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Perceived Issues of Mental Health and Well-Being of Mid-Life Immigrant Women

by

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Abstract

The immigration policy of Canada has made Canada one of the major immigrant receiving countries in the world. In view of this fact Canadian researchers implemented research into the health status and health behaviour of the immigrant population. However, there is relatively little research that focuses on immigrant women and even less on the mental health of immigrant women. The purpose of this study was to explore the perceived issues of mental health and well-being of mid-life immigrant women. Using a health determinant framework that included the migratory experience as a health determinant, this project resulted in a description of immigrant women's perceived mental health and well-being and its connection to the experience of migration as well as to other factors that may influence their mental health.

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CHAPTER ONE: INTRODUCTION

The immigration policy of Canada has made Canada one of the major immigrant receiving countries in the world. In 2001, immigrants accounted for 18 percent of Canada's total population (Citizenship and Immigration, 2005). Since the year 1860, 15,434,494 people have immigrated to Canada with the greatest influx occurring between 1900 and 1920. Canada again witnessed a surge of immigration after the Second World War and the rate steadily increased since then. In the last 25 years 4,825,615 immigrants settled in Canada with 235,824 people calling Canada their new home in the year 2004. Of this 235,824, 14,488 settled in Calgary and Edmonton, Alberta (Citizenship and Immigration, 2004).

Recent immigrants come from all over the world. However, the origins of immigrants have drastically changed over the last few decades. In 2004, six of the top ten source countries were Asian and consisted of People's Republic of China, India, Philippines, Pakistan, Republic of Korea and Iran (Citizenship and Immigration, 2005). This fact is strikingly different from the data prior to 1981, during which time the United Kingdom and Italy were the main source countries. In view of these numbers it is not surprising that Canadian researchers implemented research into the health status and health behaviour of the immigrant population (Beiser, 2005; Hyman, 2004; Hyman & Guruge, 2002).

The immigration policy of Canada imposes a selection process based on attributes such as education, job skills and youth, all of which may be clustered into a category termed

human capital (Beiser, 2005; Hyman, 2004; Hyman & Guruge, 2002; Perez, 2002). Human capital may be defined as the value one holds as a result of having a high level of skill and knowledge attained through education and training, all of which leads to an increased productivity and earning power (McLaren & Dyck, 2004). Many countries utilize a screening process as a means to select or eliminate individuals wishing to immigrate. Screening helps to ensure that immigrants are healthy and devoid of diseases that could have a negative impact on the population and health care system of the host country. Health is integral to human capital (Gushulak & Williams, 2004). An immigrant whose health is compromised is perceived as being unable to live up to their economic and social potential (Beiser, 2005). It is believed that this selection process is what underlies the "healthy immigrant effect". The "healthy immigrant effect" refers to the observation that immigrants are often in superior health to native-born populations when they first arrive in a new country, but lose this health advantage over time as they adapt to the norms of their host country and adopt the lifestyle and behaviours of the host country (Hyman, 2004).

In a review of current literature relating to immigrant health, Hyman (2004) found that the majority of published studies suggest that recently arrived immigrants are more advantaged health wise than longer term immigrants. Furthermore, the literature shows that recent immigrants demonstrate better overall health status, lower prevalence of certain chronic conditions, lower levels of disability and an increased life expectancy (Hyman, 2004). For example, Perez (2002) reports that the odds of reporting chronic conditions in male and female immigrants increased with time spent in Canada. Ali

(2002) explored whether the "healthy immigrant effect" held true for mental health. The results of the analysis showed that recent immigrants (immigrated 0 to 9 years ago) had lower rates of alcohol dependence and depression than the Canadian born population. Rates of depression amongst longer term immigrants (immigrated 10 to 20 years ago) were comparable to that of the non-immigrant population. The findings from the above two studies were based on an analysis of a population health survey in which data was reported by self or a proxy, and thus the degree to which they exact is unknown. Furthermore, one cannot determine a temporal association with cross-sectional surveys (Gordis, 2004). For example, one cannot firmly conclude that being Canadian born or living in Canada for a certain period of time puts one at higher risk for alcohol dependence and depression. The observed health advantage of recent immigrants, however, does not apply to infectious diseases. For example, in the past 20 years there have been an increased number of tuberculosis cases among the immigrant population. It is suggested that the majority of cases are a result of previous infections being reactivated post- migration (Hyman, 2004; Beiser, 2005).

