worker became her confidant, and a focal point in her life. The support, guidance and validation given during home visits to this young woman who suffered from depression, were invaluable because someone recognized and acknowledged her social and emotional isolation. This woman was rendered a tremendous service by a paraprofessional who grasped her plight, was knowledgeable concerning other community agencies, and responded immediately.

Prior to this she had been hospitalized because of a threatened miscarriage, and she described the sensitive, tender care she was given:

"And then I start crying, and I don't know where these ladies like angels came to me. Those Sisters, those nuns at St. Vincent's. They came to me, two of them, and they said: Child, what's wrong?"

These two 'angels' listened; they treated her with
respect and dignity — a new experience it would seem, and quite the reverse to the way she had been treated by her common-law spouse.

Time, consideration and respect in the counselling relationship were referred to as critical factors in the counselling relationship by a fourth South Asian woman:

"Before that I went to see another psychologist. That was about a year before that — a male psychologist. He treated me as I was a doll. Yes, like a little doll who was... Oh, you know, you still have a little baby inside you who wants attention and that. And I found that was a very male chauvinistic, patronized approach. And I just went to him once. I did not go again. And I found that was just ridiculous counselling. And I felt like I sat there for one hour, and did not achieve anything."

The perception of lack of respect experienced by the client from this professional obviously left her feeling dissatisfied as well as displeased: having decided that the psychologist devalued her concerns as a woman, she subsequently terminated the counselling relationship. There was the potential for alienation inherent in this situation too, but she had not let this experience deter her search for help:

"After that I went to see another psychologist — a woman. It was the first time I came across — made me realize how a woman can understand woman's feelings. How I could express my feelings. She could just really perceive what I was saying. It made me feel so good. I was just touched by her. Like, she could even feel my pain, the emotional pain. And
when I went to this other psychologist -
the male psychologist, he was so cold.
There was something bothering me, and I
was confused about it. I needed very
strong assurance from somebody that it's
nothing in my mind. I am not a crazy
person. And that's what my feelings are.
They are very genuine feelings."

Asked how long she had remained in therapy with the
empathetic counsellor, she replied:

"Twice, but it was so costly, so I had to
stop. And I feel that if we have a
psychologist service like that in the
public health, it will be really good for
the people who can not afford. All these
marital problems we are having, we do need
a psychologist like that also available
for the public - people who can not
afford."

This was the second time she emphasized the influence of
unfavourable economic conditions on help-seeking behaviours.
Another reminder that economic factors frequently serve as a
barrier to obtaining adequate health care.

The discussion continued:

Interviewer: "Yes, but I think you are
saying more than that. Are you saying not
only available, but a woman psychologist
for a woman client?"

"Yes, very much so! I am totally
convinced. I do have a preference."
South Asian Women's Counsellor Preference

Each contributor to this exploratory study was asked if anyone had asked if they would prefer to see a primary therapist who was a man or a woman (Appendix D:5). All twenty women responded in the negative. Three South Asian women stated they had a preference for a woman; two said that gender didn't matter, but what they did need was "someone who will listen thoroughly", and "someone who will treat me with dignity". Another South Asian woman said quite emphatically:

"Sure! My doctor was born in India and raised in England."

Then she quickly added:

"My mother would prefer a white person. It doesn't matter if it's a man or a woman. My mother thinks white doctors know more about medicine because in Fiji it was a commonwealth country and all the doctors, lawyers, and other professionals were white. They come from Britain, Australia and New Zealand. She worked for a white judge as a cook in his house, and a white police commissioner, so she thinks they are all very nice, kind people. As long as somebody listens to her; as long as the person is gentle with my mother it doesn't matter whether it is a man or woman."

Many immigrant and refugee women have experiences in their country of origin which have roots in historical and cultural factors, patriarchal ideologies, and a colonial consciousness. Having lived in an environment where all the positions of power and knowledge were held mostly by caucasians from commonwealth countries it is not difficult to
understand why her mother thought white doctors would know more about medicine.

In summary, the South Asian women identified the counsellor’s role as mediator and advocate, plus qualities of kindness, patience, helpfulness, concern, consideration, sensitivity to feelings, and especially respect for the dignity and self-worth of the client. They did not refer to such counsellor attributes as understanding, warmth, friendliness, compassion, sincerity, or body language. But they did share with the Latin American women the concern that a counsellor take enough time to listen to the problems they wanted to discuss. Most especially South Asian women needed a supportive confidant outside of the family circle because, they said, they did not feel comfortable discussing their personal difficulties with other family members.

Utilization of Services from a Latin American Perspective

Activity Rather Than Reflection

One of the Latin American women described the beneficial effects she derived from belonging to a social support group organized by staff of the Broadway Mental Health Team:

"It has involved over in there, some bowling for example. All the week in the clinic is involved in activity. Have crafts too. Before, I going to help over there. Is very good for patient."
Political ideology had set this woman and her whole family aside from the local Chilean community. They were socially isolated from the community, and she seemed to have little or no interaction with Spanish speakers other than some seniors whom she met through her volunteer work. This participant literally 'came alive' and spoke with great enthusiasm whenever she referred to volunteer work she contributed for the betterment of the community. Obviously her self-esteem moved up several notches when she felt needed and appreciated. In the meantime, her description of support group activities continued:

"I have some days for bowling, you know. And M. (psychiatric social worker) take some group for the Italian ladies, and I go for. Especially in summer, is going out for lunch. Is very good because it has too many activities for the patient. Yes, it's very important for the patient sick to stay involved in some activity. And kind (activity) that the patient like, you know. Not force it! Only when the patient is liking something. It's very important stay activity. No is stop. Is too many help to the people sick."

Previous research has shown that the activity orientation has proved effective with Hispanic migrants in family therapy, and activity rather than reflection is a common theme as a key ingredient in therapies for migrant patients (Review of the Literature on Migrant Mental Health, 1988).

The encouragement she received from the Spanish speaking social worker seemingly acted as an antidote to her ethnocultural isolation and the loss of a supportive
environment (Milne, 1990); obviously the programmes which this woman described met her need to stay physically and socially active, and especially to be involved with people outside of the family home. In effect, these support activities counteracted the effects of the social disconnectedness and diminished social networks which she and her family experienced.

Knowledge of Community Services is Empowering

Speaking about her fears of going to the Broadway Mental Health Team for the first time, a second Latino woman explained how her attitude and values had changed over time:

"Well, there are many things in my mind that I would like to express, but the main thing for me to say is that I feel so glad to have met these people. To have knowledge of that clinic. Even though in the beginning I didn't want to go, now I feel glad that I was told to go there. I feel so glad to have met these people, to have knowledge of that clinic. I have three or four friends, and I have told them: If you are having the same problem, go there and just talk to them. They will help you. So I have been recommending this."

A third Latin American woman spoke about how she would do things differently now:

"I would not have delayed seeking help. I would have gone much earlier. It's not just availability, but because now I'm tuned in. If I'm depressed or have a down day, I know what's going on."
Apparently, she has learned to recognize the signs and symptoms of depression, and knows how to access professional help.

Utilization of Services from a South Asian Perspective

The majority of participants, like the woman quoted above (see page 59), did not want to be seen as complainers: they were reluctant to be critical while generous with words of praise.

A System Free of Racism

However, one South Asian woman was willing to express her opinion concerning under-utilization of services:

Interviewer: "If you had to do the same thing again, would you do anything differently?"

"I would be more open. My approach would be more strong. Like more demanding, because that's my right as a taxpayer."

Interviewer: "Do you think that perhaps you were a little diffident in your approach?"

"Yes! More like as if they were doing me a favour, rather than a service. And I think that when we start feeling like that we hesitate to go for these services."

Interviewer: "Are you suggesting that perhaps this is one reason why people don't use the services?"

"I think so. Like it's not educated, it's not injected to people's mind what these services are for. Even I think, when person goes there this is a professional's job to make the client feel that we are
here to serve you. We are not here to do a favour. We are not up there. And you are not there." (She pointed down.)

Interviewer: "Do you think then that some new immigrants to Canada don't see these services as a right?"

"They see more as a favour. Look what they are doing for us, so we should be very thankful. Everybody should be thankful, no matter they are providing or what. And then at least we should be aware of that these are here. We pay our tax. This is our government. This is our state's responsibility to provide us with social services. They are not doing us a favour. We elect them to give us a good service.

I feel that it's a responsibility to be sensitive to every culture. We should not isolate ourselves no matter who we are. Our basic needs are the same of all human kind; if we can just make our approach on that level then we will not have all these problems of isolation, or ghettoizing ourselves to our own communities. And I think the sad part I see is when we value people from their outlook - from different dressing up. The sad part is when we judge others on external appearances.

These forthright comments from an immigrant woman established in Canada for twenty-five years are perhaps an exception to the norm as findings reported by Bergin (1988), quoted respondents who believed, "Most people from minority ethnic groups feel they have no right to fight the system" (72). And more than fifty percent of respondents in the Bhagavatula study (1989) did not reply to the question which asked why they did not access community agencies. And yet, as Bodnar and Reimer (1979) pointed out more than a decade ago,
"As contributors to society and the economy as mothers, workers and taxpayers, immigrant women have the right to services that meet their needs" (105).

Professional Objectivity

Commenting on her decision to consult a professional, this woman added another insight:

"The one reason that I went to a psychologist, or a professional, because I did not feel easy to discuss my personal feelings with my friends. I did not want to disclose my issues or reasons to the friends. This was something I could really be open up with the professional, and never have to see them again (laughs), and don't have to deal with them. And this is one thing I really like. To have a good psychologist or psychiatrist that you can be really open up with them."

The Need to be Treated with Dignity

A second South Asian woman spoke very strongly about the need for dialogue between consumer and health care provider concerning the process of treatment:

"The least I liked was the lack of care, attention, and sensitivity to my needs. First of all, I think the physician should develop a treatment plan along with the client. And that would force the doctor to understand what the client's situation is. The doctor should attempt to understand if the client is able to follow some of the things they are prescribing. And whether those methods agree with their own value system. And what in fact is the whole process of going through a particular treatment going to have on their lives? And on other family members? For that person."
And, as I said before, the doctor should really explain to the client as to why they are prescribing that. And what are some of the effects. And how long. Besides that, now I would - I don’t know if I will be successful - but I will ask more questions. And I will ask them more persistently. And consistently. And if I had to, I’d do everything in writing. I would have considered it a helpful service if I would have been told why am I going? Wherever it is that I’m going. Which is a question I asked. What kind of services am I gonna be provided? What is going to be the effect of those services? On my mind; on my physical health. What changes in my lifestyle I have to do in order to follow the treatment regime which has been prescribed to me? How different will I be if I were to follow the treatment regime? How long do I follow it?"

Interviewer: "In other words, you want very thorough explanations."

"Yes. But I think that what I am asking for is not too much. I think that’s the minimum I’m asking. Maybe dignity was what I also expected! As I said before. There was never any opportunity to discuss. You go to a place, and you are treated like as if you are on the conveyor belt. And you are just given a referral slip to go somewhere else. So I had to obey orders. There was no question of discussion. They gave me no advice. In fact, it was all iatrogenic treatment."

From the researcher’s perspective, it appeared the issue was one of autonomy. This woman’s emphasis on her need to be treated with respect, with dignity, and her need for information reflected the sense of shame and humiliation she felt. She was the only participant out of twenty who said that she would like the process of care made explicit. She was also the most educated.
Unfortunately, inadequate understanding and insensitivity can lead to the iatrogenic dis-ease which this woman described. During the interview she displayed extreme anger, distrust and suspicion toward the medical profession. In her opinion, "Mostly health providers tend to play God."

How Ethnocultural Beliefs Act as Barriers to Utilization

The following comments were transcribed from an interview at the researcher's home with a community counsellor who works with Punjabi, Hindi, and other Indian languages. Her comments serve to broaden and confirm the opinions and perspectives of the participants quoted earlier. This community counsellor has worked for fourteen years with members of the South Asian community; she emigrated from India with a Master's degree in Economics, and has lived in Canada for almost twenty years which makes her well qualified to comment on those social factors which she believes are related to under-utilization of mental health care services.

"I am talking from my personal experiences with my clients. If a woman has mental health problems and has teenage daughters, it will be very natural for this mother to hide the fact that she has any problem because her daughters are of marriageable age. And no-one in the future would ask their hand in marriage if they think they have mental health problems running in their family. It's a stigma. Second, as a woman she doesn't want to lose face from her husband. She would even hide it from her husband. Third, the married woman will not tell her mother-in-law or any other in-law that she feels depressed. But she will tell her own family members
Clearly, mental illness brings dishonour to the South Asian woman and her children; such dishonour also jeopardizes marriage opportunities. The consequences of the condition becoming known within the larger ethnic community are dreaded because public disclosure leaves a blemish on the family name, not to mention humiliation, disgrace, shame and rejection. In this case, in-laws are not considered a viable source of help.

A second professional South Asian woman, very actively involved in mainstream and ethnocultural community organizations, also emphasized during a telephone interview, the propensity to turn to family and neighbours for advice. She too stressed the general inclination to keep mental health problems a secret. Furthermore, she emphasized how many South Asian women are removed from information which other people have because they don't read English.

Waxler-Morrison, Anderson, & Richardson (1990) believe, "Health care is a social process in which each party - the professional and the patient - brings a set of beliefs, expectations, and practices to the encounter" (5). The anecdotes, quoted verbatim in this first section of the findings, have provided examples and useful insights into health-related cultural beliefs, customs, initial expectations and frequent shifts in attitude towards the utilization of mental health care services. The women who participated in
this exploratory study experienced differing levels of shifts in attitude toward utilization of mental health care services depending on their perception of the effectiveness of the care they received. Consequently, as consumers, their perspective provides information necessary for the provision of accessible, culturally appropriate and sensitive, mental health care services.

The case study method used in this research provided important data contributing insights into the question of how cultural sensitivity of mental health personnel toward ethnicity and gender impact upon the utilization rates of mental health services. In the following section, case study data are presented which can help illuminate the parallel social-environmental problems of South Asian and Latin American women in Vancouver, British Columbia.
Section Two

The Social Context as a Stressor

The preceding section of this chapter documented mental health-related cultural beliefs, values and practices from the perspective of twenty first-generation immigrant and refugee women. Living in an urban industrialized environment, all of these women had used mental health care services prior to participating in this exploratory study. The single most reported mental health problem for these women was depression. Using the case study method as a tool for identifying essential components of culturally sensitive services, this investigation attempted to uncover social-environmental factors which may account for previously reported different use (Peters, 1987).

Aside from cultural differences, the first significant difference between the two groups of women was their immigration status at time of entry into Canada. While none of the ten South Asian women was a refugee, five of the Latin American participants were. Four of the Latin American women were sponsored by the Canadian government, and one entered the country seeking refugee status. In other words, the latter was a refugee claimant. Three women were independent immigrants, and two were in the Assisted Relative category.
The woman with the longest residency in Canada was a wife and mother of a family forced to flee Chile because of their political beliefs. Four of the women who had refugee status when they entered Canada were from the Central American countries of Nicaragua and El Salvador, and one was from Chile, South America. Five others migrated from Brazil, Chile, and El Salvador. The second significant difference between the two groups of women was their period of entry into Canada: seven Latin American women arrived after 1980, whereas eight of the South Asian women arrived before 1980. The youngest Latin American woman was twenty seven, the oldest fifty one. There were six widowed, separated or divorced women, plus a seventh never-married with child. There were 1.9 children on average per Latin American participant. Nine were mothers of children who ranged in age from an eight month old infant to a twenty seven year old. Five were single mothers with dependent children (see Table 4.1).

The South Asian women were all first-generation immigrant women. Most had been admitted to Canada as sponsored immigrants. Six of these women were born in India; three in Fiji, and one from Bangladesh. On average, these women had been in Canada twice as long as the women from Latin America, i.e. just over thirteen years. The oldest was forty five, the youngest twenty six. Nine of the South Asian women were separated or divorced: the tenth had a second marriage. Nine had children ranging in age from eighteen months to twenty.
Table 4.1 - Demographic Characteristics of the Latin-American Sample

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of years in Canada</th>
<th>Occupation</th>
<th>Marital Status</th>
<th>Number of dependent children</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>8</td>
<td>Emergency Group Home Operator</td>
<td>Divorced, single mother</td>
<td>Two</td>
</tr>
<tr>
<td>47</td>
<td>15</td>
<td>Full-time university student</td>
<td>Divorced</td>
<td>-</td>
</tr>
<tr>
<td>39</td>
<td>3</td>
<td>Secretarial; part-time student</td>
<td>Divorced, single mother</td>
<td>Two</td>
</tr>
<tr>
<td>28</td>
<td>3</td>
<td>Full-time comm. college student</td>
<td>Married</td>
<td>Two</td>
</tr>
<tr>
<td>48</td>
<td>5</td>
<td>Part-time janitorial</td>
<td>Widow, single mother</td>
<td>Two</td>
</tr>
<tr>
<td>51</td>
<td>5</td>
<td>Unemployed</td>
<td>Widow, single mother</td>
<td>One</td>
</tr>
<tr>
<td>33</td>
<td>10</td>
<td>Part-time janitorial</td>
<td>Married</td>
<td>One</td>
</tr>
<tr>
<td>32</td>
<td>2</td>
<td>Unemployed</td>
<td>Never Married, single mother</td>
<td>One</td>
</tr>
<tr>
<td>48</td>
<td>12</td>
<td>Unemployed</td>
<td>Separated</td>
<td>-</td>
</tr>
<tr>
<td>27</td>
<td>2</td>
<td>Job re-entry program</td>
<td>Married</td>
<td>One</td>
</tr>
</tbody>
</table>

Range 27-51*  
Average = 6.5 years  
* Average age: 39
five years; the tenth was pregnant. There were 1.8 children on average per South Asian participant; six were single mothers with dependent children (see Table 4.2).

Although these demographic data highlight some of the obvious differences, there were also distinct similarities. For instance, all of the women were born outside Canada, and the average age of each group was thirty nine. At least half of the women in each group had entered the country in a position of economic dependency. Five women with refugee status were dependent upon the Canadian government for financial support during their first year in the country, and seven South Asian women were economically dependent upon their sponsors. Sponsored immigrants are admitted under different rules from independent immigrants, and are usually close relatives of permanent residents or Canadian citizens. The sponsoring party agrees to take total financial responsibility for the relatives he/she sponsors for up to ten years. Consequently, those who are sponsored may become economically and socially dependent upon the sponsor (Estable, 1986). Seven of the South Asian participants were in the Assisted Relative category. Three came to Canada with a Visitor's Permit. Nine women in each group had borne children, and almost equal numbers were single parents. As Conway (1990) has pointed out,

Single mothers and poor women experience the greatest risk of mental illness. And when a woman is both poor and a single parent, as is usually the case, the risks
Table 4.2 - Demographic Characteristics of the South Asian Sample

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of years in Canada</th>
<th>Occupation</th>
<th>Marital Status</th>
<th>Number of dependent children</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>12</td>
<td>Part-time Homemaker</td>
<td>Common-law</td>
<td>-</td>
</tr>
<tr>
<td>45</td>
<td>13</td>
<td>Unemployed</td>
<td>Divorced, single mother</td>
<td>One</td>
</tr>
<tr>
<td>38</td>
<td>16</td>
<td>Full-time service industry</td>
<td>Separated, single mother</td>
<td>Two</td>
</tr>
<tr>
<td>45</td>
<td>11</td>
<td>Part-time clerical</td>
<td>Divorced, single mother</td>
<td>One</td>
</tr>
<tr>
<td>32</td>
<td>13</td>
<td>Unemployed</td>
<td>Divorced, single mother</td>
<td>Four</td>
</tr>
<tr>
<td>26</td>
<td>6</td>
<td>Unemployed</td>
<td>Separated</td>
<td>First pregnancy</td>
</tr>
<tr>
<td>42</td>
<td>22</td>
<td>Full-time professional</td>
<td>Divorced</td>
<td>-</td>
</tr>
<tr>
<td>40</td>
<td>.5</td>
<td>Unemployed</td>
<td>Separated, single mother</td>
<td>One</td>
</tr>
<tr>
<td>43</td>
<td>25</td>
<td>Employed secretarial</td>
<td>Married</td>
<td>One</td>
</tr>
<tr>
<td>35</td>
<td>14</td>
<td>Employed bookkeeper</td>
<td>Divorced, single mother</td>
<td>One</td>
</tr>
<tr>
<td>Range 26-45*</td>
<td>Average = 13.25 years</td>
<td>* Average age: 39</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Average age: 39
are that much greater. (133)

Consequently, aside from differences in class of immigration, analysis revealed two groups of women who were assuredly at risk because: first, their first language was other than English; second, because they led isolated, socially and economically marginalized lives; and third, because there was the shared experience of violence. This section, therefore, will focus on the social context as a stressor (the relationship between environmental adversity and depression), and the premise that socio-economic factors play a large role in achieving emotional well-being (Shepel, 1984).

