WORKING WITH IMMIGRANT WOMEN: GUIDELINES FOR MENTAL HEALTH PROFESSIONALS

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Women may choose to migrate for a variety of reasons including economic incentives, family reunification, and educational opportunities, as well as to escape from gender-based and/or political violence and to gain more social independence (DeLaet1999). The numbers of women immigrants and refugees to Canada have increased over the years and the percentage of women settling in as immigrants (and refugees whose claims have been approved to become permanent residents) is usually 2 to 7% higher than that for men (Citizenship and Immigration Canada [CIC] 2006). In addition, the number of women entering Canada as economic immigrants, in comparison to those entering as family class immigrants, is slowly increasing. This is partly due to the increase in the number of women arriving as skilled or professional workers. Approximately half of refugees are women, and women also comprise a significant proportion of illegal immigrants. These statistics call attention to the need for health sciences research specifically on the health of women immigrants.

Upon arrival in Canada, immigrants[1] are generally in better health than those born in Canada (Chen, Ng & Wilkins 1996a, 1996b; Parakulum, Krishnan & Odynak 1992). Factors related to immigration selection criteria (e.g., rigorous health screening) and the immigration process itself (e.g., healthier people tend to move more than those with a poor health status) have been associated with this *healthy-immigrant effect*. However, after 10 years in Canada, immigrants are more likely to be in poorer health than their Canadian-born counterparts (Chen et al. 1996a, 1996b; Hyman 2001; Vissandjee et al. 2003). The research is less clear about the healthy immigrant effect in relation to mental health (Canadian Task Force on Mental Health Affecting Immigrants and Refugees 1986; Hyman 2004; Mental Health Commission of Canada, 2009). One of the reasons for this lack of clarity is the limited health sciences research on mental health and illnesses of immigrants.

Home-country circumstances notwithstanding, there are common factors that immigrants face following migration that are associated with health status. Most of these have been recognized as social determinants of health, and include income and social status, employment and working conditions, physical and social environments, social networks, gender, culture, and access to health services (Health Canada, 2002). Additional determinants of mental health for immigrants include social isolation, language barriers, financial and employment constraints, role reversal, new intergenerational struggles, racism, and discrimination (Hyman & Guruge, 2006). Some of these aspects of the settlement process may be dehumanizing and particularly stressful (Sandys, 1996). For example, having to respond to repetitive questions regarding experiences of violence and abuse in the context of immigration procedures, can have profound implications for mental health. Mental disorders such as depression, anxiety disorders, and post-traumatic stress disorder may be precipitated in part by repeated re-traumatizing experiences.

Access to services is one determinant of health that can be overlooked for its effects on mental health. While there are many services that are intended to assist newcomers during the post-migration period, the actual experiences of accessing such services can be difficult. Practically navigating bureaucratic hurdles, completing many application forms, or physically getting to various agencies that may not be in close geographical proximity are some examples of this (Collins, Shakya, Guruge & Santos, 2008; Guruge & Humphreys, 2009). Additionally, language barriers insidiously contribute to these difficulties. Sometimes volunteer or un-trained interpreters may not translate/interpret accurately (Abraham & Rahman, 2008), which may compromise situations involving government authorities such as immigration, child welfare, and/or legal aid (Guruge, 2007). By extension,

the stress of such circumstances may affect psychological and emotional wellbeing, and exacerbate existing mental illnesses.

Challenges of the post-migration context in Canada persist for women specifically, even after the initial resettlement period. Material, social, and systemic challenges might include downward career mobility, immigration requirements that restrict women's choices (e.g., when dealing with abusive employers or abusive husbands), unsafe work conditions, and lack of social support for raising children or caring for elderly family members. While some of these concerns can be experienced by Canadian-born women and/or immigrant men, immigrant women consistently experience most of these challenges, and/or to a greater degree. For example, immigrant women are disproportionately poorer than Canadian-born women and men, as well as immigrant men (CIC 2006). Furthermore, immigrant women have to cope with these realities of daily life while navigating social systems, government bureaucracy, and new cultures in an unfamiliar setting and, perhaps, in an unfamiliar language. In the post-migration context women often experience changes in gender roles, are forced into low paying jobs, and may have to work at home and in paid jobs without the support of extended family and/or community (Baya, Simich & Bukhari, 2008). Also, violence may be precipitated by social conditions such as isolation, changed gender roles, and possibly a clash of cultural norms and intergenerational expectations regarding women's rights and responsibilities (Guruge, Khanlou & Gastaldo, 2010).