Until recently, a majority of research on women's health has focused on reproductive health paying little attention to the diagnosis and prevention of health problems related to gender issues not related to reproduction such as gender based violence. Gender is a determinant of health that was only recently adopted into Canada's health policy (Public Health Agency, 2002). Immigrant women face the same inequalities as non-immigrant women such as inequalities in education, work and health care (Meleis, Lipson, Muecke, Smith, 1998). Further barriers to health care access for immigrant women include

adapting to a different culture, language, and social isolation. For example, a woman who does not understand the host country's health care system, fears deportation or is not proficient in English is unlikely to access health care services until it is urgent (Kramer, Ivey, Ying, 1999). Consistent with this view is a review of Canadian health promotion strategies for new immigrant women which revealed that immigrant women who are not fluent in English or French are less likely to be exposed to health promotion programs than those who are fluent and thus potentially less likely to access health services (Hyman & Guruge, 2002). This review further revealed that the ability of immigrant women to maintain or change health behaviours, compared to that of the general population, is compromised by being exposed to poverty, marginalization, and disparity related to gender such as underemployment, multiple role burden, social isolation and discrimination (Hyman & Guruge, 2002).

The few studies conducted on immigrant women's health have shown that immigrant women employ a holistic perspective of health, integrating physical, mental and spiritual aspects of health. Good health is often perceived as enabling the women to fulfill multiple roles, such as mother, wife, homemaker, employee and caregiver (Barn & Sidhu, 2004; Meadows, Thurston & Melton, 2001). They also tend to conceptualize and experience their health in relation to establishing themselves in their host country and their experiences related to acculturation (Anderson, 1991; Barn & Sidhu, 2004; Meadows, Thurston & Melton, 2001).

For many immigrants the process of settling in and adjusting to a new country can be very stressful. Fantasies of a chance to lead a better life and enjoying freedom that is constrained in their home countries are often the reasons that lead immigrants to immigrate. Pre-immigration beliefs of success are often met with hard reality when even the most educated immigrants find themselves working in low paying jobs because their education and qualifications are not recognized in their host country. This loss of social status coupled with financial stress may contribute to mental health issues of depression and anxiety (Bhattacharya & Schoppelrey, 2004; Grimaud, 1993).

Hattara-Pollara and Meleis (1995) found that stress experienced by immigrant women is often related to managing resettlement, protecting ethnic identity, cultural value conflicts, hopes and aspirations for their family and recreation of familiarity. Many women found helping their children and family members maintain their culture of origin whilst at the same time helping the family integrate into their new environment particularly challenging. Recreation of familiarity was an attempt to ease the stresses related to these challenges. Feelings of loss related to their social support and status, isolation and loneliness were often associated with the process of settling in. These feelings are often exacerbated by discrimination, unfair judgment, marginalization and language barriers (Hattara-Pollara & Meleis, 1995). Loss of their social support network was noted as a stressor that persisted over time for immigrants. Social support networks do not only provide social and emotional support but also provide practical support in the form of help with childcare and other domestic duties (Salaff & Greve, 2004). Therefore, it can be argued that migration affects men and women in gender specific ways. Some

immigrant women find themselves having to find paying jobs for the first time while still being expected to care for their children and husband and perform traditional domestic duties (Hattara-Pollara & Meleis, 1995; Salaff & Greve, 2004). Furthermore, although some literature discussed the adjustment faced by immigrant women as being negative, other research has shown that these changes can also be positive.

In Meadows et al. (2001), women saw immigration as offering new opportunities, such as paid employment and the opportunity to interact with people of both sexes, which were often rare or non-existent opportunities in their homeland. Other positive aspects of immigrating include the opportunities available to children such as a high-quality education, freedom and the opportunity to achieve wealth and upward social mobility (Bhattacharya & Schoppelrey, 2004).

Being faced with adversity could result in positive changes to the inner strength of immigrant women and increase their capacity to deal with potential stressors. Hattara-Pollara and Meleis (1995) found that the immigrant women in their study were resilient and found ways to manage the stressors they experienced by recreating familiarity. This method of coping included attempting to create an infrastructure in which ethnic continuity could be maintained and that could offer opportunities for socialization in an environment similar to their homeland. This infrastructure also immersed their children in their homeland's culture and offered them the opportunity to learn of its customs and norms. This in turn served to alleviate the parental stress associated with the perceived threat by the host country to their family's ethnic continuity.