Parallel Social-Environmental Factors

Epstein, Ng & Trebble (1978), reached the conclusion during their research that the experiences of immigrant women from different cultural backgrounds were so similar that it was more meaningful to treat the data as a whole rather than searching for similarities and differences. For example, at least half of the women in this exploratory study shared a common fear of physical and psychological violence. Before resettling in Canada, fifty percent of the Latin American women had experienced violence such as warfare, harassment, threats, confinement, rape or torture which have all been defined as catastrophic stress (Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988). Life-threatening circumstances and loss of
control over their environment motivated five courageous women to flee their countries of origin. Although they realized that many close family members and loved ones would be left far behind, they could not know that they themselves would become labelled and stigmatized in the process: "refugees" in a country of resettlement. They were compelled to leave their homes, driven by fear, their lives shattered, their dreams lost.

The South Asian women, on the other hand, left their homelands with their dreams intact: with hopes for a happy marriage, in a country where the prospects for economic advancement seemed good. Although seven of the ten South Asian women in common with the Latin American participants, shared a fear of violence, their ordeal occurred after migrating to Canada, when they were physically, emotionally and psychologically battered by abusive partners. Four had a spouse with either an alcohol or drug problem. Fearful for themselves, and for the safety of their children, five of the seven chose to flee the family home, while the remaining two were abandoned by their partners. (Of the nine South Asian women who had an arranged first marriage, all were either divorced or separated when they contributed to this study.) Bearing the disapproval of their ethnocultural community, shunned and ostracized, they were effectively banished. In this manner, these women too were destined to become socially marginalized and isolated.
Profiles of Latin American Women and Pre-migration Violence

The Latin American population in Vancouver is a direct reflection of present conflicts in Central America. Five of the ten Latin American participants had experienced catastrophic stress before resettling in Canada; wounded immeasurably by the grievous losses they suffered, the cruelty they witnessed or experienced, they were inexorably marked by the oppression, aggression, insecurity and change which befell them in their countries of origin. But not all of the Latin American participants were driven to leave their homelands, for some came as economic immigrants in search of a better, more prosperous life in Canada. One such woman described how previous experience of military violence coloured her first expectations of what the response might be to a picket line in Canada:

"When I first saw a picket line here it scared me, but it was so different. No violence."

She then proceeded to describe the 1981 general strike in Brazil the memory of which was still very vivid some eight years later. Soldiers attacked the crowds with sabres. However, political beliefs had not jeopardized her personal
safety as was the case for several other participants. Two
widows had particularly horrendous memories to live with. One
described the period of time preceding her husband's
"disappearance":

"The police, the soldiers, they thinking
my husband working for the guerillas.
After somebody talk to my brother. After
somebody call. Please, you tell your
sister and her husband to go out because
this night somebody kill them. After, we
go out."

Interviewer: "You mean leave the country?"

"Yeh, for Nicaragua. But after I talk to
him we coming to Costa Rica. My husband
stay in Nicaragua."

This woman never saw her husband again: she now believes
he was murdered early in 1982 by the Guardia Nationale in El
Salvador. From her comments it was evident this unforgettable
date is permanently engraved on the family calendar. She was
clearly depressed, still grieving the loss of her husband,
feeling isolated and lonely, dependent on teenagers living at
home because of language problems. Language difficulties had
impaired her ability to transfer educational and professional
skills to the Canadian labour market. Consequently, she was
under-employed: she worked evenings part-time in the service
industry in a job which required fewer language skills, had no
benefits package and was therefore less secure. She voiced
feelings of loneliness and hopelessness concerning her ability
to manage independently without her mate. Having been in
Canada for almost five years, she seemed to have lost hope for
the future, and spoke as though her life were over. Socially, politically, and economically she had been unable to integrate into the new society.

In the same manner, a second Salvadoran woman, described her husband's "disappearance" in the mid seventies when she was four months pregnant with their first child. Active in a teacher's union, he was never seen or heard from again. A union member herself, she was arrested during a meeting at the school where she taught. Bursting into the classroom without warning, soldiers raided the school, ordering everyone to lie flat with their faces on the floor. She was among those arrested. After she was taken from the school she simply 'disappeared': her family had no knowledge of her whereabouts. She was forcibly confined for seventy days. Only outside political pressure exerted upon the government resulted in the release of this woman and the other teachers arrested with her. She was classified a political exile and accepted for resettlement in Canada. Although, compared to others, she could be considered as one of the more fortunate, these harrowing ordeals had obviously taken a great toll, especially the humiliation of arrest and imprisonment. Like the first widow, the psychological wounding she had undergone appeared to have impacted every aspect of her life. She could remember the exact dates of her arrest and subsequent release, although her memory of recent events, she said, was quite hazy due to
the psychotropic medications she was taking. She described symptoms similar to those of Post Traumatic Stress Disorder.

She expressed feelings of frustration and pessimism at the inability to meet her parent's need for financial assistance in El Salvador, and her inability to contribute to society here. Previous attempts to enter the Canadian work force had proved ineffectual because she needed more English language upgrading courses. Unemployed, she felt useless and unproductive. One of the most heartbreaking comments she made during the interview was: "Here in Canada I feel impotent." Unemployment appeared to have obliterated her sense of self and eroded her self-esteem. Doubly bereaved, both widows appeared to have lost hope for the future. Both seemed in despair over their apparent powerlessness to improve their socio-economic conditions.

A third woman from El Salvador, spoke of a well-founded fear of persecution underlying her flight into exile:

"How can they expect to have proof? It's very difficult showing proof that you were persecuted there. That some people were threatening you by 'phone. Or some people went to look for you at your home. Not all the people have been tortured. But just being tortured does not say that other people is not a refugee just because he or she wasn't tortured. So it's kind of difficult you know. If you don't have enough time, and you don't have the tranquillity inside you for preparing for a hearing, I don't think that it's good."

Interviewer: "Did any of these things happen to you? The 'phone calls to your home, or people looking for you?"
"Yes, in my country. Because I was working with defendants, you know. Political defendants. So they start... And people know you, it's a very small country. And even if it's crowded and big population, but they know you. Especially in San Salvador capital. So I started having calls, telephone calls. And one of the woman who was also working with defendants, she was a professional like me. And when she was leaving the jail some people grabbed her. Some men who were waiting for her grabbed her to an empty lot and they throw acid in her face. And this poor woman was agonizing about two weeks. After that she died with all her face burned with the acid, you know. I remember that thing. So that was when I decided to leave. To leave my country."

In this particular case it was not the date, but the details of the triggering event which were indelibly engraved into this woman's psyche. It seemed she could not forget the face of the victim. Driven by fear of abduction, and a potentially life-threatening situation, she had little choice or control over the decision to flee the homeland with her pre-adolescent children. Subsequently, she suffered a significant loss of personal identity, prestige and job status because her professional qualifications were not recognized in Canada. She felt worthless, devalued and of no consequence: a shadow of her former self. She too was under-employed. Despite adequate English language skills, class of immigration proved to be a deskilling experience, forcing her into a restricted socio-economic role with fewer occupational choices and employment opportunities (Bonnerjea, 1985; Lindenberger, 1989;). Moreover, pre-migration stress, and the uncertainties
of life as a refugee claimant, heightened by the stress of waiting for a decision from immigration authorities (she was in limbo for three years), left her feeling helpless, pessimistic, vulnerable to an acute depression and suicidal thoughts. She, like the widows whose stories are given above, had no hope of return. Besides, immigration status was a major restraint, impeding her economic and social integration into Canadian society.

During the late seventies, as a result of the political situation in Chile, a fourth Latin American woman was forced to flee with her husband and children from Chile in order to save their lives. She described the family's narrow escape from a repressive, violent political regime, and of associated on-going psychological effects:

"I am nervous because all the time I take pill. After I arrive in Canada, take pill for my nervous. But I no see to a special psychiatrist or something, only the family doctor. Yes, he gave them to me and all the family because the family arrive very bad when I arrive here, no? Yes, all the children, me and my husband, everybody is staying in therapy. All the family going when we arrived here. Yes, because my family stay in my country for fifty two days is stay in arrest at home. Children stay out the school, and everybody stay inside. I can't go alone out because the military put two men for stay with my family. Live in my house. Change every twenty-four hours. And used to guns. But the people say is for...how do I say? The people explain that we ask for help, but my husband and me...because he told me: Understand, it's not true. It's an arrest in our home, no?"
Interviewer: "And then what happened? Did you escape?"

"Afterwards, no. After that time the military say: Now everything is o.k. and you go to the military court for explain everything. Because the military start for shoot. The military my husband say something, but it's not true. My husband the truth say in front to the court in that time, the lawyer, our lawyer, and to the church. You know, the Cardinal, the Bishop is help for us. Me and my kids going to the convent for protection. And my husband and my son are going to the church. Stay in that situation for about two weeks. That time to the Embassy Canadian is doing something for take out. But I am go out only me and my kids arrive alone here in Canada because my husband, my oldest son is staying behind under arrest. Yes, they stay in the jail. My son was fifteen years only. They stay in the jail only one week because the Canadian Secretary at that time, Mr. Drapeau, he speak up for me and my kids. And Diplomatic Cards. He speak up for us, and give to the airport. And put us in the aeroplane. So all the time tell me my husband is coming with us, but when us arrive to the aeroplane he no come. But when it is time to take to the aeroplane, Mr. Drapeau explain to me that my husband and son don't come. He say to me: Please, you go because it is more easy for the Canadian Embassy to help two people, not a large family. And so I pray inside: "God help me." What can I do? Because I think me stay over there for looking to my husband, but Mr. Drapeau told me: You can do nothing. Leave your husband and son in my hands, I promise you to send him next week. After one week my husband and son came."

The entire family suffered psychological trauma associated with their forcible confinement and imprisonment, and later differences in political beliefs worked against
their social integration into the Chilean community in Canada. Later some family members made suicide attempts.

This woman began working outside the home soon after the family arrived in Canada:

"In my free time, my think is looking for job for help to my husband because we have many children. So after two months is staying in Canada, I have some job in the factory for sewing machine. I have some experience because I take teaching in my country for sewing machine. For shirts, dresses, and sew for clothes for peoples. And so my profession is a teacher for kindergarten in my country."

With nostalgia in her voice, she described her previous dynamic, active lifestyle:

"I working when my children is small. I working in my house sewing, you know. Or hairdressing. But when my children is more teenager, you know, I working in my profession - teacher - out. Because in my country me is very active. I am teacher. Teacher for kindergarten, and teacher for women in the evening for crafts - craft teacher. And volunteering over there for poor people, you know. All the time I am very busy and working, and help. And for my family, and looking for my kids going to school. It is support to my husband together for the family. So in that time me no think is sick or nothing, you know. Only my mind is stay in working, working, you know for help."

In one city she was happily employed with an immigrant aid agency, but then they moved again because of social harassment. During a period of four years the family moved four times because her husband's previous union activities in their country of origin have made the family unpopular in
Canada. Aside from the harassment experienced by the family, the absence of satisfying employment and the friendship of co-workers, represented another significant personal loss.

Interspersed between periods of poor health, she took English upgrading, and a number of employment training courses. Dependent on her husband and family because of inadequate English, she experienced a keen sense of failure:

"All the time my mind is thinking, and I pray to the God for help me in my language (English) because about that me is too down. For that problem me is.... My depress is too bad. Because all the time stay around to my house. Only one time, or three times I go to out for my volunteer job. And take the course. All the time I am thinking it is doing something for me going up, you know. Because I take that course and I am thinking for me is better."

With three years of university education she would have preferred teaching, but the documents for her offshore credentials were left behind during the escape to Canada, and English language acquisition presented another obstacle:

"Yes, but in another kind of job I can't because my English is not very well, you know. And I take the janitor industrial housekeeping. Yes, I take that course for three months for my help to me up. Yes, for my morale. Because I know it is difficult for me I do it, you know. Is necessary I do it. And so I receive my certificate, and I'm going to some hospital. A nursing home for the training, because I need training. I need one week, two week in the hospital, and two week in a hotel before to finish the course. I finish my course in November, no? But in December an operation me. Yes, here my neck. I no come back to the nursing home for working, no? I stay in
bed for a couple of weeks, and that time I come depressed. Yes, I start sick because I can't working."

She agreed to train for janitorial work because she recognized the difficulties inherent in the language barrier, and then when she could not handle the physically heavy work of janitorial/housekeeping duties her sense of self, previously built around a professional career, seemed to have collapsed. She grieved the loss of job satisfaction, job status, autonomy and financial independence of earlier years:

"My problem is, me is stuck. You know stuck? Because before me is too activity, you know. Because I am working, and doing everything myself, you know. And now all the time I'm is come down, down. Yes, depressed. And this year I stay involved to my volunteer job for the refugees. For Latino women. Yes, but it's not complete for me because I need another. Not the voluntary. I need my job, my work, you know. And so I think maybe me is transplant here. Yes. I no me complete. You understand me?"

Interviewer: "In Canada you feel incomplete."

The strong sense of failure she experienced because she was no longer able to follow her chosen career, seemed to have obliterated her sense of self: only one of the stress-related consequences of unemployment (Hyatt & Gottlieb, 1987).

The words chosen by these Latin American women to express their feelings and experiences in relation to political, economic, and social forces were "transplant", "impotent", and "incomplete", all of which convey images of women who felt
uprooted, powerless, and inferior. They felt as though they were only shadows of their former selves — without substance: inadequate, unqualified, and ineffective. Competent, educated, intelligent women (two under-employed and two unemployed) labelling themselves 'failures'. Traumatic life events had left them vulnerable; traumatic life events and socio-economic conditions undermined their sense of competence and control; life-disruptive situations entailing major losses provoked emotional reactions which fostered a general sense of hopelessness (Katz & Bender, 1990). All four case studies given above illustrate the experiences of middle-class educated women who have undergone downward mobility since coming to Canada, and provide examples of the under-utilization of skills and the under-employment of visible minority women (Burke, 1984). Services to these five Latino women were provided by GVMHS; psychiatrists in private practice; and MOSAIC (Multilingual Orientation Service Association for Immigrant Communities).

Profiles of South Asian Women and Post-Migration Violence

Five of the South Asian women who participated in this study were of the Sikh faith or had married into a Sikh family. All five had an arranged first marriage: four married in India, and one left Fiji for Canada with a Visitor's Permit, and married here. Three were now divorced; one was separated, and one had remarried.
South Asian families are very closely knit units, and entire villages in India are considered 'family'. There is a tradition of arranged marriages, and it is usually accepted that a woman will break with her own family when she is married to become a devoted, uncomplaining wife and daughter-in-law. She will see her own parents and relatives infrequently. The newly married couple often live in the same house with the husband's parents, brothers and sister-in-laws, and unmarried siblings. South Asian children, especially females, are raised to respect and obey their parents and elders, and a young wife is expected to subjugate her needs to those of her husband and her in-laws. According to Misri and Sanghera, "Others before self" is the basis for all interactions (personal communication June, 1988.) The well-being and needs of the whole group are considered to be stronger and more important than in the general community in North America where personal freedom and happiness of the individual appears to predominate. Accordingly, interdependence is considered a cultural strength, contrary to the Western ethos of individualism and independence.

The attitude toward divorce is based on the belief that the Sikh marriage (Anand Karaj) is a sacrament and not a civil contract, and there was no provision for divorce under The Anand Marriage Act of 1909 (Waynik, 1985). Nowadays, applications for divorce may be made under the Hindu Code or the civil marriage Act. It used to be that if the marriage
broke down, the woman would leave her husband and return to her parents, but if a South Asian woman's parents do not live in Canada this becomes impossible.

Traditional Roles for Women

One of the participants described her observations of contemporary gender roles for Sikh women in Canada:

"In Indo-Canadian culture up to the recent years husband and wife start having a personal relation. Before that it was a totally different role. You were raised as a producer: child producer, housemaid, provide to do the cooking, and looking after the house. And give birth to the children. That was wife's role. No say at all!"

Now in her second marriage, she spoke respectfully about her mother-in-law who appeared to fit the above description. It was quite clear she had a close relationship with her mother-in-law with whom she felt it was safe to express her true feelings:

"My mother-in-law is a very saintly person. She would just involve herself in the kitchen, just like more subservient. As a good mother, you don't speak out. You just do for your family."

She went on to explain that should a woman choose to leave her husband (as she had done), she should not anticipate any emotional or moral support from either in-laws or siblings who might also be living in Canada, or the ethnocultural community. Her perceptions of Sikh family and community
attitudes concerning husband/wife relationships were as follows:

"A woman should stay with her husband, no matter how crazy guy he is. I cannot talk with my sisters about that. Our relationship is different. I cannot communicate on that level because they are more traditional than I am."

Employed outside of the home after furthering her education at community college level, established in Canada for twenty-five years, this woman had a broad field of general knowledge which in turn had increased her frame of reference. Nevertheless, attitudes within her family of origin had apparently remained the same toward socially-created male-and-female roles, and these habitual attitudes functioned as a communication barrier between the sisters.

MacLeod (1987), proposes that sex-based inequality and a patriarchal family structure silences women because male roles are socially created as dominant over female roles. This concurs with remarks made by some of the participants at a multicultural mental health and substance abuse workshop held at Surrey-Delta Immigrant Services Society, June 27, 1990 when the participants reported a commonly held view that Indo-Canadian wives and children are seen as property and thus have no rights (Johnston, 1991:4). Likewise, Klimack (1988), identifies three groups of women who are more likely to be resigned to abusive relationships: women with a strong traditional ideology (Pagelow, 1981); women who have strong
religious beliefs (Stacey & Shupe, 1983); and older battered women who were raised when emphasis was placed on traditional values and keeping the family together. 'Traditional' in this case, appears synonymous with a culture which is male-dominated, and has patriarchal values and expectations.

Traditional gender roles, patriarchal values and expectations appeared to weigh heavily on the lives of several of the South Asian women who contributed to this exploratory study, and their language echoed this feeling. Compared to the metaphors used for 'failure' by the Latin American women, the metaphor which they chose to express their feelings about the social-environmental factors in their lives was burden. This next section of findings will therefore consider two 'burdens': the burden of fear associated with feelings of dependency, loss of control and powerlessness; and the humiliating burden of poverty. The anecdotes which follow illustrate how these burdens shape the psychological well-being of the women who shared their stories.

The Burden of Fear and Grief

Three of the four Hindu women had an arranged marriage, but were already divorced when the research interview took place. The fourth was newly separated. She also happened to be the only South Asian participant who had both parents living in Canada (a significant interpersonal resource). This
was fortunate, as she was distraught with fear and sorrow during the research interview:

"Actually, he was pushing me out, and I didn't know where to go. I didn't want to go to my mum and dad's place, and I didn't want to break up this marriage. And I never included my family. No. But then when he started hitting me and stuff so I had to let my family know probably one day I will be dead. And I won't forget that night ever in my life. Like he really hit me very bad. And I begged him not to hit me. And he said: oh, don't beg me, I'm a very stone-hearted. Like I was in a bad shape. And he just took off. I told him, I am going to 'phone the police now."

This was not the first time she was assaulted by her husband; rather it was the seventh or eighth time.

"And then two days after, like he didn't get really settled down - he was still mad on me. And he 'phoned me, actually from work, and he says: why don't you pack your clothes, and just leave. I said: I don't have any place to go. And then he 'phoned my dad and said: Why don't you take your daughter? And my dad said: Why should I? You are the one who begged to get married with her. Why should I take my daughter? It's you and her had a fight or whatever. You go and settle down, or work out things. And then he 'phoned me, and then he threat me: If you are not moving out today, and if I come home -I'll kill you! And things like that. I was so scared. I was sick that he hit me so bad. He could have done that, and I told the police that I am scared. If anything happens to me you know, I'm scared. So the police 'phone and talk to him. Actually, I didn't lay charges, or anything like that, but I just wanted ..." (her voice petered out).
MacLeod (1989), reports, "Female victims do not report assaults to the police because they fear revenge by their attackers." On the other hand, she also states:

The majority of women who do report violence do so because they hope that by reporting the violence she and her partner will be helped to return to their pre-violent state. Behind it all she often just wants for them to be happy again. (8)

This woman said she did want to give her husband another chance. He had moved out, but she was hoping he would change his mind and come home:

"So actually they talked to him, and he was really scared. And he says that tell the police that we are getting settled down, and everything is over now, everything is o.k. Or else, I will be put into jail."

Although her father seemed extremely careful not to interfere between his grief-stricken daughter and her estranged husband, she obviously perceived the presence of family members living close by as moral support. The social support provided by this woman's parents was in effect, a reassurance of her self-worth. It was an opportunity for her parents to provide nurturance and guidance, and she knew she could rely on them (Schaefer et al., 1982; Weiss, 1974). Pregnant with her first child, her parents provided material help at this time of crisis, shopping and cooking so she could rest. However, feelings of anxiety and apprehension appeared to be dominant. Aside from the grief of abandonment, the most severe problem from this young woman's perspective was how to
deal with the fear that her baby would not have a father. There was no doubt she was grieving multiple losses (Klimack, 1986).