Such post-migration contextual factors are indications of the troubling influence of the social determinants of immigrant women's health, which are reflected in the growing body of literature addressing the topic (e.g., Oxman-Martinez, Abdool & Loiselle-Leonard, 2000; Vissandjee et al., 2001; Hyman 2002; Hyman & Guruge, 2006). In addition, some women who migrate may have lived through war, slavery, political violence (Tsang & George, 1998) and violence at home (Guruge, Khanlou & Gastaldo, 2010) in the pre-migration context. Such experiences, whether as isolated encounters or long-standing relational situations, can intersect with the post-migration social determinants to affect women's mental health and exacerbate existing mental illnesses (Mawani, 2008).

How immigrant women respond to and deal with these issues is unique to each woman's situation and position in society based on the intersections of such aspects of identity as age, race, class, ethnicity, language, education, and sexual orientation, along with the economic, cultural, socio-political, historical, and geographical contexts of their daily lives (Guruge & Khanlou, 2004). Yet the majority of immigrant women actively participate in shaping their health and that of their families, despite the post-migration challenges and barriers they face in Canada. Women are also engaged participants in various community activities and in organizations including schools, places of worship, and volunteer sectors to improve the health and wellbeing of their communities. This is a testament to their strengths and resilience.

IMPLICATIONS FOR RESEARCH, EDUCATION, PRACTICE, AND POLICY IN MENTAL HEALTH

Migration experiences can have a negative impact on mental health for both women and men; however, research on immigrant women has limited representation in health sciences literature. In order to address changes in mental health practice, there is a need to examine macro, meso and micro systems, to determine how knowledge is generated, how practitioners are educated, and how preventive and curative aspects of care happen at both the face-to-face relational level and within communities. In this final section, we present some recommendations, based on several chapters in our book, *Working with Immigrant Women: Issues and Strategies for Mental Health Professionals*, categorized according to future directions for research, education, practice, and policy in mental health.

RESEARCH

While there have been considerable collaborative efforts in expanding mental health research on immigrant women, certain research questions still require answers. Broadly, how is women's mental health defined and understood? How do the social determinants of mental health manifest in women's lives? How do perceptions of one's mental health differ for young girls, adolescent girls, adult women, and older women? Specifically, how do immigrant women's mental health statuses change over time, and across countries? Are there current holistic interventions for addressing women's mental health issues? What are some innovative strategies for addressing challenging aspects of the immigration experience that impact on mental health? How do health care professionals engage in diminishing the negative effects of post-migration determinants of women's mental health? Finally, within the area of mental disorders, what are the direct links between a particular social condition and the symptomatology of specific disorders, and how does migration itself confound these?

Limited empirical research exists on the mental health concerns of newcomer girls and female youth (Berman & Jiwani, 2008), those who have been trafficked, who are homeless/street-involved (Collins & Guruge, 2008) , or lesbian, bi-sexual, or trans-gendered immigrant

women (Doctor & Bazet, 2008). Little attention has been focused on older women's health, both physical and mental health, in the post-migration context (Guruge, Kanthasamy, & Santos, 2008; Guruge & Kanthasamy, 2010). Research gaps also remain in such areas as the intersections of immigrant experiences and homelessness, addictions, and violence and trauma. The need for further work in the area of intimate partner violence in the post-migration context is particularly highlighted by the limited number of health research publications on the subject (Fong, 2010; Guruge, 2007; Hyman, Guruge, & Mason, 2008). Furthermore, we know little about the growing number of immigrants who are under-housed or live on the street, and how experiences of violence in these situations either contribute to or exacerbate mental illnesses. Finally, research approaches to understanding violence must widen to address the broader social conditions such as patriarchy, racism, and poverty.

Researchers must pay close attention to the theories and conceptual frameworks, and the methodologies that they employ in their research to ensure that the work that is done is collaborative, inclusive, and based on social justice and equity. Developing and testing culturally appropriate multidimensional instruments to assess stress, conflict, violence, and mental illness is critical (Guruge et al., 2007; Sidani, Guruge, Miranda, Ford-Gilboe, & Varcoe, in press). In terms of research team composition, immigrant women themselves ought to be included in the research process to strengthen their awareness of their abilities and resources, strengthen the quality of the final product, and support women's efforts to mobilize for change and facilitate their input into policy and decision-making.