Religion also emerged as a major coping strategy. Religion served as a way to bring their ethnic community together to socialize as well as to worship (Hattara-Pollara and Meleis, 1995). In their study with South Asian women, Ahmad, Shik, Vanza, Cheung, George, and Stewart (2004), also found that a variety of coping strategies were utilized by immigrant women to alleviate negative feelings post immigration. Similar to the findings of Hattara-Pollara and Meleis (1995), they found that coping strategies included increased efforts to socialize and form social support networks. In addition to these strategies, the women in their study also emphasized preventative health practices as a means to cope and to maintain good health, such as regular physical check-ups, physical exercise and the use of home or alternative remedies.

The paucity of literature on immigrant women's health is evident. The literature on the mental health and well-being of immigrant women is far scarcer (Hyman, 2004; Beiser, 2005). In order to fully understand the health determinants and health needs of immigrant women all aspects of their health must be explored. More research is needed on the determinants of immigrant health and the types of programs and services necessary to maintain immigrants in good health over time (Hyman, 2004). Research in the area of mental health and well being of immigrant women will add to the knowledge of immigrant health and potentially serve to inform health policy and health program development.

The following chapter will include an outline of the purpose of this study, the research questions, and the conceptual framework used for this study. The design and research methods will be presented in the next chapter, followed by results and a discussion.

CHAPTER TWO: PURPOSE AND CONCEPTUAL FRAMEWORK

2.1 Purpose

The purpose of this exploratory study was to discover how midlife immigrant women perceive their mental health and well-being. Midlife is defined as between the ages of 40 to 65 inclusive. The definition of health adopted for this study is in line with the definition of health promoted by WHO. The WHO definition of health (WHO, 2006) states that optimum overall health includes aspects of mental health and general well-being. Furthermore, for the purpose of this study the definition of mental health was also adopted from the World Health Organization (2000) which states:

> Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality (p.11).

It is important to note that this study did not examine diagnosable psychiatric conditions, but rather those mental health issues that may impact one's well-being and one's capacity to cope. For the purpose of this study the terms mental health and well-being will include all aspects of the definition of mental health described above.

Research questions for this study were:

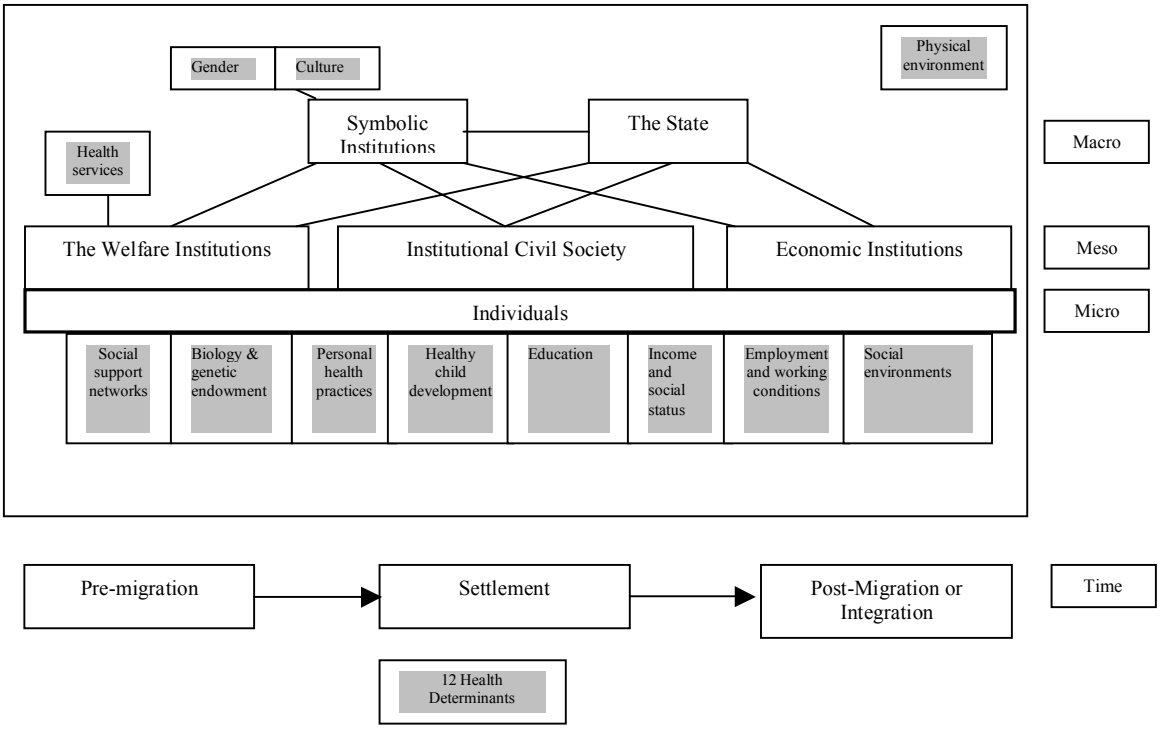
1. What mental health issues are experienced by mid-life immigrant women?
2. What do mid-life immigrant women identify as their mental health needs?
3. What factors impact these mental health issues and needs?
4. What is the capacity of mid-life immigrant women to overcome potential challenges encountered post immigration?
5. How has immigrating impacted the mental health and well-being of mid-life immigrant women?