This woman was first assaulted four months after she was married. As Flitcraft (1977) and Walker (1979) have pointed out, the violence begins early in the relationship; for most, within the first year. This is usually the time corresponding to pregnancy or the arrival of the first child. The time when the woman is most dependent and most isolated. Alone in Canada without the support or love of parents, suffering from physical abuse and depression, another South Asian woman described how fearful and suicidal she had felt. She was hospitalized for six weeks. During this time the hospital became her refuge: she was provided with a safe place, comfort, support and consistency, conditions of which she had little prior experience. By contrast to the hostile environment she inhabited with an abusive partner, she experienced warmth and closeness with the nuns at St. Vincent's Hospital. The support and nurturance given by religious women ministering in the health care system is in sharp contrast to the tyranny of a cruel common-law spouse who had beaten her severely many times. She was virtually defenceless when the physical abuse escalated during her pregnancies, invariably accompanied by the demand that she have an abortion. She acquiesced on two previous occasions, but with urging from her doctor did not go ahead with a third
abortion. At this point her common-law spouse abandoned her: she remembered the exact date.

"I don't know, when this thing happens, I remember! A good thing happens, I don't remember!"

Another example of a woman with a date indelibly engraved into her psyche, she explained how no South Asian man would want to marry her now because a) she was divorced, b) she had no sons, and c) had experienced sexual violence: namely, she was raped in her own home by her common law spouse. A single parent with small children and no financial security, she was dependent on social assistance, and especially vulnerable to sexual intimidation and exploitation (Bonnerjea, 1985).

As in many other cultures, South Asian women are judged to be the guilty party in a rape situation. They are also judged by their fertility, and especially the ability to bear sons. There is more recognition from her in-laws for the woman who bears sons. She is given a social recognition for her reproductive role that is withheld from her productive contribution (Bonnerjea, 1985). Not only had this victimized woman lost her hopes and dreams for any future marriage prospects, she was regarded as an individual with a character flaw, a failure for what a 'good' woman is meant to be; she was seen as having shamed her whole family. She was labelled, and condemned to a life of social and emotional isolation. This reflection of widely held beliefs and attitudes of many other ethnocultural groups including mainstream Canadian
society, fosters the belief that a woman is raped because of her own conduct. In other words, she is the author of her own misfortune. Conway (1990), for instance, quotes experts who tell us repeatedly that rape, and other sexual assaults, are more acts of violence and domination than sexual acts. Our institutions, in fact, tolerate sexual violence, while society seems determined to blame the victim and overlook the larger structural issues—the physical and sexual oppression of women.

Generalizing from this experience, it would follow that South Asian women who have experienced similarly traumatic life crises have also been subjected to value judgements by their friends and families and found unworthy of the community support and nurturing which are inevitably required to heal such psychological and emotional wounds. The community labels them 'failures' instead of 'victims'. They are not acknowledged as victims of violent crime, wife assault and sexual assault (MacLeod, 1989). If expectations that "a woman should stay with her husband no matter how crazy guy he is" are as prevalent as they appear, then these women remain at great risk. Given current patriarchal family structures, women who are battered will continue to be silenced and blamed.
The Burden of Poverty

In a Brief to the Board of Health, Special Hearing on Poverty, Toronto, Ontario, April, 1989, Christina Benson (Women and Poverty) stated:

Women who experience abuse and assault are often marginalized in their social and economic lives, and become trapped in cycles of poverty because of violence and abuse. The largest factor for the increasing feminization of poverty may well be the factor of unsafety for women and their children. (3)

The poverty cycle first began for one South Asian woman when she came to Canada as a new bride:

"When I came in Toronto in 1975 I worked as a shirt packer. I was paid $2.40 an hour. Then I was laid off after two months. I was pregnant and got sick. I started to work again in t.v. parts assembly, $2.40 also. I got my baby, and stayed eight months in the home. Then I started to work as a presser in a sewing factory for $2.75. Then assembler/packer in a chocolate factory for $3.75. This is my life in Canada - so low paid jobs."

This under-employed, economically exploited woman had earned both Bachelor of Arts and Bachelor of Education degrees, and taught English and Social Studies to high school students in India. Like most immigrants, this woman probably came to Canada with the expectation of a higher standard of living. In reality, she swelled the ranks of cheap labour (Lindenberger, 1989). When she was asked about the multiple losses she experienced - loss of self esteem and self confidence, as well as loss of competence - she answered:

"I lost confidence in Toronto. It is like being a machine. In factories they have machines, and you have to work like a
machine. There is so much noise of machines in factories, you feeling like they are hitting with your head. I lost confidence in Toronto. I was with my husband. He treated me so badly, I left him. After my marriage life became so miserable. Then I got daughter. Then I became so frustrated more, and life became more hard."

There were only two of the twenty participants who chose the option to switch off the microphone during discussions of traumatic episodes: this woman was one of them. It was apparent she was reluctant to describe family relationships in any great detail. Furthermore, Struser's research (1985) with Indo-Canadian women found that these women attach great importance to having sons:

The women described how, if they did not bear sons, their husbands might take second wives; their mothers-in-law might cause problems; their husbands would control the number and timing of future pregnancies, and they would have nowhere to live in their old age. (124)

This participant did not discuss this particular aspect of her cultural background, but her voice faltered when she talked about giving birth to a baby daughter which made the researcher think things might have been different in her marriage had her first born been a son. Her own personal welfare may have been more secure, had it been so (Waynik, 1985).

Violence against women takes many forms. One divorced Hindu woman spoke about the role reversals which occurred within the family because of her ex-husband's manic-
depressive behaviour. She had not been told about this closely-guarded family secret before their marriage, the family secret which was the root cause of the marriage breakdown. The illness often prevented her husband from going to work, and although she worked regularly outside of the home she was allowed only limited access to money. Denying any control over money was the means her ex-spouse used to restrict and control her actions. Advised by a sister-in-law to separate from her husband, her brother-in-law sabotaged the plans. When she decided to leave she had nothing, except for fifteen dollars which she had managed to hide - saved from returns on empty bottles. Using deprivation and domination to maintain control, this participant's husband kept her isolated and economically dependent. Economic and emotional battering created an environment with significant potential for psychologically damaging this woman. For example, Epstein, Ng & Trebble (1978), found that many immigrant women in Canada, in fact, find themselves in a trap (battered or not) as a result of their economic dependence on husbands who control household finances.

These five South Asian woman used the following services: GVMHS; a psychiatrist in private practice; a psychologist in private practice; a Vancouver Public Health Department Psychologist; the Healthiest Babies Possible Programme (Vancouver Public Health Department); MOSAIC, also first and second stage shelters for battered women. All five
women were ostracized and shunned because they broke cultural taboos when they left husbands who battered or abused them physically, emotionally, psychologically and economically. Battering exists in the physical, social and cultural context of the environment encountered by these women (Hepworth & Larsen, 1986), and where there is a power imbalance between women and men (Dobash & Dobash, 1979; The Church Council on Justice and Corrections & The Canadian Council on Social Development, 1988).

In summary, four of the Latin American and four of the South Asian women whose stories have been used to inform this section of the findings were single mothers. Two of the five Latin American women who entered Canada as refugees perceived themselves stigmatized as well as marginalized because of class of immigration. Language training, employment opportunities, and depression were identified as particular concerns. In addition, the South Asian women were particularly concerned with rigid patriarchal attitudes, physical, emotional, psychological and economic oppression (violence against women), and depression. None of these women's lives (Latin American or South Asian) had worked out as either they or society had expected, consequently they bear not only their own grief, but also the burden of society's discomfort or disapproval (Silverman, 1981). As a result, social, economic, educational, and political inequalities had
stress-related consequences for the physical and mental health of the ten women whose case studies are presented here.

Case study data will also be used in the next section of this chapter to illustrate how stereotypes, prejudices, and social practices related to gender and ethnicity interact to affect mental health.

Section Three
Systemic Racism: Discrimination and Gender Bias

Federal government policies and programmes in the past, for instance, have stereotyped immigrant women. This systemic racism has resulted in exclusion from educational and economic resources, particularly language training and employment opportunities (Estable, 1986; Seward & McDade, 1988). In the same manner, analysis of data from this exploratory study has revealed how gender-role socialization, and rigid patriarchal attitudes have encouraged the stigmatization and victimization of separated and divorced South Asian women, resulting in their exclusion from supportive ethnocultural community activities. Moreover, writers in the field (Henry & Rees, 1983; Rees, 1983), have argued that racism, sexism, and other forms of discrimination are responsible for the personal and institutional oppression of non-white women in Canada. Accordingly, this section of the findings explores how the adverse effects and consequences of institutionalised
discrimination, sexist attitudes and gender bias were aggravated in some cases by either inappropriate attitudes or insufficient, incomplete interventions by members of the medical community.

Latin American women: Government and Ethnocultural Community Responses - The Burden of Exclusion

The desire to learn English, get a job, and make a new life in Canada are major aspirations for all immigrants. Learning or improving upon already existing English language skills represents the first step towards fulfilling these goals. But, first of all, as the participants in this study discovered, they have major hurdles to overcome.

Restricted Access to English Language Training

A woman, arrested in a classroom of the school where she taught in El Salvador, described the difficulties she experienced at a local Vancouver community college:

"I was very upset when I went to the financial aid for other application form. But the person there in his office was write down my application. Something wrong. No more they don't want to give me more English school because the other people are on the wait list. And the people, maybe they are healthy. And I bring my application form to the doctor that evening, and I explain to him. Doctor, what do I do? What can I do? I can't get job. I try. I try many times. Nobody give me job, because when people see my cane. Or maybe, they want people healthy. Because the important thing is production. But, then I can't get the job. I can't go to college. What happen to me? I felt terrible. Every morning I
The graphic imagery she used was, in fact, a very apt reflection of her socio-economic position in Canada: a woman on the periphery watching through a pane of glass as life passed her by. (An unemployed widow with a dependent child, she rented subsidized housing, and had an annual income of just over seven thousand.) First, she was victimized in her homeland by virtue of her professional status. According to The Canada-Latin American Resource Centre (1991), in fact, teachers, students and church workers are among the groups most often persecuted by the military. Second, she was marginalized after she arrived in Canada on the basis of her immigration status. She had become one of the victims of persistent Provincial and Federal government bickering over the provision of adequate English-as-a-Second Language programmes; throughout the Eighties both levels of government have used the issue of responsibility as a political football, to the detriment of those who are most needy (Seward & McDade, 1988). Already handicapped in her search for suitable employment these further restrictions (over which she had no control), decreased the few viable options even further. See Malatest (1991), for an example of gender bias inherent in Canada Employment and Immigration Centre policy regarding
eligibility for full-time English-as-a-second language classes with a training allowance.

Feelings of frustration and despair were very obvious as a second Latin American woman described her experience of applying for registration in English language up-grading classes, and the institutional barriers she encountered:

"You know that here in this college I was more than one year fighting to let them enter me here just for study here. And I feel so bad. Because the first thing I went to Douglas College. First they said: Please, your student papers. Show them your Social Insurance. Oh, you're a landed immigrant? No, I'm not a landed immigrant. So I'm sorry, but you cannot study here. You cannot be a student here. You feel so horrible!"

Systemic discrimination is widespread in our society and it affects whole groups of people, not only those who are categorized, and excluded, on the basis of immigration status.

**Restricted Access to Employment Training**

This Latin American woman suffered double jeopardy: first, she spoke about her unsuccessful efforts to access employment training and English language upgrading courses, and then she described a second unsuccessful attempt to register for a course which would have made the difference between receiving financial assistance from the provincial government, or becoming economically self-sufficient:

"OASIS (Orientation Adjustment Services for Immigrants Society), have a beautiful secretarial course. And I would have liked to take it. But I couldn't take
because they said: Sorry. You are not a landed immigrant.
Secretarial courses are the thing I am looking for because I would like to be a legal secretary, or a para-legal. With my professional background it would make sense."

A less motivated person might just as easily have judged the situation to be hopeless. But, despite the adverse structural discrimination she faced when she did seek English upgrading or employment training programmes, she continued to persevere: when interviewed she was working half-time and attending community college English classes half-time. A single mother in a country of resettlement, she was also carrying the additional burden which falls to women: maintaining her traditional role of nurturing and transmitting culture to the children in the family; keeping the family together; and learning the skills necessary for survival and mental well-being in a new cultural environment - all of this while being totally responsible for child care (Bonnerjea, 1985). In conclusion, restricted and insufficient access to English language up-grading classes, or delayed access to services because of protracted refugee claimant procedures, produce conditions of double jeopardy. Such women are high risk, and remain at risk for triple hazard if the doors to universal medical services are also closed to them, as this woman was to discover.
Feeling pessimistic and disheartened by her apparent powerlessness to affect any change in her English language fluency or to increase her prospects for employment in a higher strata of the Canadian workforce, she described an additional source of stress:

"When I talked with the counsellor at SAFER I think we probably did talk about going to my doctor for medication. Especially because I was very depressed at that time. But I am always thinking about drugs. I don't like any kind of medication. Especially these kinds of drugs which I think they are addictive. I don't think they are good. I think we talked about that. But anyway, even I wished to have these things, I couldn't because I don't have any medical insurance."

Interviewer: "Why was that? Do you want to tell me about how you didn't have any medical insurance?"

"Because when I came here, I came as a refugee claimant. And I am still in that category, and that status. So for all this time (three years), we don't have medical. As I understand it, it has this law this year (1989), for people like me to have this medical insurance, but they are about $58 a month, so I cannot afford that. When I was with this depression, I came here because at that time I was a student at King Edward, and so somebody contact me to have the appointment with the doctor because I have been here. But in that moment I was desperate because I don't have medical. I don't have medical!

And in Toronto, my boyfriend - he is there. Even when he was in my situation, he have medical insurance and he could go to the psychologist, you know. But here there is a lacking of services for
emotional health, for mental health, in this province."

Interviewer: "He was a refugee claimant in Toronto, but he could go to a psychologist, or to some mental health service? Those services are provided in Toronto, but not here?"

"Exactly! He could have that. Now he is a resident because he enter Canada one or two months before me, and he could get the application for welfare. But not me, because I enter after that. There was an amnesty, so he went. But not me. But even before that, he was with that because he has two boys. There he could have a lot more of attention than here. He doesn't speak English — very poorly. He is working in factory, so good money. But, his English is no good. But the service is there. And, it's provided in his first language. We don't have that here."

A single mother with two dependent children, she rented subsidized B.C. Housing. Employed part-time, she was one of the 'working poor' with an annual income of approximately $6,000. Not only were economic and structural barriers preventing access to universal medical care (Bergin, 1988), this woman also pinpointed another area of concern: lack of settlement services in the province of British Columbia for immigrants, and appropriate counselling services for survivors of catastrophic stress. For instance, the Vancouver Association for the Survivors of Torture (VAST), a not-for-profit volunteer organization, has no municipal, provincial or federal funding.
The Price of Political Allegiance

The following case study illustrates how the ethnic community in Winnipeg rejected and punished a newly arrived refugee family for their previous political affiliation. Intimidated, fearful and anxious, this newly arrived family found themselves harassed and victimized in Canada for their political beliefs—almost a replay of their experience in Chile. Differences in political ideology, the ensuing ethnocultural isolation and loss of a supportive environment, impacted upon the emotional and mental well-being of the whole family. In the years to come, these events would have a bearing on the social integration and functioning of the entire family:

"And so I am going to my family to the community. The community the Spanish in the church in Winnipeg. But when I arrive over there, the people say: Stop! You can't go in. I say: Why? He say: Because I no like your family. I say: Why? The church is open for everybody. More especially for the family because my family is Catholic, and you never Catholic - communist people. Communist people is never Catholic. Is nothing, no? And I has discussion, you know. A big fight. And I come back home, and I never more back try to go to the church in Winnipeg because a fight to my children.

The government in Winnipeg take my family, and put out. Nobody around that speaks Spanish around my family. And put some social worker for help us. No speaking in Spanish. No nothing, because there has been big, big problem over there for the Chilean people. Very big. And too bad for my family, because all of the children stay very nervous, you know. My youngest child is only four years, and has ulcer.
Everybody has ulcera, you know. And nervous!

This woman connected the onset of her depression not only with inadequate English language skills and the stress-related effects of unemployment, she also related feelings of total cultural isolation because of rejection by the ethnocultural community. In many ways, her experience is a close parallel to the experiences of South Asian women who were rejected and punished by the ethnocultural community for protecting their children and themselves from abusive relationships. Both ethnocultural communities ostracized women who embrace a different ideology.

South Asian Women and Ethnocultural Community Responses: The Burden of Exclusion

Much has been written on the "double victimization" of women, and research has shown that many women victims of crime, particularly victims of wife assault find their friends and family withdraw from them, become critical and blame them for their victimization (MacLeod, 1989).

Restricted Access to Community Activities

Clearly, it is not only the families of South Asian women who withdraw, because similar behaviours are to be found in the general community of North American culture too. However, analysis of the data revealed that South Asian women find themselves in a position of triple jeopardy should they chose
to leave a violent, abusive spouse. A survivor of wife assault explained why this should be:

"The community won't look after violence in a marriage because community is condemning the woman. They don't like it. There are so many people they don't talk to me because I left my husband. They are thinking I am not worth anything. Some other women. Some even men. Some families. They don't talk to me. I am rejected in the community. By most of the community, but I don't care. I say: Go to hell. My life is here with this community, Canadian society. So I don't care about my own community."

This particular anecdote illustrates how much determination and will power it takes if women are to survive after they have been battered, shunned and ostracized. Ostracized by her own ethnocultural community, the battered South Asian woman typically finds herself in triple jeopardy when she has no support from family, friends, or community institutions. A second South Asian woman described her previous experience of systemic discrimination:

Interviewer: "Would your family ostracize you for that kind of behaviour?" (leaving her husband)

"They did! They did to me. Because that was my decision."

Interviewer: "How is that disapproval expressed?"

"Isolation - socially. The families would avoid to invite me. They would ignore me in public. They would not like to see with me."
Szasz (1973), would probably refer to this as an example of the victimization and dehumanization process which happens to persons who deviate from the norm. This woman had remarried; she was fluent in English and employed full-time; she reported the highest total household income of all ten South Asian participants, i.e. $60,000+.

**Restricted Access to Religious Institutions**

Asked about the social and religious aspects of her life, a South Asian woman who fled the family home from an abusive spouse, replied:

"No, I don't have social life. And I don't go to the temple. Only very rarely. They stare at me. So I hardly go. Once in a blue moon."

She was stereotyped because of rigid patriarchal and sexist attitudes concerning a woman's role. She realized she was not welcome to worship at the local temple: she was excluded and discriminated against on the basis of gender and marital status. (The name Gurdwara refers specifically to a Sikh temple. For ease "temple" is used for both Sikh and Hindi):

"They don't talk about family violence. They talk about racism. They talk about racism because it is their problem, no? Because of their jobs, or something like that. So they talk about their own things; they don't talk about women or family violence. They say it is men's right to beat women. Big deal!"
Minimizing problems of women is a subtle form of discrimination — functioning as a barrier to preserve the status quo in patriarchal systems. At a workshop held June 27, 1990 at Surrey-Delta Immigrant Services Society, the primarily Indo-Canadian participants said they hoped the temples would play a larger role in addressing community issues, including those of isolated house-bound women suffering from anxiety and depression (Johnston, 1991).

Gender-Role Socialization

Role conflict has been identified as a significant issue for immigrant women because many women feel pressured by the family to remain traditional in some respects, but to change in others (Johnston, 1991). One of the South Asian women who left her husband because of a drinking problem, said her husband put his parents and family before his wife. She was not the only woman in this particular group to refer to intergenerational power and control conflicts, a fourth woman explained how divisive family politics can be:

"Like he 'phoned me, and he said he wants to come home and I agreed. Like we'll talk to the police and whatever, in the court. Have this Restraining Order cut off, and say we are getting settled down. And then right after two hours he 'phoned me, and said: Oh, I'm at my family's place, and my auntie doesn't allow me to go home because they said, once someone put you to jail, she'll put you another time. But they don't think what is he doing."
This woman was seen to have deviated from the norm because she acted in an independent rather than an interdependent way, and just when the couple seemed ready for reconciliation, a family member intervened. The effect of this intervention was to divide and separate the couple further, rather than the family networking to empower them. In the long term, it would seem the chances are high she will lose status, devalued because of the reproaches of her husband's relatives, alienated and estranged, become marginalized, peripheral to her spouse's family, and excluded from the support which extended families are usually able to provide to young couples who are just establishing themselves.

Responses from the Law Community

Deeply ingrained patriarchal values and expectations permeate Canadian society and institutions. Sexist, patriarchal systems, in fact, function to preserve the status quo: they also reinforce the culture of gender dominance indigenous to traditional societies. From the next anecdote it would appear that this woman decided some ethnic lawyers dictate rather than mediate and negotiate:

"If I had a marriage problem, I would not like to deal with that marriage problem just on the Indo-Canadian cultural level. I would like to have a broader support, you know. Open-minded, rather than just having that narrow circle with just the same values. We used to have a single woman's support group. And at that time we came into contact with some ethnic lawyers. They would impose their values
on Indo-Canadian women. And they would just say: Oh, you should go back to your husband. And would not understand the woman's situation."