EDUCATION

Mental health professionals in Canada are educated in a wide range of disciplines with each possessing its own professional culture and emphasizing specific areas of knowledge and skills. In all of the health disciplines, education has developed primarily from the Western medical model and reflects Canadian socio-political and cultural perspectives. This preparation does not reflect Canada's changing demographics, the significant presence of immigrant groups, and the increasing numbers of women from diverse ethno-cultural groups who are consumers of mental health services. There is a pressing need for education that accounts for and responds to these shifts to better prepare mental health professionals to respond appropriately to the needs of diverse groups. Such initiatives are possible only when administrators of educational institutions commit resources to organizational changes in faculty staffing and curricula that reflect diversity, inclusiveness, and capacity-building. As Sleeter (1993) pointed out, educators who represent minority groups are likely to bring experience that facilitates a critique of the dominant standpoint. Collaboration with community agencies that reflect the changing needs of ethno-cultural and racialized groups ought to be a priority for clinical practicum experiences, where students may have opportunities to learn from and work with immigrant women who may staff and/or draw from these services. Additionally, all faculty members (from senior tenured professors to contract teaching staff) ought to become familiar with and utilize the growing body of research on mental health and illnesses of immigrant women.

PRACTICE

Mental health professionals in various practice settings are in key positions to recognize the often negative experiences of immigration and settlement on mental health and illness. In particular, they must pay attention to the following questions: What forms of trauma and violence have clients/patients encountered in the pre-migration contexts? How do these experiences influence women's ability to cope in their new environment? What are their border-crossing experiences? What are their post-migration experiences? How are these affecting their mental health? And what can be done to intervene? What are the ways in which they cope with mental illnesses? What are the ways in which their access to care for mental illnesses can be improved?

Service agencies that espouse a vision of mental health promotion must implement programs and strategies that practically reflect a supportive environment for cultivating women's strengths and resilience. For example, programs could be organized to bring together women and young children to share resources and experiences, and build supports within their own communities. Mental health practitioners must also examine their own values, beliefs, powers, and privileges in order to identify how actions in their practice support immigrant women and facilitate their resilience, or how the practitioners themselves and/or organizational structures create barriers and disadvantage for these clients/patients (Gustafson, 2008).

POLICY

It seems evident that governments at all levels must continue to provide appropriate funding support for new immigrants arriving in Canada. The Task Force on Mental Health Issues Affecting Immigrants and Refugees (1986) recommended that Health and Welfare Secretary of State and the Status of Women develop and provide multilingual educational materials on women's rights and roles in Canada for discussion within immigrant services, general community service agencies, and ethno-cultural agencies.

The changes that have taken place since, however, require further work. To this end, the Mental Health Commission (2009) has proposed a plan for a National Mental Health Strategy, with four pillars: co-ordination, information, community engagement, and more appropriate services. Each pillar implicates the need for specific attention to women. For instance, information brochures are available in some languages other than English and French, especially where there are large numbers of a population who speak a non-official language, however with the growing number of ethnic groups especially in urban centres, the language challenges in reaching all women are great, and require creative solutions. On another level, legislation governing immigration and refugee claims should be amended to reflect gender-specific issues that have an impact on women; for example, under current immigration laws, when families apply to immigrate, men tend to apply under the economic class, and the women then tend to be assigned dependent status (Vissandjee et al., 2003; 2007) even when both hold equal or comparable education and employment skills and experience. Changes to this legislation are critical because the current system fails to acknowledge women's potential for economic contribution (Guruge & Collins, 2008).

Finally, policy development should reflect the voices and aspirations of the women to whom policy is directed. Representatives from groups who have expertise in mental health issues affecting immigrant women should be consulted in the development of collaborative mental health promotion strategies for immigrant populations across various sectors including government agencies, educational services, and ethnocultural agencies.

CONCLUSION

While there are many benefits to immigrating to a country like Canada, immigrant women's mental health in the new context is also negatively influenced by post-migration social determinants such as to racism, sexism, social isolation, among others. For some individuals, stressors are resolved positively while others experience mental illnesses. Increasingly, newcomers are accessing mental health services but are also facing many barriers, related to unfamiliar culture, language, and limitations in the services themselves. We believe that significant changes need to be made in delivery of mental health services to include innovative holistic approaches that address the needs of immigrant women in Canada.

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