2.2 Conceptual Framework

This study adopted a determinants of health framework. Specifically, the conceptual framework for this study is based on an ecological model for immigrant women's health developed by Thurston and Vissandjée (2005). The ecological model maintains that the migratory experience acts as a health determinant for immigrant women. This model of health is augmented by Bronfenbrenner's (1986) model of health that includes micro-, meso- and macro levels that impact health. Each level is an open system and is viewed as being interactive and interdependent (Bronfenbrenner, 1986; cited in Thurston & Vissandjée, 2005). This ecological model also represents institutions commonly found in societies such as: 1) welfare institutions that may include education and social services; 2) regulatory institutions that may include political representation, termed "the state"; 3) institutional civil society; 4) economic institutions; and 5) symbolic institutions such as gender, culture and religion. At the macro and meso levels respectively, the health

determinant of health services is described as one of the welfare institutions and the determinants of gender and culture are linked to symbolic institutions (Thurston & Vissandjée, 2005). The full model may be seen in Figure 2.1.

FIGURE 2.1: Ecological Model of Migration, Gender & Health (Thurston & Vissandjée, 2005)



Thurston and Vissandjée (2005), argue that cognitive schemas can be used to explain how gender and culture relate to each other and to other health determinants. Cognitive schemas are used by individuals to store, organize and process information about people, events, groups, and situations. When an individual is met with new people, events, groups, or situations, these schemas are drawn upon to see if the specific instance fits

within an existing schema. If an existing schema does not exist then one must be created or adapted to fit the specific instance (Howard & Hollander, 1997).

Currently, the population health approach that guides Canadian program and policy development consists of a health determinants model that includes twelve determinants, all of which exercise a role in determining the health of Canadians. The Thurston and Visandjée (2005) model includes the twelve determinants: 1) income and social status; 2) social support networks; 3) education and literacy; 4) employment/working conditions; 5) social environments; 6) physical environments; 7) personal health practices and coping skills; 8) healthy child development; 9) biology and genetic endowment; 10) health services; 11) gender and 12) culture (Public Health Agency, 2002). As seen in Figure 1, the majority of these health determinants are found at the micro level because it is believed that these determinants act at the level of the individual. The physical environment refers to the macro and meso levels of the model indicating that it encompasses both the physical geography and the built environment.

In this ecological model, gender and culture are seen as factors that greatly influence the migratory experience and are central to the understanding of immigrant women's health. They are concepts that are often mistreated and misunderstood (Thurston & Vissandjée, 2005). The term gender refers to those characteristics that society expects of men and women in terms of their behaviors, roles, and responsibilities. Gender roles and norms are socially constructed by the society in which we live and may vary from culture to culture. It is a complex concept that is shaped by an individual's culture, politics, social

mores, religion and media (Nelson & Robinson, 2002). Culture refers to the customary beliefs, social forms, and material traits of a racial, religious, or social group. It encompasses a set of shared attitudes, beliefs, values, goals, and practices that characterizes a cultural group (Public Health Agency of Canada, 2002). An evidence based review conducted by the World Health Organization (2000) on women's mental health showed that women's mental health is impeded by the social and cultural factors that promote unequal rights and access to resources between men and women. These factors work to create, maintain and exacerbate exposure to risk factors that impede women's mental health such as poverty and gender-based violence (WHO, 2000).