The kinds of behaviour and attitudes described in this anecdote are a close parallel to findings of recent research which found that the kinds of behaviour and attitudes endorsed by clinicians as appropriate for women are ones that keep women "in their place", submissive to men, engaged in caretaking activities, and as objects of male sexuality (CMHA, 1987; Anderson, 1985). In short, sexist attitudes and gender bias are not exclusive to members of the law profession.

Latin American Women and Federal Government Policies

Refugee Claimant Category

Refugees who have been selected abroad for immigration to the host country or who are recognized as refugees by the host government, are in a very different position to those who arrive in the host country without status while they await determination of their refugee claim. A Latin American woman explained how she perceived herself as trapped and unprotected in the lowest strata of Canadian society because of the definition of her immigration status as "refugee claimant".

"I am a refugee claimant, and have been here for about three years. If I was a landed immigrant maybe I would feel more protected by the State, kind of more secure inside myself because now I feel completely insecure with the uncertainty. I don't know what is going to happen to me, and my children. For the other side, I am not able to take this training course
which could prepare me for a better job. So in my country I am a professional. But here I have to work in a restaurant. It's o.k. because it was the beginning. But I would like to work in an office better than a restaurant. I went once to the Employment (Canada Employment Centre), and they said: I'm sorry. But you are not a landed immigrant. You cannot take this course."

Interviewer: "You are not entitled to take courses?"

"Any kind of course!"

Interviewer: "Do you know when you might hear about your status? When will you know if you are going to be allowed to stay in Canada?"

"I know absolutely nothing about that because they are sending a letter from Ottawa to the people which are in the backlog. But I haven't received nothing because when I came here they gave me a Ministerial Permit, so I was renewing this, but now it finished in January this year (1989). So now we are nothing. We were not legally here. Just waiting for this letter from Ottawa, and they are going to tell us when we will have our hearing. And I don't know if we will be accepted or not as a refugee. And a lot of stress also. It's terrible. You are in this situation, and you don't know what's going to happen!"

Interviewer: "Do you feel there is a difference being a 'refugee' as opposed to being an immigrant woman?"

"Of course! I feel that is a second-class citizen. Definitely!"

Typically, Minister's Permits are very widely used (37,000 issued during 1989). They are usually issued for a maximum of one year to anyone who has been deemed 'inadmissible' to Canada for a wide variety of reasons
This woman's experience was not unique: most recently a refugee claimant committed suicide as a result of the stress-related consequences of waiting several years in limbo while the Refugee Determination Board processed the claim.

There was no doubt this woman felt marginalized:

Interviewer: "Do you feel put to one side?"

"Yes, sometimes. Not always. But sometimes. When I cannot get something that the other people have. Other people which are immigrants. Because I think you know, inside myself, I think I can be a good citizen here. I can be a person who can afford to be social. How come I feel that way? Because they don't allow me to have work sometime, and things like that."

These comments were made in response to a probing question at the conclusion of the interview: "After this long discussion is there maybe something else you'd like to add, to ask, or to have clarified?" The 'door knob' information which was forthcoming provided an example of systemic discrimination as practised by a Canadian social institution. Although refugee claimants sometimes wait three years or more, as this woman did, for confirmation of their immigration status, existing Federal government policies continue to prejudge throughout the entire process, excluding them from services which would enable such applicants to become self-reliant, socially responsible, contributing members of Canadian society. Or, at the very least, during the time they are
living in the country. The very nature of systemic racism and the stress-related consequences, in fact, impact upon the individual's physical, emotional, psychological and spiritual well-being making it almost impossible for the person to contribute in an optimal way to society (Lindenberger, 1989; Milne, 1990). As Henry and Rees (1984) have pointed out:

Non-white women are institutionally penalised as non-whites and as females. Although Canadian data are hard to come by, indications are that there are an alarming number of poor non-white women confronted with triple oppression. (24)

Assisted Relative Category

Another Latin American woman made reference to feeling like a second-class citizen when she described the process the family was going through to sponsor their mother into Canada via the Assisted Relative category, and spoke of Federal government staff attitudes:

"Now I am dealing with my mum’s sponsorship. It is very hard. You cannot go to Immigration to trying to sponsor anybody unless you have enough money. And the way that they treat you is like if they are really trained to humiliate people."

Interviewer: "It seems like they are trained to humiliate people?"
"Yes, in Immigration. And if you go to the Welfare. Well, actually my husband is working, and we were only on welfare for two months."

Interviewer: "Did you find that experience humiliating?"
"Yes, oh yes!"
It seems fairly apparent this woman felt shamed and chastened by the attitudes, procedures and policies encountered at both Federal and Provincial institutions.

South Asian Women and Federal Government Policies

Depending on the gender of the immigrant, immigration policies and practices have differing impacts, chiefly, because of practices which discriminate on the basis of sex and marital status (Estable, 1986). Moreover, the Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988) states,

Among immigrants, men usually make the decision to leave a homeland. Women entering Canada over the past decade were many times more likely than men to emigrate as dependent spouses, and much less likely to enter Canada in a category designated to participate in the labour force. (73)

Consequently, immigration status can have a number of serious long-term consequences for women classified as 'dependent' (Estable, 1986).

Family Class Category

A South Asian woman described the combined effects of a cultural tradition, and Canadian immigration policy:

"I came to Canada after getting married with this man. He came to India pretending to be a bachelor. I married with him. It was all arranged marriage. I got pregnant. He brought me here, and here I find out he was married and his wife is here. What to do? And I was carrying fifth month all pregnancy. I suffered a lot. Thrown out two times by
immigration people because there were no spaces. They were not willing to give me immigration. I went back two times to India under pressure from immigration people. It took me three years to go here and there so finally got divorced from his first wife. He married me here in this country second time when my child was three years old. But in that process I was getting all the time beatings. Every day beatings, beatings. I have twenty five stitches on my head, but still I did not put charges on him. Why not? Because I was a visitor, and I knew if I will put charges on him I will be sent back to India with my little child. What am I going to do? Because when I go back there is no job for me. I was working there as a secretary, and I am graduate from Bombay University. But when I go back there is always age concern, and they will not give me job back. So what do I have to do?"

The fear of deportation was not unrealistic. As a sponsored immigrant (usually sponsored by her husband), a battered woman is typically dependent on the man who beats her - both for economic support, and also for her right to stay in Canada (MacLeod, 1987).

**Latin American Women: Responses from the Medical Community**

Functioning in a pluralistic society such as Canada, many immigrant women come to realise that health professionals do not always perceive them from a holistic perspective, but rather from the perspective of a medical model where the power of the physician is supposedly played out against the passivity of the patient (Weick, 1986). Some of the Latin American participants in this study found that patriarchal
interactions between doctor and patient did not create a healthy environment (Weick, 1986).

Latin American Women and Attitudes of Medical Professionals

Well educated, completely fluent in English, a self-employed para-professional Latin American woman described her experience of narrow-mindedness during an encounter with a hospital doctor:

"Doctors here carry their own baggage. My doctor in a small town in the interior of B.C. was a Moslem from Uganda. And I assume he has his own attitudes towards women. He was very judgemental, and told me I was trying to be seductive because I was wearing a pretty pink nightie, matching robe, and ballet slippers. His own cultural thinking got in the way."

It would appear these remarks were intended to shame and chasten this woman - she could have felt humiliated. Instead, she seemed able to identify this attitude later as cultural 'baggage'. Nonetheless, this doctor's remarks were out of context, inappropriate and irrelevant. Hospitalized because of an acute crisis state (a single mother with two teenagers, no family or relatives in Canada), the consequences of such a sexist attitude could only have been increased stress for an already distressed woman. The question of whether or not this was racial bias is very much open to debate, but certainly gender bias represents a very real barrier to the provision of appropriate health care. Recent research has revealed the ways in which the mental health of women has been jeopardized
by the sexist orientation in society, a society that has taught men to believe they are superior to women (Kjervik, 1979; CMHA, 1987).

Another Latin American woman felt alienated by the attitude of the first medical doctor she had contact with in Canada:

"When I just came here we went for some tests with some doctor. He is a Mexican doctor so he speaks some Spanish I suppose. But, he has been living here a lot of years. And I feel so mad with that doctor. I feel that because we are refugees, he was thinking about us as stupid animals. The way he asked a lot of questions. It was so idiotical. I just felt very bad with that doctor. The way he asked some things. As if we were stupid because we were refugees, you know.

I just changed the doctor."

Interviewer: "Because you were refugees, you didn't understand?"

"Exactly that kind of thing. It's not something that people are going to tell you. But it's something that you feel that people feel. You can perceive some things because sometimes they have an idea that because you are a refugee you came with no clothes, no shoes... Terrible! And that you are stupid and ignorant."

Already extremely sensitive about being labelled 'refugee', this woman experienced discrimination and racism during contact with this medical doctor: she felt dehumanized and devalued. Henry and Rees (1984), concluded from their research that non-white women in Canada are discriminated against: they believe such discrimination includes inadequate
health care, under-employment or unemployment, and deteriorating education for themselves and their children.

Latin American Women and Prescription Drugs

Describing her use of medication, a Latin American woman was asked whether or not the doctor had explained the prescribed medication may have some side effects, she replied:

"Yes, always I have. I feel strong headache, like today. Every day is. I had to take the medicine."

Interviewer: "Does the medicine make you feel sleepy?" (Her speech was slurred.)

"No. The doctor change the medicine. No pill. No more pills...The pill from the psychiatrist, yes. He change because I want to improve my English, but my memory is no good."

Interviewer: "Your memory is no good when you take the pills?"

"I have to take everyday. These pill make like more I can't retain. I can't understand. The teacher explain, I get some English. I get maybe ideas, and then I can make the exercise. But the other day, it's bad no? Because my memory is up and down."

Interviewer: "So the pills are really quite strong. The doctor gave you weaker pills, did he? He changed them?"

"Yes, to stimulate my memory. I told him: Doctor, please my problem! I want to learn. My problem is my memory. And he change the medicine he give me. He (the psychiatrist) change the pill he gave me. Yes, he change because I want to improve my English, but my memory is not good.

When I have the headache I don't want to
stay at home. I have to go outside. Walking, walking, walking."

Interviewer: "If I ask you questions and your head is aching, is it going to feel worse talking?"

"No! Talking is therapy for me."

This woman's attempts to upgrade her English language fluency were impaired because of the insidious side-effects of prescribed medications, and her inability to concentrate. Not only was her ability to learn impaired, the inter-related issue of her ability to become financially independent was also threatened. A double-bind situation: English language acquisition hampered because of impaired memory and learning through the use of medications: medications which were prescribed for psychological wounds suffered in her home country (Legge et al., 1989).

A second Latin American voiced her concerns about sleeping pills:

"It's not good to give a patient too many sleeping pills. I've taken pills ever since I arrived in Canada. Yes, pills! Everything I think is about to the nervous, and to the depress. And so all the time staying in doctor. And to special doctor. Take too many different medications. Never after 1984 is I well. All the time more down, down. In that time my family doctor send to me for the psychologist. In that time I stay to Venture House. They talk to me. And give me medication. Pills. Pills for sleeping. And pills for depression. And so after I have another complication in my body because I have problem in my back, you know. And so has angina. And I has ulcer too."
There were two women who mentioned side-effects of sleeping pills and an ulcerated stomach wall, a South Asian woman made very similar comments. Although minor tranquilizer use is recommended for periods of up to four weeks, unfortunately, most prescriptions are repeated for many years (Naegele, 1984). This woman indicated she had taken pills for approximately ten years, and referred several times to frequently "feeling nervous". As Naegele (1984) notes,

Relying on tranquillizers one becomes able to cope, while at the same time, one loses control of personal initiative. Tranquillizer users were more likely than non-users to perceive themselves suffering from nervous symptoms encountered in their daily lives, and to describe themselves as usually being nervous or anxious. (238)

Latin American Women and Prescription Drug Addiction

A Latin American woman spoke about using mental health services, and how prescription drugs interfered with her life:

"Yes, but I think me, what now? Why no happen this before when me is working? I don't know. I don't know. Maybe is too much, but I need it (the medications). Because I tried to stop all the medication. I say: Now you change. None you come out. Not looking job... But me say: What kind of job? Clean the house? Working in the hotel? I don't know! And me is back again, and depressed."

Link community prejudice and rejection with lack of social support networks, and restricted employment opportunities, then the hidden connections between emotional distress and the potential for the over-use of minor
tranquillizers and psychotropic drugs becomes more apparent (Naegele, 1984). However, over time it becomes apparent how such drugs can complicate rather than alleviate problems. In addition, Prather (1984), who studied the use of psychotropic or mood-modifying drugs by women in the United States for ten years, found that problems with prescription drugs were hidden and treatment difficult to acquire.

South Asian Women: Responses from the Medical Community

In a highly complex, urban industrial and multicultural environment such as is found in the Lower Mainland of British Columbia, many visible minority women encounter situations and events over which they have no control, but which shape their experiences and expectations concerning their lives as women in Canadian society. When experiences of humiliation lead visible minority women to feel devalued in the larger social context because of skin colour and dress, this perception of marginality may also be re-experienced as mistrust during contact with health care providers. There are times when it becomes difficult to trust that others will treat them with dignity or show respect.

South Asian Women and Attitudes of Medical Professionals

The need to be treated with dignity by health care providers was the major focus of a professional woman who felt she had been looked down on. She is the most highly educated
woman in either of the two groups, fluent in English, employed full-time, and with third highest household income in the South Asian group, i.e. $35,000 compared to $48,000 average family income for B.C. (Statistics Canada, 1989). Her perception was that she had been labelled, and she subsequently felt a loss of status:

"They treat you...they treat you as second class citizens. As a coloured woman you get treated as second class, and sometimes as a third class citizen, all the time! Everywhere! And it's double jeopardy, you know. You have to be a woman. And you have to be a coloured woman. And in my case, I have to be a coloured woman in a sari. And so what my comments are that nobody seems to realize that coloured women also have the capacity to think. And they also need to know what is the procedure. What is the policy? And what is the practice? These are all relevant questions which coloured women need to know, just as white women. And they ought to be explained those with dignity. The fact that I'm a patient, I'm a patient because I've had a serious injury. It has nothing to do with the fact that I'm Indian, or I'm a professional. My body is just like anybody else's body. I thought that was in very bad taste. I still remember it to this day because I just cannot repress it enough."

Throughout the interview this woman made several references to the need for procedures which preserve the dignity and integrity of the client/patient. Her comments are very similar to those quoted in another Vancouver study (Anderson, 1985):

People from the poorer non-white countries of the world are looked down on. They are stereotyped as
incompetent. This perception in itself undermines the competence of the women. (72)

As an illustration, Bergin (1988) quotes ethnic leaders: "Respect for immigrant women's backgrounds is lacking. They feel put down by professionals, even when language is not a problem" (73). And other writers have reported Indo-Canadian women feel discriminated against on the basis of skin colour and dress (Milne, 1990). Consequently, women who are victims of racism are in double jeopardy: they experience oppression not only because of being female, but also because of colour.

South Asian Women and Prescription Drugs

A battered South Asian woman described many years of physical abuse before she finally fled the family home: inevitably the tremendous burden she was carrying had an effect on her physical health. She explained the process:

"Like I was really getting bad health, and that doctor used to give me so many tablets to sleep, and which caused me an ulcer. He used to tell me to take six pills. I did not listen to him. If I would have taken six I would have been dead. I used to take two, and I still got sick. I never took six. He said six. I took two. I got very bad ulcer. So bad, I threw up blood."

Interviewer: "And in your mind there was a connection between the ulcer, and the sleeping pills?"

"That's what the other doctor said." There are lots of things, no? Depression, and then you are taking so many pills like that. Something is going to happen, definitely! And you don't eat proper food
when you are worried. No food, depression, and pills!"

As Sinclair (1985) and MacLeod (1987) have pointed out, fear is encouraged by the abuser's psychological abuse, and reinforced by the escalation of the violence. This plays havoc with sleep patterns, causing insomnia and nightmares, and can lead to drug dependency, and addiction. However, as Jane E. Prather (1984) remarked almost a decade ago, "The problem of misused or abused prescription drug use among women has until very recently been ignored or hidden" (6). These findings have particular significance because the potential for over-medication of psychotropic drugs exists for immigrant and refugee women who tend to visit a doctor instead of accessing more appropriate services (Johnston, 1991).

Finally, Anderson (1987) has noted, "Health care ideologies reflect the dominant perspective about women's role in society. They are geared toward 'helping' women 'adjust'" (430). Just as this woman described the damaging side-effects of sleeping pills, the Indo-Canadian women in the Anderson study also found from experience that what health professionals recommend might not help them. Likewise, a community counsellor made the following comment:

"If a woman is having arguments with her husband every day, she thinks how can pills (tranquillizers and sleeping pills) help the situation?"
South Asian Women and Prescription Drug Addiction

Belle (1987) suggests, "If a woman is heavily involved in providing support to needy relatives while receiving little support in return, the result may well be demoralization and depression" (270). Sleeping pills were prescribed for a South Asian woman when the seriousness of her mother's mental illness seemed to have had most impact (i.e. about twelve months before the interview took place). With an apparent insensitivity to the needs of caregivers of the mentally ill, this unhealthy intervention proved to be an additional and unwarranted source of stress for this woman. In addition, she believed the pills affected her memory, and was the second woman to complain about the alarming side-effects of prescription drugs on memory functions. She tried, but found it extremely difficult to cut back on the sleeping pills; subsequently she discussed feeling 'hooked' with her family doctor. She was taking a reduced dosage when the interview took place, but, she said, she couldn't sleep unless she took a pill at bedtime. She also said she felt 'stupid' after taking the pills: on one occasion she fell over onto the kitchen floor. If this woman's experience is typical, then apparently sleeping pills affect motor co-ordination too. As a result, prescription drugs had stymied her efforts to live a relatively normal life despite the seriousness of her mother's illness. Both she and her mother were dependent on prescription drugs.
In summary, the stories of five Latin American and five South Asian women have been used to inform this third section of the findings. In the Latin American group, three were single mothers (two low-income), and in the South Asian group, two were low-income single mothers. The Latin American women encountered structural barriers which serve to preserve the status quo in a sexist, racially stratified society. Systemic discrimination and the stress-related consequences functioned to restrict their political, economic and social integration into Canadian society. These environmental stressors, in short, threatened their self-esteem, as well as creating stress and anxiety. They felt devalued, lacking control over their lives. Again, the South Asian women encountered systemic discrimination in the form of 'traditional' values and expectations: cultural norms which operated to preserve the status quo in a patriarchal system. Essentially, these women had been 'written off' due to their dependent and devalued status by Federal government policy-makers, and social institutions at the personal, family and community level. Finally, these instances of systemic discrimination were exacerbated for both groups of women, because of the inappropriate attitudes, and the insufficient, incomplete interventions of medical practitioners. In sum, the data from the foregoing case studies suggests that both economic 'dependent' immigration status, and prescription drugs with the potential to create chemical dependency, have serious
long-term consequences for immigrant and refugee women (Estable, 1986; CMHA, 1987).

In the final section of this chapter, recommendations made from the perspective of women who have used mental health services are documented. Once again, the goal was to identify social-environmental factors which function as obstacles to mental health service utilization.

Section Four

Recommendations for Improvements in the Delivery of Health and Social Services

As mentioned earlier, in order to provide an active and responsive role for those being interviewed, and to effectively capture the needs and concerns of women, participants were asked if, from their own experience, they could suggest improvements. Five areas of concern emerged.

Non-threatening Points of Entry from the Latin American Perspective

One of the Latin American women spoke about the location and visibility of mental health clinics:

"And it came to my mind just now, if they will be any chance that somebody else from this clinic visits you at your home. If somebody visit you sometime because you feel afraid to call. I have many friends who are living around there - the Broadway neighbourhood - close to there. And every time I go there I feel afraid."
She didn't want her friends to know, she said, but subsequently spoke of advising her friends to go for help from the clinic if they were having problems like hers. Then she addressed the issue of Community Care Team hours:

"Maybe they could change their schedule."

Interviewer: "O.K., but what exactly do you mean by that?"

"Well, actually I am taking this training programme, and I have to be at my work place early in the morning, and I just finished worked until 5.00 p.m. So I want to see M. (psychiatric social worker), or the doctor, but it would be good if they had some time in the evening for people who were working in the daytime."

Taking unpaid time away from work is a luxury many women cannot afford.

A second Latin American woman made a suggestion which she believed would help patients feel more accepted:

"I think that it is necessary in the profession medical or social worker, is necessary stay sensitive, is open, because the patient is not staying comfortable."