Thurston and Vissandjée (2005) further hypothesize that the cycle of migration occurs in four stages, each of which influences health differently. The pre-migratory stage includes the experiences that occur upon making a decision to immigrate. The settlement stage includes experiences after arriving in the host country and up to five years thereafter. The post-migratory stage refers to years 6 to 10 post migration and finally, the integration stage refers to experiences after 10 years of being in the host country. Thurston and Vissandjée (2005), argue that the migratory experience is shaped by locality and time and that immigrant women use cognitive schemas to both produce and reproduce their health. These migratory stages can be seen at the bottom of the model indicating their temporal nature.

This conceptual framework was used with the analysis of secondary data to explore immigrant women's mental health.

CHAPTER THREE: DESIGN AND METHODS

3.1 Study Design

This research consisted of the analysis of existing data collected on midlife immigrant women as part of the Alberta Mid-Life Women's Health Project (WHEALTH). WHEALTH is a program of research whose purpose was to examine and understand the health experiences of mid-life women in Alberta. The aim of the study was to explore the mechanisms through which determinants of health affect women's everyday health and well-being. The WHEALTH project was based on the perspective that women's health is influenced by a variety of physiological and psychosocial factors and health determinants (Meadow, Thurston & Lackner, 2001; Thurston & Meadows, 2004; Meadows, Thurston & Berenson, 2001; Meadows, Thurston & Melton, 2001; Meadows, Thurston & Lagendyk, 2003). Thus far, a series of qualitative investigations, using individual interviews and focus group interviews, have been conducted with four sub-populations of women that include, urban, rural, aboriginal and immigrant women. More specifically, the objectives of the WHEALTH project as it related to immigrant women's health were: 1) to describe the health experiences of mid-life women who had immigrated to Canada as adults; 2) to identify patterns and variations in their descriptions of their health and 3) to describe immigrant women's contact with the formal health care system and its role as an aspect of health and management of illness and poor health (Meadows et al., 2001).

3.2 Recruitment, Sample and Data Collection

Investigators approached several immigrant serving agencies in Calgary and Edmonton, Alberta to solicit their cooperation in the study. Investigators met with those who agreed and worked collaboratively to develop an interview guide for the study. Several meetings with the participating urban agencies took place to reach agreement around the final products of the study and to ensure that the data collection procedures, including recruitment and wording of the interview guide, were suitable for use with women who had immigrated to Canada. For example, general and basic terms were used in the questions of the interview guide in an effort to help respondents with limited English to understand the question. The final interview guide consisted of questions around participants' definitions of health, their current health issues and what made them feel 'good' or 'bad'. Furthermore, participants were asked to describe family influences on their health, resources and coping strategies, occupational health concerns and how immigration impacted their health. A pilot test with the final interview guide was undertaken before full data collection ensued. The primary means of data collection for this study was individual interviews that were lead using this interview guide. All interviews were conducted by trained interviewers (Meadows et al., 2001). The final interview guide may be viewed in Appendix A.

Recruitment of participants for the study was also done in collaboration with participating urban agencies. These urban agencies offered English as a Second Language (ESL) courses in an effort to facilitate the acquisition of English language skills. An agency

member agreed to speak with the class about the project and solicited their participation. This sampling strategy ensured that participants were able to communicate in English.

Written informed consent for participation and to be audio-taped was received from all study participants (Meadows et al., 2001). All interviews were audio recorded and transcribed verbatim (Meadows et al., 2001). Data collection continued to the point of saturation leading to a total of 42 interviews (Meadows et al., 2001). Saturation is the point during which no new information is being discovered (Creswell, 1998). A majority of the participants had immigrated to Canada from countries in the Middle East, including Lebanon, Egypt, Iraq and Kuwait, and from the Far East including Hong Kong and China. Length of time since immigration varied from one year up to 10 years. Therefore, the characteristics of this sample varied in cultural background, ethnicity, class in country of origin, current social status in Canada, or degree of acculturation. Demographically, the majority of participants were between the ages of 46 to 50, were married at the time of the project (72%) and had children (86%). The majority of women had received education in their country of origin and slightly more than half worked either part-time or full-time (Meadows et al., 2001).

3.3 The Present Study: Secondary Data Analysis

The advantages of secondary data analysis include cost-effectiveness and timeliness. It is an area that has not been strongly pursued in qualitative research (Szabo & Strang, 1997; Thorne, 1998). A further advantage of secondary data analysis is that it allows the researcher to continue research on a topic related to the population in mind without

having to recruit new participants. It allows for the maximum use of data without burdening the population with continual data collection. Furthermore, it allows the researcher to view the data with a new lens, a lens of detachment that may be difficult for the original researcher. However, this detachment may also be a disadvantage to the researchers' understanding of the nuances of the data that most often comes from being submerged in the data collection process. Further limitations include problems associated with the fit of the data to the secondary research questions which in turn may lead to a questioning of the credibility and validity of the research (Thorne, 1998; Hinds, Vogel, Clarke-Steffen, 1997). Hinds et al., (1997), suggest that the fit of the original data to the secondary research questions may be determined by the extent of missing data. For example, missing data in qualitative research most often results when an issue is explored in one interview but not in others. This may occur when the issue arises unexpectedly, out of the scope of the interview guide and thus is not addressed in subsequent interviews. Hinds et al., (1997), suggest that the issue of missing data in a secondary data analysis may be minimized if the methods of the primary research involved asking the same questions (i.e., via interview guide, semi-structured interview) of all interview participants. They further propose that the degree of the difference between the purpose of the primary research and the purpose of the secondary study may be a second methodological challenge in secondary data analysis. Furthermore, Hinds et al., (1997), suggest that in order for a secondary analysis to be successful the phenomenon of interest should be closely related in both the primary and secondary study, and that the data is rich in detail and appropriate for further analysis. Therefore, the detail in the data will determine whether new and valid information can result from a secondary analysis.

In order to ensure that the original research is amenable to a secondary analysis the secondary researcher must become familiar with the original research to be confident that the original data was collected ethically, efficiently and with utmost attention to rigour. Thus, the secondary researcher must have direct access to the data and be knowledgeable of sampling, data collection and analytic procedures, as well as have direct access to the principal investigator in case further clarification is needed (Thorne, 1998; Hinds, Vogel, Clarke-Steffen, 1997).

The following steps were taken to overcome some of the limitations of secondary data analysis. Familiarity with the immigrant women's study was enhanced by participating in meetings with the primary investigator of the WHEALTH project. During these meetings the student gained knowledge on the background, purpose, sampling and data collection strategies of the immigrant women's study. The intended purpose of the secondary analysis was communicated to the primary investigator as a means to investigate whether she thought that the original data were a proper fit to the secondary research questions. The primary investigator supported the suggestion of exploring mental health issues within the data and informed the student anecdotally that themes related to mental health had emerged from the data in the original analysis. The primary investigator agreed to provide the student with all relevant material needed for such an analysis such as verbatim transcripts, the original consent form, and interview guide (Meadows, personal communication, July 14, 2005). The primary investigator was available for further communication throughout the research process. The support given

by the primary investigator also addressed the concern of the degree of disparity between the purpose of the original study and that of the secondary study.

The purpose of this secondary analysis was deemed consistent with that of the original study. Once again, the purpose of the original study was to explore the perceived health and health-related experiences of mid-life immigrant women in Alberta. The interview guide included questions around health issues, strategies for attaining optimum health and the roles and responsibilities that may influence health (Meadows, personal communication, July 14, 2005). More specifically, the interview guide included questions on coping strategies utilized by the women when they feel bad and if and how they perceived their health changed after immigrating to Canada. The use of an interview guide ensured that the same information was gathered from all participants therefore reducing the amount of missing data for the secondary analysis.

The definition of health adopted for the secondary study argues that optimum overall health includes aspects of mental health and general well-being (WHO, 2006). Furthermore, other reputable associations such as, the Canadian Mental Health Association (2005) define mental health as striking a balance in all aspects of health which include physical, social, spiritual, economic and mental. Therefore, the purpose of this secondary data analysis and the conceptual framework described previously were found to be in line with that of the original study.

3.4 Method of Data Analysis

The student had access to all 42 WHEALTH interview transcripts from the immigrant women's study. Each verbatim transcript was uniquely identified by a tape number. This number was used to select interviews for analysis. Selection began with the earliest number and proceeded numerically until informational redundancy was reached. The qualitative software QSR N6® was used as an aid in this analysis. Informational redundancy is the point in which no new information is being discovered or the information discovered becomes redundant (Sandelwoski, 1995). Each transcript was read at least once before coding began in order for the student to get a sense of the content. Coding began after this review.

The interpretive process in qualitative research involves five phases: 1) describing; 2) organizing; 3) connecting; 4) corroborating and legitimatizing; and 5) representing the account. Data analysis is made up of the latter four phases of organizing, connecting, corroborating/legitimatizing and representing the account. The phase of organizing includes classifying or categorizing data into meaningful units of data. This phase gives the analyst a formal method for developing analyzable categories that will then be used to form connections within the data and create new insights (Miller & Crabtree, 1999).