She also spoke about feeling threatened by the busy urban environment where the psychiatric emergency facility was located:

"That is good place, you know. But it's a house, and too closed, you know. The people only around in this living room. But when going out it is only around to the house, in the street. Maybe is better to take some big place. Take a yard. A backyard for sit outside, or walk outside. And too many times I think is better to take place with many trees, and walk around, you know. Because when I stay there, when the lady (the nurse) take us
for a walk outside, all the people looking
us. And so I'm nervous. The person and
the traffic looking us. And me is
thinking: maybe the people looking us
think is crazy people. And I thinking
that people think I is crazy. I didn't
feel good about that."

A third Latin American woman referred indirectly to her
social and cultural isolation when she said:

"In that case maybe I don't like that the
time is so little (the therapeutic hour). Or maybe, that the time was more longer. I would like to have somebody to talk to. Maybe I have one hour three times (meaning a three hour block)."

This same woman also suggested that at each of the mental
health clinics they have someone on staff who speaks Spanish.

Non-threatening Points of Entry from
the South Asian Perspective

One of the South Asian women focused on the atmosphere of
clinics rather than location, and referred to the creation of
surroundings which she thought should reflect the multi-
ethnic, multi-racial, multicultural reality of communities in
the Lower Mainland of British Columbia:

"I think all the social services
atmosphere should be more multicultural -
even when the client walks in."

Interviewer: "How do you think we could
achieve that?"

"In the set-up of the waiting area. There
should be more pictures displayed of the
different cultures. Something that as
soon as you walk in it's something that
can relate to your culture. Right away it
makes you feel close to the place. Even
just one painting."
And more multilingual workers. There should be more bilingual interpreters, or bilingual psychologist professionals, more multilingual workers in the Public Health so when people go they don't feel very much outsider."

In general, the South Asian women referred more often to feeling like "outsiders" than the Latin American women did.

**Education for Accessing Services from the Latin American Perspective**

Women born outside of Canada, particularly those who are raising children, need orientation programmes which would provide them with knowledge of health and social services. A Latin American woman who said that her expectations of services did not match reality because she had no knowledge of what to expect, said:

"New Canadians should be more informed about what services are available to them."

This point is further substantiated by Health and Welfare Canada (1988) literature which suggests that the inclusion of orientation programmes as one of several preventive measures "reduce psychiatric morbidity among migrants, and prove cost-effective in the short, as well as the long run" (18).
Education for Accessing Services from the South Asian Perspective

A South Asian mother with a child in elementary school thought that the school system, as well as mental health clinics could provide a mechanism for responding to the public's need for information:

"A lot more work to be done. More information exchange in public, and in the Community Care Teams."

Interviewer: "Does that imply some translated materials?"

"Translated, yes. Also just the public awareness. Like more hand-outs from school to the kids, to take home to the parents."

Lack of knowledge about appropriate services has already been identified as a factor which aggravates the mental health of immigrant and refugee women (Johnstone, 1991).

Culturally Competent Service Delivery from the Latin American Perspective

The first Latin American woman to be interviewed for this exploratory study spoke of being hospitalized during a suicidal ideation episode some years earlier:

"They were all Canadians in the group sessions, except me and one Native Indian. The violence in my background wasn't relevant to other group members, even the therapists. They were very naive. They came from very protected backgrounds, and their knowledge of South America was very limited. We have a very complex society down there (Brazil) - with values from the Middle Ages in a Westernized, technological world. Service providers should have a basic knowledge of
geography, and what's going on around the world. They need a broader vision of general world problems if they are working with more than just the Canadian born population."

Her comments have implications for those who work with survivors of torture too.

Another Latin American woman also believed that ethnic and cultural background were very important:

"Because for the person these are the usual behaviours. And culturally has been raised up. Every person, there are some things that you are born with and your father do, the family, the customs. Yes, I think it is important to have in account when a person is talking to a doctor or talking to a counsellor."

Culturally Competent Service Delivery from the South Asian Perspective

The South Asian participants in this study gave a unanimous "Yes" in their response to the question:

"Do you feel that a person's place of birth, their ethnic and cultural background, and their family customs are something that should be taken into account by doctors, psychologists, social workers, and counsellors?"

Those women who had either survived wife battering episodes or had worked with battered women were most emphatic:

"Definitely! They should understand our culture, yes. And accordingly they should do counselling, because when these people don't know our culture, so what they will talk? They will talk according to the point of their view, no? Their own culture.

O.K., you feel depressed? You go to beer parlour, and you enjoy your life. But,
for Indian woman it is not possible to go to beer parlour and enjoy her life."

Interviewer: "You are saying that is inappropriate?"

"Yes, inappropriate. So they have to know our culture first before they do get a job there to do counselling with an Indo-Canadian, or Indo-Pakistani, Indo-Bangladeshi woman, because our background is different. White people, they cannot understand those people. Or, they have to be educated about our culture. If they don't know our culture it is difficult for them to deal with our community. If they are educated they go to that education. They read our books in the library, and they know about our culture more. It will be easy for them to deal with patients."

This woman expressed the opinion that counsellors from all different ethnic groups should be hired,

"People from all the corners they should hire as counsellors, because this country is made of immigrants. There should be more visibility of all the cultures."

But, she said, she believed there were some requirements for applicants to be Canadian citizens.

A second South Asian woman responded in a similar vein:

"Yes, I do feel that a client's place of birth and their cultural background is something that should be taken into account because the majority of people are more conservative (than herself). And they are more limited to their own values. That's very important for professionals and counsellors to know about the cultural background. To understand about their feelings and their beliefs. Just for example: when the woman goes to a lawyer, a non Indo-Canadian lawyer, and if she says: "Oh, I have gone to transition house five times, and every time I go back to my husband." He'll say: "You know, there must be something wrong with this
woman. Why she keeps going back?" Because that's ignorance of the cultural background. If you know the values of the culture, if you know the traditions of the culture, then you would realize why she is going back. You think ten times before you make any judgement of the person, of the individual. And it's very, very important."

Obviously, an awareness of traditional cultural values are an important consideration for all of the helping professions. But, if the South Asian women who contributed to this exploratory study can be considered typical, most do not have the expectation of being understood if the health care professional is from the majority culture.

**Latin American Women and Prescription Drug Addiction**

The previous section of this chapter raised the issue of prescription drug addiction among both groups of participants, and when asked for suggestions for improving services one of the Latin American women voiced her concerns:

"It's not good to give a patient too many sleeping pills. I've taken pills ever since I arrived in Canada. Yes, pills. Pills for sleeping, and pills for depression. And so after I have another complication in my body because I have problem in my back, you know. And so has angina. And I has ulcera too. Take too many medications. Maybe I think is no better to giving the patient too many pills for the sleep. I think is no better. It is my opinion because for myself, you know. Because when take the sleeping pills in the next day the patient is staying dizzy and lazy. No power. Sometimes I thinking that when me is too bad depressed, you know. Especially when stay depressed. I like to go out to my
house, you know. I like run. I like run away. Maybe is better than take some pills."

It seemed she knew there had to be some alternative choices.

**Primary Prevention Measures**

The problems which result from social and cultural isolation, drop in socio-economic status, and limited options, are all included in the following statement of a Latin American woman's needs:

"The only thing there was this thing I was telling you about how was my feelings about being here not a landed immigrant, but a refugee. That is maybe one of the main concerns of people which is in my situation. It is one of the things sometimes when we have the opportunity, we like to talk about because we feel kind of a desire, everything. And the other thing I think is very important, that the government or the institutions which are dealing with the immigrants, they should have more health, not just health service, but more of this kind of family service. Or mental health service because immigrant people suffer a lot. A lot of stress. A lot of situations inside them. Inside the family. Their marriage which they really need a support. At least a support, an emotional support because there is a lot of things going on inside our language. Adaptation. Single mothers having to care the kids. Having to learn the new language. And so having to have also the studies because you have to study for having at least a decent job. Those kind of things. And so sometimes you feel completely ... you cannot be more. In these situations we need."

Language and job-training programmes, orientation programmes, and immigration policies which support family
reunification have long been cited as primary preventive measures for migrant populations (Allodi, 1984; Health & Welfare Canada, 1988; Plaut, 1985; Reubens, 1980; Strand and Jones, 1985). However, when these options are not available, where can immigrant and refugee women turn to? And, if they have the added burden of raising children alone, they obviously constitute a sub-population at risk for mental disorder.
CHAPTER V
DISCUSSION

The original research questions which formed the basis for this cross-sectional exploratory case study centred on three aspects: 1) social-environmental factors which might account for previously reported different use of mental health services by Latin American and South Asian women in Vancouver; 2) how cultural sensitivity of mental health personnel toward ethnicity and gender may affect utilization rates; and 3) how stereotyping and prejudices affect mental health.

The anecdotal data presented in Chapter IV describe the social context and parallel social-environmental problems for immigrant and refugee women living in a highly complex urban, industrial and culturally pluralistic environment. The data also illustrate social issues that are particularly relevant to women's mental health such as depression, sexual and physical abuse, and stress related to poverty (Canadian Mental Health Association, 1987). The stories and images which emerged from open-ended interviews clearly portray how pre- and post-migration variables discussed in the literature include both issues of cause, and issues of cure (Health &
Welfare Canada, 1988). The case study method, using the insights of Latin American and South Asian women, identified cultural conceptions of mental disorder, essential components of culturally sensitive services, social-environmental conditions which had an influence on their decision to use mental health services, as well as the adverse effects and consequences of systemic racism, discrimination and gender bias towards women.

**Summary of Key Research Findings**

**Barriers to Access**

As Doyle & Visano (1987), have pointed out, most studies in the past have emphasized a "needs analysis" or have focused alternatively on the "availability of services". However, those studies which address the issue of access to health and social services by members of ethnocultural groups (Bergin, 1988; Doyle & Visano, 1987), have identified factors which impede or prevent equality of access - these are: 1) cultural factors; 2) lack of information about available services; and 3) language problems. These factors also emerged as decisive variables in health-seeking behaviours for the Latin American and South Asian women participating in this exploratory study.
Cultural Conceptions of Mental Disorder

From the standpoint of cultural factors - both groups of women feared being labelled 'crazy'; they feared the shame, social stigma and ostracism which their ethnocultural group associated with mental illness; they feared losing their children; they feared the unknown; and initially they feared the stigma which they associated with attendance at a mental health clinic. Consequently, women in each group felt a great deal of reluctance, apprehension, suspicion and ambivalence when first advised to consult a mental health practitioner. This was especially true for South Asian women who violate social norms when they break a cultural taboo by discussing mental illness with someone who is outside the family circle. Nevertheless, motivation to act due to feelings of responsibility, love and concern for children or dependent others served to counteract all fears or cultural taboos, becoming a key variable in women's health-seeking behaviour.

Knowledge of Services

Concerning information about available services: length of residency in Canada did not appear to be a critical factor. Both groups of women - from relatively recent arrivals to those established in Canada for several years or more - lacked information about types of services available. This lack of information did nothing to dispel the belief that services are
Communicating with Health Care Providers

It is now a well established fact that more immigrant women than men arrive in Canada speaking neither English or French, and this in itself creates a number of situations which are known to put these women at risk (Health & Welfare Canada, 1988). First, the inability on the part of some to express their symptoms in cultural and linguistic terms presents major barriers to appropriate treatment. For instance, the inability to communicate fully poses major treatment dilemmas not only for the practitioner, but also for the patient/client. Second, the inability to express psychological concepts in an additional language creates additional stressors for an already anxious patient/client. In addition, pronunciation can act as a communication barrier. Finally, cross-cultural mis-communications occur because of discrepancies between systems of belief and cultural values. In this case, it was pointed out that women should have the process of care fully explained, thereby providing an opportunity to assess whether or not the method of treatment agreed with their own social value system.

Although previous studies have identified factors of culture, knowledge of services, and language problems as barriers to services, this analysis of case study data also
identified structural factors, namely poverty, and immigration status. Because socio-economic status and sociocultural support have been identified by Health & Welfare Canada (1988), as the two most effective measures for promoting mental health, it is important to note key findings in this regard.

Socio-economic Status

Some of the dilemmas faced by immigrant and refugee women after resettlement in Western countries include role changes, culture shock, health, education, housing and economic problems. As an illustration, economically disadvantaged women are over-represented in this study, as are a disproportionate number of single mothers. As mentioned earlier, single mothers and poor women as sub-populations are known to be at greatest risk for mental illness (Conway, 1990).

In the first place, depression related to lack of employment opportunities, thwarted expectations, downward mobility, financial difficulties, and the stress-related effects of unemployment were all identified as particular concerns of Latin American women. In addition, the damaging psychological effects of unemployment and under-employment were evident during disclosures of prescription drug addiction, suicidal thoughts and behaviours. Under-employment as a potent risk factor for emotional disorder has also been
identified for highly educated and highly trained immigrants and refugees who often find it impossible to work at the level for which their training has prepared them (Burke, 1984; Canadian Mental Health Association, 1989; Hyatt & Gottlieb, 1987). Latin American women associated depression with their inability to access language and employment training programmes. Gender bias is inherent in Employment & Immigration Canada policy regarding eligibility for full-time English-as-a-second language programmes with a training allowance (Malatest, 1991). Denied access, women in this situation have little comprehension of their new environment: as a result, they are unable to participate fully in Canadian society - socially, economically, or politically. Access or non-access to language training programmes structures women's lives by organizing patterns of employment, isolation from society, and dependency on family and others (Paredes, 1987). First victimized in their homelands, Latin American women become victims of government policies and programmes which control and restrict their ability to become fully participating responsible members of Canadian society.

On the other hand, South Asian women's mental health problems were more related to rigid, strongly patriarchal cultural beliefs and attitudes. South Asian women's problems were also related to gender-biased policies which perpetuate economic dependency and oppression as women make the transition from one culture to another (Milne, 1990). For
instance, early socialization patterns which encourage women to be dependent are upheld by policies which do not acknowledge that the vast majority of immigrant women are headed for the Canadian workforce, and which in effect, deny them basic living allowances for language/employment training programmes (Estable, 1986; Health & Welfare Canada, 1988; Seward & McDade, 1988). For instance, a battered immigrant woman often fears deportation if she decides to leave her home and the man who sponsored her (Health & Welfare Canada, 1988; MacLeod, 1987). But ability to speak English or French would decrease women's dependence on their husbands, employers and children (Health & Welfare Canada, 1988).

In general, class of immigration creates structural barriers which influence the way immigrant and refugee women are integrated into Canadian economic and social life. The data support the thesis that economic and social inequalities had stress-related consequences for the emotional well-being of the twenty women participating in this study.

The Health-Related Function of Social Support

Adaptation to a new life is easier if migrants are fortunate enough to have extended family with them. As an illustration, sisters and mothers are sources of support as confidants, while parents provide nurture, guidance, and reassurance of self-worth (Schaefer, Coyne & Lazarus, 1981; Weiss, 1974). In addition, the psychosocial support provided
by an ethnic community is particularly crucial during the early phases of resettlement (Canadian Mental Health Association, 1989; Health & Welfare Canada, 1988). Unfortunately, except for three married women, the Latin American participants had few, if any, family members living in Canada, and women with emotional problems and self-destructive thoughts said they were reluctant to confide in friends.

Social support was lacking for South Asian participants in this study; they reported that women will hide mental health problems from a spouse and in-laws because mental illness brings dishonour to women and their children, and leaves a blemish on the family name. In this case, in-laws are not considered a viable source of help. Likewise, participants at a Matsqui-Abbotsford Community Services workshop identified social pressure to maintain the honour of the family as an additional factor which aggravates the mental health of South Asian women (Johnston, 1991). Protecting the family from gossip, in fact, may be of greater concern than one's personal health needs (Phills, 1990). Already socially marginalized by the larger society because of skin colour and dress, South Asian women endure triple jeopardy when they face rejection and ostracism by their own ethnocultural community.
Culturally Sensitive Services

A significant number of participants seemed to have been touched by the quality of the relationship with the caregiver: for these women empathy was paramount. South Asian women identified the counsellor's role as a mediator and advocate; they wanted someone with qualities of kindness, patience, helpfulness, concern, consideration, sensitivity to feelings, and especially respect for their dignity and self-worth. Most especially, South Asian women needed a supportive confidant outside the family circle because, they said, they did not feel comfortable discussing their personal difficulties with family members. They did not refer to such counsellor attributes as understanding, warmth, friendliness, compassion, sincerity, or body language, as the Latin American women did. But they did share with the Latin American women the concern that a counsellor be respectful and considerate toward them, and take enough time to address the concerns and problems they were experiencing. Likewise, women identified the need for procedures which preserve the dignity and integrity of the client/patient. In conclusion, if the South Asian women who participated in this study can be considered typical, most do not have the expectation of being understood if the health care professional is from the majority caucasian culture.

The Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees emphasizes the need to sensitize Canadian-born mental health personnel, and advocates the
inclusion of cross-cultural education as a standard part of curricula for students in education, nursing, social work, psychology, psychiatry and family practice (Health & Welfare Canada, 1988). The case study method used in this exploratory study provides important insights into the manner in which mental health personnel can respond with sensitivity and understanding. Case study data also reinforces the existing knowledge that a biomedical approach with sexist, hierarchical relationships, which rely on prescription drugs to counter social problems, does not adequately assess social-environmental conditions which serve to maintain the link between women's mental health problems and women's social roles (Canadian Mental Health Association, 1988; Kleinman, 1981; Weick, 1986). In other words, the potential exists for Latin American and South Asian women to experience professional medical intervention as oppression more than assistance.

A synthesis of the twelve high-risk factors identified for women from traditional cultures by the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988), and analysis of the twenty one-on-one in-depth interviews with women participating in this study, uncovered six basic handicaps, because of which Latin American and South Asian women perceived themselves as carrying the following burdens: 1) poverty and shame; 2) social isolation; 3) loss of their traditional support networks; 4) fear and feelings of
dependency, powerlessness, and loss of control; 5) responsibility for caring for dependents; and 6) the burden of role reversal as she assumes the major role of providing for the family. The first three 'burden' categories have been merged into the section on barriers to access, and the last three categories will be presented under the headings of prescription drug addiction and violence against women in the next section of this chapter.

Risk Factors

Prescription Drug Addiction: A Metaphor of Failure

Since immigrant and refugee women are more likely to visit a doctor than access other more unfamiliar services, the potential for over-medication with psychotropic drugs becomes a distinct possibility. This situation comes about because of a number of failures in the social environment: failure by governmental institutions to eradicate sexist, gender-biased policies which prevent access to English language and employment training programmes; the failure of traditional networks such as the family, the temples, and the ethnocultural community, to recognize battered women as victims, and as such, worthy of social support; the failure of medical professionals to refer to more appropriate services; and finally, the perception of Latin American and South Asian women who internalize the failure label because no one has helped them to re-frame the problem in a larger societal
context. The consequences of prescription drug addiction include: increased social isolation, exacerbated family problems, and the potential for women to encounter professional medical intervention as oppression more than assistance.

Violence Against Women

Analysis of data revealed two groups of women who were assuredly at risk: first, because their first language was other than English; second, because they led isolated, socially and economically marginalized lives; and third, because of their shared experience of violence.

The pervasiveness of violence against women and the impact on women's mental health emerged as an issue of staggering proportions in this exploratory study. Sixty percent of the women in this study are survivors of violence and torture. For example, the principal features of the mental health needs of five of the ten Latin American women were: a) traumatic experiences, b) a process of grieving and c) depression - all characteristics of women who are survivors of pre-migration violence. It is not difficult to appreciate how this sub-group of women face triple jeopardy when they experience lower levels of social support together with a drop in socio-economic status.

On the other hand, seven of the ten South Asian women had been subjected to wife battering. Four of their spouses had
substance abuse problems. The mental health needs of these women were also triggered by traumatic experiences, grieving and depression - all characteristics of women who are survivors of post-migration domestic violence. As pointed out in the literature, elevated mental health risk several years after resettlement is associated with the emergence of family problems (Health & Welfare Canada, 1988). The essence of acute crisis for battered South Asian women who flee the family home is ostracism, social isolation and loss of social support systems.

**Implications for Social Work**

From the preceding discussion it is hopefully apparent that social workers in all health care related disciplines should be aware of how ethnicity and gender can impact upon utilization rates of mental health care services by Latin American and South Asian women. Social workers must know what the survival issues are for immigrant and refugee women in Canada, and act upon this knowledge by:

1) Advocating: a) for changes in social policies which have an impact on immigrant and refugee women's mental health; b) for social action by temples playing a larger role within the community by addressing the issue of wife battering; c) and lobbying Health and Welfare, Secretary of State, and Status of Women Canada for multilingual educational materials on women's rights and roles in Canada for discussion at immigrant service
agencies, general community service agencies and ethnocultural organizations; and d) for changes to what is currently considered legitimate medical practice concerning wife assault.

2) Educating - by promoting the need for cross-cultural training at the service delivery level. Social workers must become more understanding of the beliefs, customs and lifestyles of hitherto more or less alienated sub-populations. A major role for social workers and other mental health professionals is to raise awareness among women from the Latin American and South Asian communities about the options available to them.

3) Education for Accessing Services - Immigrant and refugee women need information available in their first language. Educational materials in Spanish, Punjabi, Hindi, etc. which aim to remove the stigma of treatment for mental health disorders, and to let women know that services are available for help with emotional problems. Ethnic media and immigrant serving agencies can be instrumental in getting the message to specific target groups.

3) Culturally Competent Service Delivery - social workers must be educated concerning Post Traumatic Stress Disorder, as well as the insidious side-effects of long-term use of tranquilizers and sleeping pills; and both they and other mental health professionals must be able to mobilize community resources and networks on behalf of these women. An
obligatory stage in the clinical intervention process is to explore the issue of violence.

4) Liaison Services - by assisting as resource persons for mutual-aid groups who can act as non-threatening points of entry to services. As stated by Gartner (1990), nearly six million women in North America will be abused by men in any one year. Further, a woman's chance of being raped at some point in her life is conservatively estimated as one in ten. Mutual-aid groups can provide crucial support for people who feel stigmatized, ignored, or isolated. Mutual-aid groups offer members an opportunity to rebuild personal identities and improve their self-esteem. Mutual-aid groups facilitate both personal and community development. The basic philosophy of mutual-aid groups conveys the message: "You are not alone."

Having 'no one to turn to' was a pervasive theme across both groups of women - women whose experiences of violence were characterised by loss. Analysis of data illustrates four stages in a process of recovery from experienced violence - stages which are discussed and displayed under Appendices G and H. As this theme emerged it became increasingly apparent that a basic social process was emerging - a process from which future research could attempt to construct theory, as well as hypotheses (Cummerton, 1986; Glazer, 1978; Glazer and Strauss, 1967; Pennington, 1989). The becoming-a-survivor findings (Appendix G) can be generalized to social work
practice in other contexts (e.g. psychotherapy groups and psychiatric wards) where their utility remains to be tested.

In addition, one woman in each group spoke of her teenaged daughter who had made suicide attempts. These findings have particular significance for those social workers counselling teenage girls from refugee families who have survived catastrophic stress, or teenage girls growing up in a family where their mother is battered. This could be an avenue for further research.

Furthermore, the data suggests that children of South Asian women also experience the stigma of separation and divorce. Are they shunned and ostracized by their peers in the ethnocultural community when there is the double stigma of mental illness and divorce? Social support from natural resources (e.g. family, friends) is particularly significant for adolescents as they struggle to form an identity for themselves, and doubly so for young people who live in a racially stratified society. This is an avenue of research which remains to be explored.

Moreover, the participants in this exploratory study spoke English, but many South Asian women who lack English language fluency work in the Fraser Valley area of the Lower Mainland area of British Columbia and belong to the Farm Workers Union. These women represent an important target group for future research.
Conclusions

The question: "What might account for differences in utilization rates of mental health services between South Asian and Latin American women in Vancouver?", has not been answered fully. The purpose of this cross-sectional exploratory research was to study access issues from the consumer's perspective, as well as to seek information concerning different use. The research questions were:

1. What are the social-environmental factors to account for previously reported different mental health services utilization by women in the Latin American and South Asian communities in Vancouver?

2. How do cultural sensitivity of mental health personnel toward ethnicity and gender impact upon the utilization rates of mental health care services?

3. How do stereotyping, prejudices, and social practices related to gender, race and/or ethnicity affect the mental health of Latin American and South Asian women?

Social-environmental problems identified by the Latin American women were the stress-related effects of unemployment, under-employment, gender bias and depression, plus their inability to access language and employment training programmes. Social-environmental problems identified by South Asian women related more to oppression and violence.
which they associated with rigid, strongly patriarchal cultural beliefs and attitudes. Lack of social and institutional support, which South Asian women experience if it is known in the ethnocultural community they are suffering from emotional problems, mental illness, or family violence, would appear to account for their reluctance to seek professional help. This knowledge, with the parallel belief that services are provided only for people who have mental problems, not emotional problems, together with the expectation that if the professional is from the majority caucasian culture their problems will not be understood, are several reasons why South Asian women use mental health care services differently to Latin American women.

Cultural conceptions of mental disorder; knowledge of services; communicating with health care providers; socio-economic status, and the health-related function of social support were all identified as decisive variables in health-seeking behaviours for the twenty women who participated in this study. On the other hand, because of feelings of responsibility, love and concern for children or dependent others, women in both ethnocultural groups were able to overcome their fears and all cultural taboos. However, South Asian women do face shame, rejection, lack of social support from traditional networks such as the family, and ostracism by the ethnocultural community when they experience mental illness, or the stigma of separation and divorce.
This research is especially susceptible to replication difficulties because it occurred in natural settings. The effects of bias between female researcher and female participants was another limitation, as was the naturalistic design of the study. Nevertheless, from the case study data which have been presented here it does become quite apparent that the present system of care does not accommodate cultural differences.

These research findings imply that social workers ought to function as advocates, educators, and clinicians who are fully aware of the staggering proportions of violence against women in Canadian society. Finally, social workers must familiarize themselves with the survival needs of immigrant and refugee women, and act upon this knowledge.
BIBLIOGRAPHY


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Khan, Verity Saifullah (Ed.). Minority Families in Britain: Support and Stress. Thetford, Norfolk: Brydone Printers Ltd.


Lindenberger, Alice (1989). "Racism in Our Community." Cultures West, 8(7), 4-5.


SOME ADDITIONAL SELECTED REFERENCES

An informative booklet, "Learning About the Law: British Columbia’s Legal System", has been published recently by the Law Courts Education Society of B.C. Free copies can be obtained by calling 660-2919 or 688-2565.


Women & Their Use of Mood-Altering Drugs: The Immigrant Experience (1984). 16 minute video. This tape presents some of the stresses that immigrants, particularly women, may have to face in adjusting to a new society. The program shows some of the short and long-term effects of using minor tranquilizers as a way of coping. A consumer’s approach to medical care is presented stressing the importance of informed consent. (416) 595-6059. Preview fee: $35 + 10% Handling.
APPENDIX A

LIST OF CULTURAL BROKERS AND PRELIMINARY KEY INFORMANTS

Jan. 17, 1989

Audrey Johnson,
#3-1909 Bayswater St.,
Vancouver, B.C.,
V6K 4A6

Dear Ms. Johnson:

I have received your proposal to interview a sample of women from ethnic minorities to obtain a consumer perspective on mental health services.

I am pleased to advise that we approve of your research proposal and will do everything possible to identify subjects for you. The only concern arising from your proposal is confidentiality, particularly with such a small sample of subjects. I am confident, however, that you will take precautions to protect confidentiality in both your data collection and in your report.

I think that your project is important and agree that we have little information on how our services are seen and experienced by people from ethnic minorities. I will be very interested in your findings and look forward to the completion of your research. If I can be of any assistance please let me know.

Your truly,

GREATER VANCOUVER MENTAL HEALTH SERVICE SOCIETY

John Russell
Executive Director

JR: sjg
BEHAVIOURAL SCIENCES SCREENING COMMITTEE FOR RESEARCH AND OTHER STUDIES INVOLVING HUMAN SUBJECTS

CERTIFICATE of APPROVAL

INVESTIGATOR: Willms, S.
UBC DEPT: Social Work
TITLE: Access to mental health services - The consumers perspective: Immigrant and refugee women in Vancouver, BC
NUMBER: B89-147
CO-INVEST: Johnson, M.A.
APPROVED: MAY 15 1989

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Dr. R.G.C. Johnston, Chairman
Behavioural Sciences Screening Committee

Dr. R.D. Spratley
Director, Research Services

THIS CERTIFICATE OF APPROVAL IS VALID FOR THREE YEARS FROM THE ABOVE APPROVAL DATE PROVIDED THERE IS NO CHANGE IN THE EXPERIMENTAL PROCEDURES
APPENDIX C
Interview number___________________ Date/time of interview___________________

Ethnic/cultural group___________________________ New:____ Established:____

Interviewee's first name ____________________________________________

Location of interview ____________________________________________

SECTION A - Client Characteristics

1. Sex:  a) Male ______  b) Female ______

2. Age: ______________________

3. Marital status:
   a) Single ______  c) Widowed ______
   b) Married ______  d) Separated ______

4.1 Number of dependent children: ______

4.2 Other dependents (exclude spouse): ______

5.1 Profession/Occupation: __________________________

5.2 Years of formal education: ______________________

6.1 a) Employed full time in the home ______
    b) Employed outside the home ______
    c) Unemployed ______
7. Citizenship status:

7.1 a) Refugee
   b) Landed immigrant
   c) Work permit
   d) Citizen
   e) Other

7.2 Length of time in Canada: _____ year(s) and _____ month(s).

8. Length of time in Ottawa: _____ year(s) and _____ month(s).

9. Language(s) spoken:
   a) Mother tongue ________________________________
   b) In home ________________________________
   c) Preferred ________________________________
   d) Other ________________________________

10. Language(s) read: ________________________________

11. Country of birth: ________________________________

SECTION B – Decision to Use Services

Please tell me about the contact(s) you have had recently, as a user, with health care organizations (or social service agencies).

12. What led you to seek services from this organization/agency?

13. Did you discuss these reasons with anyone before you went? Who?

14. What advice did they give you?
SECTION C — Reception Services

Please think back to your (first) visit to ___________________________.

15. Did someone go with you? For company, or for some other reason?

16. Do you recall how you felt when you first arrived at ________?

17. What kind of reception did you get?

18. Do you recall what happened at the reception desk?

19.1 In what language did the receptionist speak to you?

19.2 How well did you understand the receptionist?

20.1 Did the receptionist ask you to complete any forms? How many?

20.2 How well did you understand what the form(s) said?

If forms not completely understood

21.1 Did anyone ask you if you understood what the forms said?

21.2 Did anyone offer to explain them?

22. Did you ask anyone to explain them to you? Why/why not?

If interpreter used

23. Who interpreted for you?
24. How did you feel about having him/her interpret for you?

25. Do you have any other comments about the reception services you received?

SECTION D — Professional Services

26. Please tell me what happened when:

- the PHN/social worker came to visit you?
- you finally got to see the nurse/doctor?
- you went into the hospital to have your baby?
- you went to see the social worker?
- you went to talk to the daycare worker about .......?
- you went to ________ to ask for information?

27. Who was with you?/still with you?

28. Who actually took care of you?

If necessary ask/repeat

29.1 In what language(s) did he/she/they speak to you?

29.2 How well did you understand?

30.1 Were you asked to complete any forms?
30.2 How well did you understand what the form(s) said?

**If form(s) not completely understood ask/repeat**

31.1 Did anyone ask you if you understood what the form(s) said?

31.2 Did anyone offer to explain them?

32. Did you ask anyone to explain them to you? Why/why not?

**If interpreter used**

33. Who interpreted for you?

34. How did you feel about having this person interpret for you?

35. Do you have any other comment about the care (service) you received?

**SECTION E - Cultural Sensitivity**

36. Can you recall if anyone asked you where you were born? What your ethnic/cultural background is?

37. Were you asked to explain your situation/symptoms/problems in detail?

38.1 Were you allowed to? Did you attempt to?

38.2 If NO, why not?
39.1 Did anyone ask you how situations/problems like yours are customarily handled in your country? In your culture?

39.2 Were you allowed to explain? Did you attempt to?

39.3 If NO, why not?

40.1 Did anyone ask you how situations like yours are customarily handled in your family?

40.2 Were you allowed to explain? Did you attempt to?

40.3 If NO, why not?

41. Were you asked if you had consulted anyone else about your symptoms/situation/problems? If you had, what their prescription/advice was? And if you followed it?

42.1 Was it your impression that __________________ understood how people in your community do things? What your problems really are/were?

42.2 Why did you get this impression?

43.1 Did you feel you had told the service provider(s) everything you wanted to?

43.2 Can you explain how/why not?

44.1 Is a person's place of birth, ethnic/cultural background, family customs, etc. something that should be taken into account by health/social service workers?

44.2 Why do you say that?

45. Do you have any other comments to make about cultural sensitivity?
SECTION F - Consent Forms

46. Were you asked to sign any "consent forms", forms by which you agreed to release information, to authorize treatment or an operation?

If YES

47. Did you sign them?
Or did someone else sign them?

48. Can you recall if someone explained them before they were signed?

If YES

49. What language was the explanation in?

50.1 Were you satisfied with the explanation?

50.2 Please tell me why.

51. Do you have any other comments about consent forms?

SECTION G - General Satisfaction

52.1 Generally speaking, how satisfied were you with the service you received?

52.2 Can you elaborate?

53.1 Would you say that the services you received were "appropriate" (suitable) for someone with your background, with your symptoms/with your problems/in your situation?
53.2 If NO, what would you consider as an "appropriate" service?

54.1 What expectations did you have about the health care/social services you were going to get?

54.2 How did the services you received compare with those expectations?

54.3 Looking back, would you say your expectations were realistic?

54.4 Why do you say that?

55.1 What did you like about the services you received?

55.2 Please explain.

56. What did you not like about the services you received?

If DISLIKES, tell me more about that.

57. If you had to obtain the same services again, how would you like to see things changed to accommodate your needs?

58. If you had to do the same thing again, what would you do differently?

59. Is there anything else you would like to say?

SECTION H - Knowledge of Health and Social Services

60. Which of these health organizations and social service agencies are you familiar with? (Know by name?)
61.1 Which ones have you had contact with?

61.2 How did you find out about it/them?

SECTION I - What—Would—You—Do Scenarios

1. Your five—year—old child has a fever when he goes to bed. In the middle of the night, when you hear him tossing and go to investigate you find him trembling all over. His fever is now very high. What do you do? Whom do you call?

2. You answer your doorbell one morning and find a friend, an old coat wrapped around her, her hair tossed, bruises on her face and evidence of a nosebleed.

She tells you that her husband, whom you know well, has been an alcoholic for many years. She says he has been beating her for several months. She declares she is never going back to their matrimonial home.

What do you do? What do you tell her to do?

3. A friend's fifteen—year—old daughter, until recently very obedient, has begun to stay out very late. When she comes home, her eyes are often bloodshot, her speech slurred. Sometimes she smells of alcohol. Her parents also suspect she is using street drugs. They ask for your advice.

What do you tell them?

4. Your neighbour's first child is now six months old. She wants to go back to work as a waitress. She asks you to look after her baby but you can't.

What alternatives do you suggest to her?

She also says that, since the baby's birth, she and her husband have been quarrelling almost every day.

What do you tell her to do?
5. Your aging mother lives with you. Once happy and helpful about your home, she is now critical of everything everyone does and scolds constantly. Lately she has been wandering about the neighbourhood saying your husband abuses her. That isn't true. Your husband says you have to do something. What are you going to do?
<table>
<thead>
<tr>
<th>Local Health Organizations and Social Service Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Arthritis Society</td>
</tr>
<tr>
<td>2. Boys and Girls Club</td>
</tr>
<tr>
<td>3. Canadian Mental Health Association</td>
</tr>
<tr>
<td>4. Child Care Information Centre</td>
</tr>
<tr>
<td>5. Children's Aid Society</td>
</tr>
<tr>
<td>6. Community Information Centre</td>
</tr>
<tr>
<td>7. Council on Aging</td>
</tr>
<tr>
<td>8. Distress Centre</td>
</tr>
<tr>
<td>9. Family Service Centre</td>
</tr>
<tr>
<td>10. Health Unit/Public Health Nurses</td>
</tr>
<tr>
<td>11. Home Care Program</td>
</tr>
<tr>
<td>12. Interval House</td>
</tr>
<tr>
<td>13. Island Lodge</td>
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<tr>
<td>14. Kidney Foundation</td>
</tr>
<tr>
<td>15. Neighbourhood Services</td>
</tr>
<tr>
<td>16. Perley Hospital</td>
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<tr>
<td>17. Rape Crisis Centre</td>
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<tr>
<td>18. Rehabilitation Institute of Canada</td>
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<tr>
<td>19. Rideauwood Institute</td>
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<tr>
<td>20. Ronald McDonald House</td>
</tr>
<tr>
<td>21. Royal Ottawa Hospital</td>
</tr>
<tr>
<td>22. Social Planning Council</td>
</tr>
<tr>
<td>23. Visiting Homemakers</td>
</tr>
<tr>
<td>24. Welfare Department</td>
</tr>
<tr>
<td>25. YM-YWCA</td>
</tr>
</tbody>
</table>
APPENDIX D

STANDARDIZED OPEN-ENDED INTERVIEW SCHEDULE

A. Decision to use Services  Page 2
B. Reception Services  3
C. Professional Services  4
D. Cultural Sensitivity  5
E. General Satisfaction  7
F. Family Attitudes  8
G. Client Characteristics  9
H. Knowledge of Health and Social Services  11
   Local Health Organizations and Social Services  11
   Instructions for Interviewers  13
   Interviewer's Summary and Comments  14
STANDARDIZED OPEN-ENDED INTERVIEW SCHEDULE

Interview number_______ Date/time of interview___________

Ethnic/cultural group_________________________

Interviewer's Name_________________________

Location of interview________________________

SECTION A - Decision to Use Services

Please tell me about the events which led to your decision to use the services of ...?

1.1 What led you to seek services from this agency?

1.2 When did you first use the services (what year)?

2. Did you discuss these reasons with anyone before you went? Who? (Identify sex of person)

3. What advice did they give you?

4. How did you feel about being advised to go to a mental health agency?

SECTION B - Reception Services

Please think back to your (first) visit to...

5. Did someone go with you?
   For company, or for some other reason?
6. Do you recall how you felt when you first arrived at...

7. What kind of reception did you get?

8. Do you recall what happened at the reception desk?

9.1 In what language did the receptionist speak to you?

9.2 How well did you understand the receptionist?

9.3 Did the receptionist ask you if you'd like the services of an interpreter?

10.1 Did the receptionist ask you to complete any forms? How many? If NO, continue with question 13

10.2 How well did you understand what the form(s) said?

If forms not completely understood

11.1 Did anyone ask you if you understood what the forms said?

11.2 Did anyone offer to explain them?

12. Did you ask anyone to explain them to you? Why/why not?

(If interpreter used)

13. Who interpreted for you?
14. How did you feel about having him/her interpret for you?

15. Do you have any other comments about the reception services you received?

SECTION C - Professional Services

A primary therapist simply means the first counsellor who talks to you with the doctor when you come for an appointment at...

First Time Visit (Assessment) Subsequent Visits

16. Please tell me what happened when:

you had your first visit you had your next visit:
with the primary therapist was it the same person?
at... If NO, then complete
If NO, then complete question 26 through 35 for second/ primary therapist

16.1 Was the primary therapist a man or a woman?

16.2 Did anyone ask you if you would prefer to see a primary therapist who was a man? Or a woman?

16.3 Do you have a preference?

17. Were you given an injection at the Community Care Team or medication to take home with you? (If YES) did someone explain to you what effect(s) the injection/medication might have?

18.1 (If YES) who explained? In what language(s) did he/she speak to you?

18.2 How well did you understand?
18.3 Did anyone ask you if you wanted the services of an interpreter?

(If interpreter used)

19. Who interpreted for you?

20. How did you feel about having this person interpret for you?

21. Do you have any other comment about the care (service) you received?

SECTION D - Cultural Sensitivity

22. Can you recall if anyone asked you where you were born? What your ethnic/cultural background is?

23. Were you asked to explain your situation/symptoms/problems in detail?

24.1 Were you allowed to? Did you attempt to?

24.2 (If NO) why not?

25.1 Did anyone ask you how situations/problems like yours are customarily handled in your country? In your culture?

25.2 Were you allowed to explain? Did you attempt to?

25.3 (If NO) why not?

26.1 Did anyone ask you how situations like yours are customarily handled in your family?

26.2 Were you allowed to explain? Did you attempt to?
26.3 (If NO) why not?

27.1 Were you asked if you had consulted anyone else about your symptoms/situation/problems? If you had, what their prescription/advice was? And if you followed it?

28.1 What might be some other ways to solve this type of problem in your community?

29.1 Was it your impression that the counsellor and/or the doctor understood how people in your community do things? What your problems really are/were?

29.2 Why did you get this impression?

30.1 Did you feel you had told the primary therapist everything you wanted to?

30.2 Can you explain how/why not?

31.1 Is a person's place of birth, ethnic/cultural background, family customs, etc. something that should be taken into account by counsellors and doctors?

31.2 Why do you say that?

32.1 (If applicable) ask: Would you have preferred to have a counsellor and/or doctor who could speak your own language?

32.2 (If NO) why not?

33. Do you have any other comments to make about sensitivity to other ethnic groups?

34. Do you have any other comment about the care (service) you received?
SECTION E - General Satisfaction

35.1 Generally speaking, how satisfied were you with the services you received?

35.2 Can you elaborate?

36.1 Would you say that the services you received were a) helpful or b) not helpful for someone with your background, with your symptoms/with your problems/in your situation?

36.2 If NO, what would you consider a helpful service?

37.1 What expectations did you have about the health care services you were going to get?

37.2 How did the services you received compare with those expectations?

37.3 Looking back, would you say your expectations were realistic?

37.4 Why do you say that?

38.1 What did you like most about the services you received?

38.2 Please explain

39. What did you like least about the services you received?

If DISLIKES, tell me more about that

40. If you had to obtain the same services again, how would you like to see things changed to accommodate your needs? What improvements can you suggest? Can anything be improved?