The method of analysis for this study included the use of a template based on the conceptual framework of this study. A template that encompassed the twelve health determinants described earlier and migration as a health determinant was created and used for the analysis. This method of analysis and organization is most congruent with

that described by Miller & Crabtree (1999) as the template style. This style includes *entering* the data with an a priori classification scheme. This classification scheme serves to identify units of interest for analysis and interpretation. The analysis is iterative in that additional categories may emerge or initial categories may be revised according to the interaction between the template and the data. This method of analysis did prove iterative in that a new category was created while analyzing the data. In the beginning of the analysis domestic violence was being coded under gender. However, as analysis continued it became apparent that domestic violence played a great role in acting as a sole factor in determining the mental health of these immigrant women.

Making connections with the data makes up the third phase of the interpretive process. Specifically, it is in this phase that themes and patterns are exposed and that the linkages between categories are more evident. This phase involves a great deal of reflection and analytical thinking (Miller & Crabtree, 1999). Miller and Crabtree (1999) define corroborating as "to make more certain and to confirm" (p. 136). This phase of the interpretive process, therefore, includes the concept of rigour in qualitative research which is described in the following section of this proposal.

The final phase of the interpretive process, termed "representing the account" by Miller & Crabtree (1999, p.137), consists of finding a way to represent the findings and interpretations that emerged from the analysis. This representation depends on the audience, the skills of the researcher and the nature of the findings. In this case the findings and interpretations from this secondary analysis are represented in subsequent

sections of this paper which will be presented to the student's supervisory committee and will be subject to a defence as outlined in the regulations of the Faculty of Graduate Studies, University of Calgary. It is the hope of this student that this thesis will have the potential for publication in the future.

3.5 Study Rigour

Strategies of verification to secure trustworthiness or validity were addressed by employing a number of established techniques (Creswell, 1998). In qualitative research verification may be defined as those mechanisms that are employed during qualitative research in order to ensure reliability and validity and thus the rigour of the study (Morse, Barrett, Mayan, Olson, Spiers, 2002). Validation and strategies of verification are internal to the project and occur from the beginning to the end of the study. Validity or trustworthiness is judged externally and is considered an outcome goal of a study. The concept of trustworthiness is achieved by addressing issues of reliability and validity in a study (Meadows & Morse, 2001).

The concept of trustworthiness is made up of four aspects: 1) credibility; 2) confirmability; 3) dependability and 4) transferability (Morse et al., 2002). Credibility refers to the validity of qualitative research or the extent to which the results provide a valid representation of the phenomenon of interest, in this case, perceived issues of mental health and well-being of midlife immigrant women.

The credibility of this study was ensured by immersion and crystallization (Borkan, 1999). This method of establishing credibility includes being completely immersed in the literature, the data and the details of the original study. The student continuously immersed herself in literature related to the topic of mental health and well-being of immigrant women in order to extend the student's knowledge on what is known and not known about this topic. This strategy thus served to inform the research and provided the student with a means to compare and contrast developing knowledge with what is already known (Morse et al., 2002). Credibility was further ensured by the student being continuously immersed in the data and in the details of the original study. Furthermore, the method of triangulation was also used in this research study (Creswell, 1998). Investigator triangulation was utilized for the purpose of confirming the validity of the student's findings (Morse et al., 2002). The student's supervisor analyzed two interviews. The student's results were then compared to that of her supervisors. The results of the student's supervisor supported the analysis of the student. Additionally, investigator triangulation served to establish confirmability, which is considered to be a further aspect of trustworthiness.

Clarifying research bias at the outset of the study is important in order for the audience to understand the potential biases and assumptions that may have had an impact on the study (Creswell, 1998). Confirmability was ensured by having the student be reflexive of her own biases and preconceptions about the perceived mental health and well-being of midlife immigrant women throughout the progression of this study. This process of reflexivity began at the onset of the study with the student reflecting on her own

assumptions about the mental health and well-being of immigrant women while being immersed in the literature. It is important to note that the student herself is an immigrant and thus her assumptions are based on her own familial experience and familial discussions regarding reasons for immigration and the positive and negative aspects associated with it. Furthermore, the student's research experience includes working in mental health and psychiatry in the role of research assistant and analyst for a number of years. Bracketing assumptions related to mental health proved to be difficult and required a great deal of reflexivity and thought. Further reflexivity and thought occurred after the analysis was judged by the student to be complete. Discussions with the student's supervisor and co-supervisor allowed for further reflection and lead to additional analysis specifically to identify whether positive feelings were experienced by the women in the study.