41. If you had to do the same thing again, what would you do differently?
SECTION F - Family Attitudes

If applicable, ask:

42.1 Did you talk to your husband about your visit to...
42.2 Why/why not?

42.3 Did you talk to:
    - your children about your visit to...

42.4 Why/why not?

42.5 Did you talk to your mother about your visit to...
42.6 Why/why not?

42.7 Did you talk to your father about your visit to...
42.8 Why/why not?

42.9 Did you talk to your sister...

43.1 Why/why not?

43.2 Did you talk to your mother-in-law about your visit to...
43.3 Why/why not?

43.4 Did you talk to your father-in-law about your visit to...
43.5 Why/why not?

43.6 Did you talk to your sister-in-law about your visit to...

43.7 Did you talk to a friend (Male/female or any other...
relative) about your visit to...

43.8 Why/why not?

SECTION G - Client Characteristics

44. Age

45. Marital Status:
   a) Single  d) Separated
   b) Married  e) Divorced
   c) Widowed  f) Common-law

46.1 Number of children:

46.2 Ages of children:

47. Other dependents (exclude spouse):

48. Tell me about this household:
   - Do you own/rent the apartment/suite/house?
   - How many people live in the home?
   - Are they all related to each other? Please explain.
   - How many children, and how many adults in the home?
   - How many living in the home are employed?

49.1 Profession/Occupation:

49.2 Years of formal education:

50. a) Do you work at home
    b) Work outside the home
    c) Are you looking for work outside the home\ (unemployed)
51. Citizenship status:
   a) Refugee
   b) Landed immigrant
   c) Work permit
   d) Citizen
   e) Other

52. Length of time in Canada: year(s) month(s)
53. Length of time in Vancouver: year(s) month(s)

54. Language(s) spoken:
   a) Mother tongue
   b) In home
   c) Preferred
   d) Other

56. Language(s) read:

57. Country of Birth:

<table>
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<tr>
<th>Individual Incomes</th>
<th>Total Household Income</th>
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<tr>
<td>60,000 and over</td>
<td>60,000 and over</td>
</tr>
</tbody>
</table>
SECTION H - Knowledge of Health and Social Services

58. Which of these health organizations and social service agencies are you familiar with? (Know by name?)

59.1 Which ones have you had contact with?

59.2 How did you find out about it/them?
<table>
<thead>
<tr>
<th></th>
<th>LOCAL HEALTH ORGANIZATIONS AND SOCIAL SERVICE AGENCIES</th>
<th>Knows by Name</th>
<th>Has Had Contact</th>
<th>Found out from</th>
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<tr>
<td>1.</td>
<td>South Vancouver Neighbourhood House</td>
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<td>2.</td>
<td>Britannia Community Services Centre</td>
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<tr>
<td>3.</td>
<td>M.O.S.A.I.C.</td>
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<tr>
<td>4.</td>
<td>O.A.S.I.S. (Immigrant Services Centre at Main and S.E. Marine)</td>
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<tr>
<td>5.</td>
<td>Inland Refugee Services</td>
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<tr>
<td>6.</td>
<td>REACH Medical Clinic</td>
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<tr>
<td>7.</td>
<td>India Mahila Association</td>
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<td>8.</td>
<td>Pacific Immigrant Resources Society</td>
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<tr>
<td>9.</td>
<td>Canadian Mental Health Association</td>
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<tr>
<td>10.</td>
<td>Planned Parenthood Association of B.C.</td>
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<td>11.</td>
<td>Vancouver &amp; District Public Housing Tenants' Association</td>
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<tr>
<td>12.</td>
<td>Vancouver General Hospital Emergency Department</td>
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<tr>
<td>13.</td>
<td>East Vancouver Public Health Unit</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>14.</td>
<td>South Vancouver Public Health Unit</td>
<td></td>
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<td>15.</td>
<td>Family Services of Greater Vancouver</td>
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<tr>
<td>16.</td>
<td>Ministry of Social Services and Housing: Fraser Street/ Victoria Dr./East Broadway</td>
<td></td>
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</tbody>
</table>
17. 911 Fire Dept. and Rescue Emergency Calls

18. 911 Police Dept. - Emergency Calls

(Would you like a copy of this list with telephone numbers and addresses to take home with you?)

CONCLUDING REMARKS: After this long discussion is there maybe something else that you'd like to add? Or maybe to ask? Or to clarify?
INSTRUCTIONS FOR INTERVIEWERS

At the end of each interview, each respondent is to receive:

a copy of the following publications:-

- 1988 United Way Directory of Services: Guide to Social and Health Services in our Community. (available in English only)

- Surviving in Vancouver: Canadian Mental Health Association brochure (available in Chinese, Punjabi, Spanish and English)

- Bicultural Communication for Teenagers and Parents: Canadian Mental Health Association brochure (available in Punjabi, Spanish, English)

In addition, information will be given concerning any currently available programmes for Punjabi speaking and Spanish speaking women, e.g. the peer support group at Broadway Community Care Team, and the programme for Spanish speaking women and their pre-schoolers sponsored jointly by MOSAIC and Britannia Community Services Centre.
Dear Friend:

I am writing this letter to introduce myself to you, and also to give you information about a project I hope to begin during February.

I am a student at the University of British Columbia currently meeting the Requirements for the Degree of Master of Social Work in the Faculty of Graduate Studies, School of Social Work. Previously, I have worked as a social worker with refugees as well as with immigrant women and their preschool children.

The Indo-Canadian and Latin American communities in Vancouver have grown considerably larger during the past few years; health care providers and other professionals in the social services have begun to realize this, and want to talk to women about their experience as users of health care services. The purpose of this project is to talk with women who use the services of Greater Vancouver Mental Health Services.

If you agree to participate in this study please read and sign the attached consent form. Should you consent, please be aware that everything spoken about during the interview will be confidential. Your name will not be revealed or given to anyone, nor used in any write-up of the study. The information will only be discussed with an interpreter/translator should you require one, but not with any of the other women in the study, or anyone in your ethnic community. You have the right to refuse to participate or withdraw from the study at any time. If you do decline, or you do withdraw, your health care will not be affected in any way whatsoever.
Thank you for reading about my proposed study. Even if you decide not to participate, please know I appreciate the time you have already taken. If you require any further information please contact me at the School of Social Work, or contact my Thesis Supervisor, Dr. Sharon Willms (telephone: 228-3251).

Sincerely,

M. Audrey Johnson
ਸਭੀ ਸੀ।

ਜਦੋਂ ਭਾਰਤ ਦੇ ਸ਼ਹਿਰ ਸਾਰੀ ਬਜਾਲੀ ਅਚਲ ਹੋਣ ਲਈ ਦੂੰਗਾ ਦੀ ਹੋਣ ਤੇ ਸ਼ਹਿਰ 1980 ਲੇ ਵਾਰਡਕ ਹੋਣ ਦੇ ਹੁਣ ਸਿੱਖਾ ਕਰ ਲਾਗਣ ਵਾਲੀ ਸ਼ਹਿਰੀ ਹੋ ਗਈ ਸੀ।

ਨਾਖੁਸ਼ੀ ਫੈਸਲਾ ਸੀ ਕਿ ਵੀ ਦੀ ਪ੍ਰਿਨਸਪੀ ਅਲੇਖ ਤੋਂ ਕਰ ਚੁੱਕੀ ਸਾਰਾ ਦੀ ਹੋਣ ਦੇ ਮੌਕਿਆਂ ਵਿੱਚ ਕੁਦਰਤੀ ਦਾ ਸਤਾਨੀ ਦੇ ਜਮੀਨ ਦੇ ਕਲਕਟਾ ਦੇ ਦੀਪਾਂਕਰ, ਹਿੰਦੀ, ਪੁਰਾਤਨ ਵਾਲੀ ਸਾਰਾ ਬਣਾਏ ਬਣਾਏ ਹੋਏ।

ਮੁਹਾਨਾ ਨੂੰ ਲੋਕ ਨੇ ਦੋਵੇਂ ਹੋਏ ਗਣਤੀ ਦੀਆਂ ਕੱਵਿਤਾਆਂ ਵਿੱਚ ਪ੍ਰਥਮ ਮੁਹਾਨਾ ਦੀਆਂ ਨਹਿਤਾ ਦੀਆਂ ਸ਼ਹਿਰੀ ਹੋ ਗਈ ਸੀ।

ਅਚਲਤੀ ਹੋਣ ਦੇ ਖਣਾਂ ਵਿੱਚ ਕਿਸੇ ਦੋਗਾ ਮੋਹਨੀਂ ਦੀਆਂ ਹੋਣ ਦੀਆਂ ਸਾਰਣਾਂ ਦੀਆਂ ਕੁਦਰਤੀ ਨਹਿਤਾ ਦੀਆਂ ਸ਼ਹਿਰੀ ਹੋ ਗਈ ਸੀ।

ਇਥੇ ਸਾਰੀ ਪ੍ਰਥਮਨਾਂ ਹੋਣ ਦੇ ਖਣਾਂ ਵਿੱਚ ਕਿਸੇ ਦੋਗਾ ਮੋਹਨੀਂ ਦੀਆਂ ਹੋਣ ਦੀਆਂ ਸਾਰਣਾਂ ਦੀਆਂ ਕੁਦਰਤੀ ਨਹਿਤਾ ਦੀਆਂ ਸ਼ਹਿਰੀ ਹੋ ਗਈ ਸੀ।

ਜਦੋਂ ਸਾਰੀ ਕੰਮ ਕਰਵਾਣ ਦੇ ਸਮੇਤ ਕਾਰੀਗਰ ਦੁਆਰਾ ਮੋਹਨੀਂ ਦੀਆਂ ਹੋਣ ਦੀਆਂ ਸਾਰਣਾਂ ਨੇ ਦੋਵੇਂ ਸਾਰਣਾਂ ਨੂੰ ਸਰਵਾਂਵਾਂ ਦੀਆਂ ਕੁਦਰਤੀ ਨਹਿਤਾ ਦੀਆਂ ਸ਼ਹਿਰੀ ਹੋ ਗਈ ਸੀ।

ਅਚਲਤੀ ਹੋਣ ਦੇ ਖਣਾਂ ਵਿੱਚ ਕਿਸੇ ਦੋਗਾ ਮੋਹਨੀਂ ਦੀਆਂ ਹੋਣ ਦੀਆਂ ਸਾਰਣਾਂ ਦੀਆਂ ਕੁਦਰਤੀ ਨਹਿਤਾ ਦੀਆਂ ਸ਼ਹਿਰੀ ਹੋ ਗਈ ਸੀ।

ਜਦੋਂ ਸਾਰੀ ਕੰਮ ਕਰਵਾਣ ਦੇ ਸਮੇਤ ਕਾਰੀਗਰ ਦੁਆਰਾ ਮੋਹਨੀਂ ਦੀਆਂ ਹੋਣ ਦੀਆਂ ਸਾਰਣਾਂ ਨੇ ਦੋਵੇਂ ਸਾਰਣਾਂ ਨੂੰ ਸਰਵਾਂਵਾਂ ਦੀਆਂ ਕੁਦਰਤੀ ਨਹਿਤਾ ਦੀਆਂ ਸ਼ਹਿਰੀ ਹੋ ਗਈ ਸੀ।
ਸੰਦੇਸ਼ 

ਸੰਦੇਸ਼ 

ਅਸੀਂ ਅਸੀਂ ਸੰਦੇਸ਼ ਦਿੱਤਾ ਹੋਇਆ ਹੈ। ਅਸੀਂ ਅਸੀਂ ਸੰਦੇਸ਼ ਦਿੱਤਾ ਹੋਇਆ ਹੈ। 

ਪ੍ਰਵਾਸੀ ਸੰਦੇਸ਼ਾਂ ਵਿੱਚ ਸੰਦੇਸ਼ਾਂ ਵਿੱਚ ਸੰਦੇਸ਼ਾਂ ਵਿੱਚ ਸੰਦੇਸ਼ਾਂ ਵਿੱਚ ਸੰਦੇਸ਼ਾਂ ਵਿੱਚ ਸੰਦੇਸ਼ਾਂ ਵਿੱਚ ਸੰਦੇਸ਼ਾਂ ਵਿੱਚ ਸੰਦੇਸ਼ਾਂ ਵਿੱਚ 


distinctive word or phrase not visible in the image.
Estimada amiga,

Les escribo esta carta para presentarme y para ofrecerles información sobre un proyecto que espero comenzar en el mes de febrero, 1989.

Yo soy estudiante de Servicio Social en la Universidad de British Columbia, finalizando ya mis estudios para el grado de Master en la facultad de Estudios Graduados, en la Escuela de Servicio Social. Anteriormente, trabajé varios años como trabajadora social con refugiados, como también con mujeres inmigrantes y sus hijos en edad pre-escolar.

Las comunidades Indo Canadiense y Latinoamericana han crecido considerablemente durante estos últimos años. Trabajadores de la salud y otros profesionales de servicios sociales han comenzado a darse cuenta de este factor y desean conversar con mujeres que hayan usado los servicios de salud. El propósito de este proyecto es conversar con mujeres que estén usando los Servicios de Salud Mental del Gran Vancouver, sug. (con el objeto de analizar el valor de estos servicios y el conocimiento que la mujer inmigrante tiene de ellos.)

Si usted decide participar en este estudio, por favor lea y firme el formulario de consentimiento adjunto. En caso de participar, puede usted estar segura que todo lo hablado durante la entrevista será confidencial. Su nombre no será revelado o dado a nadie ni tampoco usado en ningún pasaje escrito de este estudio. Sus opiniones serán dadas solamente al intérprete, si usted lo solicita, pero no a otras mujeres participando en este estudio ni a nadie de su comunidad etnica. Usted tiene derecho a rehusar a participar o a retirarse de este estudio en cualquier momento. Si usted se niega a participar o se retira de este estudio, el cuidado de su salud no se vera afectado de ningún modo.
Gracias por leer a cerca de mi estudio. Aun cuando usted decida no participar, yo aprecio el tiempo que se tomo en leer mi carta. Si usted necesita mas informacion, por favor pongase en contacto conmigo llamando a la Escuela de Servicio Social, o llame a mi Supervisora de Tesis, Dra. Sharon Willms (al telefono: 228-3251).

Sinceramente,

Audrey Johnson.
APPENDIX F
Thank you for deciding to participate in this research project. The study is meant to find out what Latin American and Indo-Canadian women's concerns and beliefs are about health care services in the City of Vancouver, and what is happening in immigrant women's lives which could have harmful effects on their health. The expected average length of time for any one interview will be one hour and twenty minutes.

As explained in the preceding letter, your name will not be revealed; all information will be numerically coded, and kept strictly confidential. If there is anything about the letter you have just read which is not clear to you, I will gladly explain. If you have any further questions after the interview has been completed please do not hesitate, and ask the researcher.

You have the right to refuse to participate or withdraw from the study at any time. If you do decline, or you do withdraw, your health care will not be affected in any way whatsoever.

Your signature below on this page, and on the duplicate copy which is provided for your own records, indicates your voluntary agreement to participate in this research. If you would like to have a copy of the findings when they are completed, please print your mailing address in the space provided.
Signature__________________________________Name (please print)

________________________________________Address________________________________________

________________________________________Postal Code_________________________________

Date____________________________________
Formulario de Consentimiento del Participante

Proyecto de Investigación: Opiniones del público sobre los Servicios de Salud; específicamente de mujeres inmigrantes de Vancouver, Columbia Británica.

Gracias por haber decidido participar en este proyecto de investigación. Este estudio tiene como propósito identificar cuáles son las preocupaciones y conocimientos de mujeres Latinoamericanas e Indo Canadienses sobre los Servicios de Salud en la ciudad de Vancouver; como también identificar lo que en las vías de las mujeres inmigrantes, pueda tener consecuencias negativas para su salud. El tiempo promedio de cada entrevista será una hora y veinte minutos.

Como quedó explicado en la carta anterior, su nombre no será revelado; todo tipo de información será numericamente identificado, asegurando así su confidencialidad. En caso hubiese puntos en esta carta que no sean claros para usted, será un placer explicarselos. Si usted tiene más preguntas después que la entrevista haya finalizado, por favor no vacile en preguntarme.

Usted tiene el derecho de negarse a participar o de abandonar esta investigación en cualquier momento. Si usted decide no participar o abandonar este estudio, su servicio de salud no será afectado de ninguna manera.

Su firma en la parte inferior de esta página y en el duplicado, que es proporcionado para sus propios record, indica su voluntario acuerdo a participar en este estudio. Si usted desea tener una copia de los resultados, cuando esta investigación sea completa, tenga la gentileza de dejar a quién su dirección postal.
APPENDIX G

BECOMING A SURVIVOR: FOUR STAGES
IN A PROCESS OF RECOVERY FROM EXPERIENCED VIOLENCE

The ten Latin American and ten South Asian women who participated in this study spoke frankly about the events which preceded their decision to seek help from a mental health counsellor, therapist, or mutual-help group. Twelve of the twenty participants were survivors of violence and torture. Seven of the ten South Asian women were subjected to wife battering: four of the seven spouses had a problem with alcohol and/or drugs. Five of the ten Latin American women experienced assaults such as harassment, threats, warfare, rape or torture - all of which have been defined as catastrophic stress in the Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988). It is suggested here that wife battering is also a form of warfare because it also includes threats, harassment, rape, as well as physical, psychological, and emotional torture. Given this interpretation, both groups of women shared a common fear of patriarchal violence. For five of the Latin American women participating in the study their fear of violence was such that they had chosen to flee their homelands. For seven of the South Asian women fear of
violence lay at the root of their decision to flee the family home. Having 'no one to turn to' was a pervasive theme across both groups of women, and feelings of isolation and vulnerability were critical factors which triggered help-seeking behaviours.

Anecdotes from tape-recorded intensive in-depth interviews with twenty women who were using or had used mental health services during the past five years provide the framework for the four identified stages of the survivor process. These findings will not be generalizable to other groups because of the small sample size, but in this study the stages in the process of becoming a survivor are: (I) Despair and Depression; (II) Resistance and Awareness; (III) Acceptance and Receptivity, and (IV) Changing: Breaking the Silence - from Patriarchy to Empowerment (see Appendix H for Data Display). The stages which emerged in the data were first identified by the words of the participants themselves (first order codes), then named by the researcher for constructs developed from related literature (second order codes).

In the majority of cases receptivity and healing did occur although there may have been initial resistance to using mental health services, Contact with compassionate, culturally sensitive counsellors eased burdens, and also raised self-esteem.
Stage I

Despair and Depression

The first stage described by survivors was that time when first they realized how great was their despair. These feelings of despair were shared by Latin American and South Asian women alike. This was a time when they felt completely alone, isolated, had little hope for the future, and saw few options available to them. During this stage their self-esteem was at a very low ebb. Social isolation typified both groups of women: many were without close friends or relatives to whom they could turn for help. Almost one third felt suicidal: at least three women in each group spoke about suicidal thoughts and self-destructive behaviours during this first stage of the survivor process. One woman in each group had a teenage daughter who made a serious suicide attempt.

Experiences common to both groups of women were threats, physical violence, harassment, intimidation, rape and brutality. One South Asian woman described in great detail an act of sexual violence: she was raped in her own home. A Latin American woman alluded to rape, but did not disclose the details. Other Latin American women recounted the special circumstances of being both a woman and a refugee.
Stage II

Resistance and Awareness

During the second stage of the recovery process, Latin American and South Asian women became aware there were mental health services available should they choose to use them. This awareness usually came about because of an intervention initiated by a professional, or through word of mouth from a peer. But, there were women in each group who felt confused, anxious, or reluctant to act upon the suggestion that they consult a mental health professional. At this point, it became clear that negative stereotypes of mental illness had previously been incorporated into their thinking. One Latin American and three South Asian women expressed their initial unwillingness to seek help from psychiatrists. However, other women recognized their need for professional expertise and initiated contact themselves. Women from both groups were glad to accept help from outside the family, especially when they began to realize that perceptive, culturally sensitive counsellors were able to listen, understand, accept, reassure, support, respect, and validate them during difficult transitions. In effect, outside interventions by trained counsellors eased burdens, and raised self-esteem.
Stage III

Openness and Receptivity

Suffering from the effects of depression associated with violence, five Latin American and five South Asian women were drawn towards, or were guided by others, to become involved in volunteer work. At least two of the Latin American women worked as volunteers with the poor and disadvantaged in their country of origin before resettling in Canada. Involvement with volunteer work appears to have represented a turning point for the Latin American and South Asian women alike. During this stage of the survivor process, the woman felt she was capable, and that she could make a difference. This major turning point came with recognition of her own self-worth, and that she (the survivor of violence), was valued as an individual member of the larger society. As well as the recognition that she had skills and experience which others would like to share with her. This growing self-awareness, and the ensuing volunteer activities seemed to have healing powers, and represent a crucial phase in the recovery process. Social networks outside of family and home grew larger; in the process of encouraging and supporting others self-esteem appears to have been raised to a higher level for those women who volunteered their time and talents.

However, it appears that volunteer work for the Latin American women, without opportunities for job re-entry or
training programmes, was insufficient to carry the momentum toward recovery forward. Of the five Latin American women engaged in volunteer work, only one was registered in a job training programme when the interviews took place. A Latin American woman discussed her volunteer work with seniors at a community centre, and expressed the conviction she was needed there, but also stressed her need for paid employment. Those Latin American women who were denied access to English language and/or employment training programmes because of federal and provincial policies which discriminate against them, encountered serious barriers to recovery which threatened their self-esteem, creating stress and anxiety. Restricted and/or insufficient access to English-as-a-second language training, or delayed access to services because of prolonged refugee claimant procedures providing for permanent settlement, place Latin American women in double jeopardy. They will remain at risk, and vulnerable to symptoms of depression. On the other hand, the five South Asian women who were involved in volunteer work when they participated in this study, were all employed.

Volunteer work for the participants in this study seems to have functioned as an antidote to perceived failure. Failure, for the Latin American women, was their own perception that they were failures because they had failed to become as fluent in English as they would have
wished for, or that they had failed to obtain employment for which they had training and qualifications in their country of origin. This can be interpreted as a failure to integrate politically, socially, and economically into the larger society. Failure for the South Asian women, on the other hand, was the perception of others that they had failed to be good women: either they had not complied with community norms and followed a culturally imposed sex-role; or they had not concealed a 'house secret', and stayed in an abusive relationship. Those women who left abusive relationships were seen to have transgressed the social mores of their community, and they had broken cultural taboos. The price which they had paid for this perceived failure, was separation, rejection, and alienation, as well as ostracism and social isolation. They essentially had no one in their community to turn to for social support. This can be interpreted as a failure of the larger ethnic community. The functioning of both groups of women was impaired at the broader community level because gender-role socialization inhibited their full participation.

For those Latin American and South Asian women who were counselled and admitted to employment training and re-entry programmes, a sense of self-worth and self-confidence developed. Self-esteem raised through volunteer experience continued to climb. Admission to employment training programmes seemed to be a mobilizing factor focusing
awareness on the fact that previous roles no longer applied, and the opportunity to begin a new way of life. In other words, to take on a new identity. Trainees and new members to the workforce grew stronger emotionally and psychologically as they became self-sufficient, self-reliant, and more accepting of their self-worth. As a woman said: "At A.W.A.R.E. I started my life."

Stage IV

Breaking the Silence: from Patriarchy to Empowerment

The task of the fourth stage involved the creation of a new role, a new identity. Three of ten South Asian women had reached Stage IV of the survivor process. It appeared these women had learned to integrate new experiences and behaviours into their lives. These women appeared to have accepted that if change was to occur not only in their life, but in the lives of other battered women in their ethnocultural community, then each would take an individual responsibility for supporting and encouraging women who were battered through difficult transitions. Using their strengths and capacities for nurturing, caring, and sharing, as well as a strengthened belief in themselves, they became a resource for other battered women: two were leaders for self-help groups, and a third spoke on a regular basis to Kate Booth House newcomers, a first stage transition house
run by the Salvation Army. They acquired knowledge of services available for women in distress. Treated with dignity and respect, they were empowered, regained their 'voice', and became willing to speak out about their degrading experiences. They appeared able to speak with sensitivity, empathy and warmth to women still struggling to cope with the reality of living with an abusive partner, in a strongly patriarchal community. Previously reluctant to speak out about the circumstances which had caused them to flee the family home, they now talk openly about their ordeal, and break the silence which had been an expected and accepted part of their life experience.

These four identified stages should be read with the caution: like other identifiable stages such as those delineated by Elizabeth Kubler-Ross (1969) in the grieving process associated with death and dying, the process does not necessarily proceed in a neat and orderly chronological fashion. There can be overlap or skipping back and forth at any stage, and there is no clear time frame within which the process can be predicted to either begin or end. Two of three women functioning at Stage IV of recovering described a period of eleven years. The third woman appeared to have taken less time.

The Survivor Process presents original research toward an understanding of the stages which the Latin American and South Asian women participants in this exploratory study
faced as they moved from being victims of violence and catastrophic stress to becoming survivors. Becoming a survivor means becoming fully participating, self-sufficient, contributing member of Canadian society, and the model is not proposed as the final word on recovery from experienced violence, but is based on the experiences, courage, and determination of all twenty participants. As a beginning, it presents the framework as a tool for those who work with battered women, and to offer hope and encouragement for women going through the process. If further research is carried out in the future with a larger sample, and the Survivor Process is found not to be empirically supported, several underlying concepts remain important for shaping generic interventions and policy development.

First, there is the recognition that there are four stages of being which women who have experienced violence pass through before they accept that if change is to occur for themselves and for other battered women in the larger community, they have a role to play and an individual responsibility for initiating it. Second, volunteer work is an important tool for beginning to raise self-esteem. Third, volunteer work alone is insufficient to maintain the forward momentum toward recovery. Feelings of self-worth and self-sufficiency can be enhanced through placement in job re-entry, employment training programmes, and English
language training courses. The long term goal being full participation in the paid workforce. Finally, the model recognizes that because some South Asian women have a strong traditional ideology (Klimack, 1988; Pagelow, 1981), have strong religious beliefs (Klimack, 1988; Stacey and Shupe, 1983), are from a patriarchal culture and were socialized as young girls with an emphasis on traditional values of keeping the family together (Struser, 1985), they are often resigned to staying in abusive relationships. Fear of ostracism and social isolation, as well as the possibility of losing their children are sufficient reasons for them to return again and again to the family home.

In this context, becoming a survivor means becoming a fully participating, self-sufficient, contributing member of Canadian society. The model is based on the experience, courage, and determination of all twenty participants.
APPENDIX H

DATA DISPLAY

STAGE I: Despair and Depression - Second Order Code
A. "I went through so much all alone"
    - First Order Code

* When you don't have family in Canada you have to rely on your friends. I don't want my kids to go to a Receiving Home, and they wouldn't like it either. I held myself together on a previous occasion because they wanted to put my kids in care.

* When I'm alone at night I can't sleep for worrying about what would happen to my mother if anything should happen to me. Who would take care of her? And I have no family here in Vancouver, just myself here. Sometimes you need a family, and nobody is there for you, and it's difficult. I don't even know my neighbours. No one talks.

* In that moment I was thinking a lot that I don't want to live any more because my life here. I was feeling very depressed. I didn't discuss it with anyone before I went to S.A.F.E.R. (Suicide Attempt, Education and Research) because most people here are thinking that you are crazy people if you are thinking about suicide. Besides, I don't really have friends who are Spanish speaking people here. I don't have relatives here; nobody to talk to. I think I felt that I needed somebody to talk to. That was my main feeling, and I am still feeling that sometimes because I am isolated here.

* Yes, it's about the family problems you know, because all the time stay together only family because it's impossible take communication with the Chilean people, you know. I explain to you about the political problem. And so for a Canadian friend for me, I can't because my English is not very well, you know.
My parents didn't know what's wrong with me, what's going on. And my father he was thinking I am very well off. Even until today, they do not know I am divorced lady. They are thinking I am very happily married woman, and living in a palace. They don't know what difficulties I am facing here. They are living 30,000 miles away. And I know if I will tell them somebody will come here, and kill me. Nobody knows in my family. I went through so much all alone. I did not know anybody.

What happened at first I went to see the counsellor there because of my abusive relationship with this guy. And then my child started going there because of sexual abuse by the same guy. I got so much depressed.

B. "And when I get depressed I never tell anyone"

- First Order Code

When they said: Talk. About what? That I'm screaming inside!

Yes, I start sick because I can't working, because I working as a janitor, and housekeeping in a hotel (she was a teacher prior to fleeing her homeland). And so is too hard for me. I stay in bed for a couple of weeks, and that time I come depressed.

There are lots of things, no? Depression, and then you are taking so many pills like that. Something is going to happen definitely! And you don't eat proper food when you are worried. No food. Depression. And pills!

And when I get depressed I never tell anyone. I just stay in the house, and keep the depression inside me, so I never went to the doctor. So when I got pregnant then I went to see this doctor. I was very depressed, and throwing up lots. So when you get depressed you do throw up. Because why I got depressed? Why I was throwing up? Because every time whenever I was pregnant I never had any support from the father, or from the family. And that made me more and more sick, you know.
C: "And the circumstances of refugee people is so special" - First Order Code

* And I bring my application form to the doctor that evening, and I explain him: Doctor, what do I do? What can I do? I can't get job. I try. I try many times. Nobody give me job because when people see my cane, or maybe they want people healthy, because the important thing is production. But, and then I can't get the job. I can't go to college. What happen to me?

* In my country I was working with defendants - you know, political defendants. So they start. And people know you, its a very small country. And even if it's crowded, and big population, but they know you. Especially in San Salvador capital. So I started having calls. Telephone calls. And one of the women was also working with defendants, she was a professional like me. And when she was leaving the jail, some people grabbed her; some men who were waiting for her, grabbed her to an empty lot, and they throw acid in her face. And this poor woman was agonizing about two weeks. After that, she died. With all her face burned with the acid you know. I remember that thing. So that was when I decided to leave. To leave my country.

* And the circumstances of refugee people is so special because they are refugee people. There are terrible kind of stresses before they have left their country. They are sometimes very, very frightened. Or what can I tell. Most of them don't speak English, so how can they express themselves in a hearing to convince these people they are genuine refugees. How can they expect to have proof? It's very difficult to have proof of your being a refugee. It's very difficult showing proof that you were persecuted there. That some people were threatening you by 'phone, or some people went to look for you at your home. Not all the people have been tortured. But just being tortured does not say that other people is not a refugee, just because he or she wasn't tortured.

* The police, the soldiers, they thinking my husband working for the guerillas. After somebody talk to my brother. After my brother come back. After somebody call. Please, you tell your sister and her husband to go out. Because this night somebody kill them. After, we go out. Yes, leave El Salvador for Nicaragua, but after I talk to him we coming to Costa Rica. My husband stay in Nicaragua.
Yes, all the children; me and my husband; everybody is
staying in therapy. All the family going when arrived
here. Yes, because my family stay in my country for 52
days is stay in arrest at home (house arrest). Yes,
everybody. Children stay out the school, and everybody
stay inside. I can't go alone out because the military
put two men for stay with my family. Live in my house.
Change every 24 hours, and use to guns. But the people
say for...how do I say? The people explain that we ask
for help. But my husband and me, because he told me:
Understand, it's not true. It's an arrest in our home, no?

At that time I lost everything: self esteem, morale,
and confidence. It's like I don't know if I don't want
to be concentrated at anything. Or, (hesitates); You
know, I feel lazy, powerless, hopeless, every word
ending in 'less'. But I just keep trying. I just keep
trying.

It is entirely different talking in Spanish. You know
my English for talking deep feelings is very difficult.
I could read a lot of that, but it is different
expressing it, and the poor doctor was trying with all
his will to understand me, but it's not the same.

D. "I think all the time is more better for me dead" -
First Order Code

I wouldn't be here today if I hadn't gone for help. I
was suicidal for years without even knowing about it.
I could have gone for help sooner if I had known the
services were there to use.

If I get sick again, I don't want to live. Because if
I get sick, no good memories for family and friends.

Yes, in that time me is too bad. Very bad! I no
thinking nothing, you know. No have interest in
nothing too, you know. I think all the time is more
better for me dead.

It was when my husband, he put me through so much I
really decided to commit suicide, and I took my child
towards the waterfront, and I just wanted to end up our
lives. I tried to drown my child in the Burrard Inlet.
But another person followed me, and he save me. He
brought me back. He say: "Now what are you going to
"What did you said? You're not going to see me any more? You want to break off? You can't do that!" And he got the booze in his hand too. He was drinking too. And he hit me, and I tried to grab the phone to call the social worker, or the police, you know. And he broke the 'phone. It was around six in the evening. He broke the phone, and he locked the door. And he pulled all the curtains, and he started hitting me. And he dragged me to the bedroom, and he started hitting me. And he dragged me to the bedroom, and he started hitting me. I can't say it was sex. It was a rape.

Then you try to tell them. Supposing they ask you: how do you feel? How are you? And you say: "Well, I'm not feeling so great because I'm having all these problems. My back is hurting me, and I've got nobody to sort of really take care of me. And these employers are constantly bothering me. And they are harassing me." And then you tell them the harassment. And there were all kinds of harassment at my work place, including sexual harassment. You tell them what the harassment is, and lo and behold what the doctor says is: "Right, this client is depressed. This client is suicidal."

STAGE II: Resistance and Awareness: - Second Order Code

A. "I was not willing to go even" - First Order Code

I didn't feel very good about the advice I was given.

I felt confused because the doctor's opinion here was different to that of my brother who is a doctor in El Salvador.

I feel o.k. The doctors and teachers said I had to go for counselling.

I told the counsellor through an interpreter that I wasn't crazy, because it is my belief that I am not crazy. How come I have to see the psychiatrist? I didn't want to go. I didn't even want to believe that I had to see a psychiatrist, you know.

I didn't like! I told the doctor: "I am not crazy." I was not willing to go even. Who wants to go there, because in India we hate mental hospitals. Who wants to go? Only crazy people go there. Then I said: What
the hell, I should go. I said: O.K. Doctor's forcing me, let me go and see. Anyway, she's not going to eat me!

* My family doctor and my social worker was referring me long time, but I never went. And finally, I did went.

* I was referred (amongst other referrals) for some psychological testing at Shaughnessy Hospital Pain Clinic. I was never told why I was being referred. I was just told to do it. I simply had to obey orders.

B. "I know I needed the help" - First Order Code

* I took the advice because I was crumbling. I was able to go to the hospital because my friend was there to take care of my kids, and I could take care of myself.

* I didn't feel badly because I thought I would get some help for her (her mother). I didn't feel bad about it because if I didn't speak I wouldn't have had help.

* I don't feel some special bad or good thing about going to this kind of place (S.A.F.E.R.), because I need it. I need to talk to somebody.

* I decided myself to go to a psychiatrist. I told him (general practitioner) I need a psychiatrist.

* I always come and follow the advice.

* It's o.k. because I know I needed the help.

* I think it's good advice. The Healthiest Babies Possible counsellor will come once a week/month before the baby is born. And once after.

* I felt good. I really felt helpless that time because we needed the outside help; we could not handle the situation ourself. At the same time, I could not just go to any Indo-Canadian friend to talk because they would not understand my feelings, because they are more conservative.

C. "Just to lessen my burden" - First Order Code

* Sometimes I talk with the social worker on the 'phone. I open up my heart to her; she is such a nice lady.
* I remember particularly, that she was so warm with me. I especially remember that the three times I was there. She hugged me when I was coming, and when I was leaving she hugged me. And I really felt something reassuring; something really warm.

* From this woman I liked her understanding and her warmth. In that moment, that was really, really important.

* I like this clinic. I talk to M. She understands me.

* I felt good because M. speaks Spanish.
* My social worker, she can understand me very well, and she's very helpful. Whenever I in need of anything I go to her, and I tell her: Now I have this problem, or I need this kind of papers, and she always do that at the same time.

* M. is my interpreter for the psychiatrist. M. is from my country too.

* This counsellor was really good. Supportive. Even she will help me if I have a welfare problem, she will deal with that problem. She will 'phone them. She will talk to them. Just to lessen my burden. Just to give me relief. And like I didn't have money to buy vitamins, and she will give me vitamins from there free. She used to give me free passes for my child's swim, and then she used to give free passes for P.N.E., for Playland. So little, little things matters. Everything matters in our lives, no?

* Then the Healthiest Possible Babies counsellor came, thank God. She was like a mother to me, and like a God to me. She came to me; she talked to me; she helped me so much.

* There was something bothering me, and I was confused about it. I needed very strong assurance from somebody that it's nothing in my mind. I am not a crazy person. And that what my feelings are, they are very genuine feelings.

* I welcomed the idea. I was reassured that: "You don't have a problem."
STAGE III: Acceptance and Receptivity: Interventions for Change - Second Order Code

A. "I stayed involved into a volunteer job because the people tell me is good for me to stay involved out to the house because is help to me." - First Order Code

* At Burnaby General Hospital I was doing a volunteer job. Working with long term care, working with old people. I like working with old people.

* I know some nurse when I working as volunteer in unit health, the health unit in Commercial Street. Yes, they made for my depression, for exercise, for something I like. I have very nice time. I know because when I talk to them about the people - about immigrants and refugee - they are compassionate, you know. They share with you.

* In 1985 I started to that Canadian community for senior people. All the time I volunteer job for senior people. I'm happy in that time because I working too many things. I making the apron, tablecloths, knitting, and teaching to the senior people there. In that time I am making a tablecloth, and painting twelve napkins, and one cover bed, and put that in exhibition at P.N.E. Sometimes I'm tired, I have headache, but I'm thinking: No, that's people need me. And me is extra force, power, and go! But it's not complete for me because I need another - not the voluntary. I need my job, my work, you know. And so I think maybe me is transplant here. I no me complete. You understand me?

* I had the opportunity to help families, you know, Spanish speakers. To be as a translator in the welfare office. Refugee people, immigrant people need to be supported. Be more supported. In a moral way. In an economic way. Well, in any way. I have this feeling, you know. I wanted to have more English to help people, but I think that you can help people even though you don't have more English. It's just your feeling.

* Yes, I used to do lots of work, and somehow they found out I am very active in the community, so she 'phoned me and asked if I am interested to do group because I used to do group for YWCA. Yes, I did for one year. It was sponsored by YWCA, and I used to take group in Little Mountain Neighbourhood House for Indo-Canadian women.
Because I worked with the Battered Women's Support Services group. That was 4/5 years back. I still work with India Mahila. And Battered Women's Support Services, the larger community organization who have the workshops, and who train people to do group works. I used to work with Little Mountain Neighbourhood House, and help Indo-Canadian women, and have a support group.

B. "At A.W.A.R.E. I started my life"—First Order Code

And in 1986, all the time I take different course here too. Yes, and here I have too many certificates, and afterwards I show you. And take the course, all the time I am thinking it is doing something for me going up, you know. Because I take that course, and I am thinking for me is better. And I take the janitor industrial housekeeping. I take that course for three months for my help to me up. For my morale.

I went to university for six years, and I have my degree in economics, and now I am doing a training course. It's a kind of re-entry programme. I am doing my training placement to get Canadian experience. I am doing many things, and general office work.

Yes, she's the one. She took me to A.W.A.R.E. (Assisting Women's Awareness Regarding Employment) and introduced me. At A.W.A.R.E. I started my life. I did not know what is A.W.A.R.E. She took me and said: "Maybe once you start working you will be o.k." So it was her enthusiasm. She took me there, and she introduced me to the staff. And today I am working.

And in my personal experience, I have seen women who are working with good income, they would become more strong than the woman who would depend on her husband's income. That makes a big difference. Emotionally, psychologically, you become more stronger.
STAGE IV: Changing: Breaking the Silence - from Patriarchy to Empowerment - Second Order Code

A. "I have to give them encouragement by giving them my example" - First Order Code

* Even though in the beginning I didn't want to go, now I feel glad that I was told to go there. I feel so glad to have met these people, to have knowledge of that clinic. I have three or four friends, and I have told them: "If you are having the same problem, go there and just talk to them. They will help you." So I have been recommending this.

* I did not tell any of the women in my community that I am going to a mental health clinic, because I knew if I will tell them, nobody will talk to me. They will say I am a crazy woman. I tell them now. There I talk because that is an educational programme (the Self-Help Group where she is a leader). I talk about. I always give them my example. I have to give them encouragement by giving my example.

* I always tell them: Beating is not the answer. I always tell them: They (Ministry of Social Services and Housing) will take away your kid. Yes, because my husband made me so much mad, I used to hit my child on the bums. A lot! And I confessed with the counsellor, and she said: "No, this is not right. You are telling me, and if you will tell welfare people, they will take away your child." So she did lots of counselling with me. I tell them now.

B. "They respect me a lot" - First Order Code

* Office like OASIS (Orientation Adjustment Services for Immigrants Society) - that Society is made of Indo-Canadian women. They have accepted me, and of course we are running groups. And there are some ladies who are in trouble, they come there. They have accepted me. They respect me a lot.

* And then suddenly, it was a good thing because I did not abuse my freedom, and I did not neglect my kids, because we were just like a unit. Once we established that, then everyone started coming back. Then suddenly they start giving example. If you talk to any other woman who is deciding to leave her husband, or having a marital problem, they'll say: "If you are deciding, have a strength like her."
* They have a weekly group at Kate Booth House (first stage transition house run by Salvation Army). They ask me to come and talk to the newcomers.

These women's lives have not worked out as either they or society had expected. Nonetheless, Latin American and South Asian women alike, with remarkable courage and determination, defied the odds in order to go about finding a better way of life for themselves and their children.