The student continued to reflect throughout the progress of this study and kept a journal of thoughts, ideas and reflections as a means to document reflexivity. Another method of enhancing confirmability included establishing an audit trail. This audit trail involved memoing during data analysis to explicitly show how analysis and interpretations were reached. This audit trail also served to establish dependability. Dependability refers to the reliability of findings in qualitative research. Verification strategies to establish dependability also included investigator triangulation described above (Morse et al., 2002).

Transferability is addressed by providing a rich, thick description of the research design, and data analysis in this paper. The description will be detailed enough so that other researchers may determine whether the findings may be transferable to another setting (Creswell, 1998). Overall, study rigour was ensured through the use of the verification strategies described above along with the student's aim to make the process transparent to an external audience.

3.6 Ethics

The ethical consideration of study participants is always of utmost importance (Creswell, 1998). The proposal for this research study underwent ethics review and approval by the Conjoint Health Research Ethics Board (CHREB) at the University of Calgary. Approval was attained on January 12, 2006. The approval letter may be viewed in Appendix B. The anonymity of participants was protected through provision of the data to the student by the primary investigator without any identifying information. Verbatim transcripts were identified via a unique tape number rather than name. Furthermore, all original participants provided written informed consent to participate in the immigrant women's health study (Meadows et al., 2001). The original consent form may be viewed in Appendix C. The consent form outlined what the study was about and what their participation would involve. Participants were informed of the research purpose, methodology, research questions, and of their rights as participants such as:

- The right to know what the study is about and what participation will involve;
- The right to withdraw from the study at any time;

- The right to anonymity;
- Participation or non-participation will in now way affect the health care received by participants; and
- Participating in the study and signing the consent form in no way waives the participants' legal right or allows the researchers to sway away from their professional responsibilities.

Additionally, all electronic files relating to this study were secured on the hard drive of the student's computer. This computer is password protected with password access restricted to the student. To ensure the privacy and confidentiality of hard copy materials, all hard copy materials were housed in a locked filing cabinet of which only the student had key access.

CHAPTER FOUR: RESULTS

A total of 19 interviews were analysed for this study. In order to elicit some understanding of those interviewed some background and demographic information on the study participants is first provided. The characteristics of this sample varied in cultural background, ethnicity, class in country of origin, current social status in Canada, and degree of acculturation. A majority of the participants had immigrated to Canada from countries in the Middle East, including Lebanon, Egypt, Iraq and Kuwait, and from the Far East including Hong Kong and China. Length of time since immigration varied from one year up to 10 years. Demographically, the majority of participants were between the ages of 46 to 50, were married at the time of the project (72%) and had children (86%). The majority of women had received education in their country of origin and slightly more than half worked either part-time or full-time (Meadows et al., 2001).

The results of this analysis will be presented in three sections. The first section will outline how immigrant women talked about their mental health and well-being. This section will include the context in which immigrant women defined optimal health and their perception of their mental health and well-being. Their perception is framed around the negative and positive feelings they experienced before and after immigrating to Canada. The subsequent section will address the factors that determine immigrant women's mental health and well-being. Although determinants of health worked together to influence the mental health and well-being of the women for clarity of illustration they will be discussed separately. Lastly, the strength and resilience of the women and their determination to rebuild their lives in Canada will be discussed. The

results show that the women played an active role in ensuring their mental health and well-being by employing a variety of coping strategies when they were met with hardship.

4.1 Mental Health and Well-being of Mid-Life Immigrant Women

The women's definition of health was all encompassing. For example, the women did not tend to separate mental health and physical health in a dualistic manner. They described health as including both physical and emotional aspects. The women believed that both aspects are important to overall health and well-being as they were seen as balancing each other out. Optimal health was also described in the context of being able to fulfill their roles mainly, mother, wife, homemaker and paid employee along with a need to be stress free. Stress was often associated with difficulty in balancing their roles and responsibilities at home and in the work place. Stress was described as being overwhelming at times.

> Healthy is a big name, it covers a big area, so to be healthy is to be able to stay healthy in both ways mentally and physically and also if you are working outside so that you can carry your outside job and also your inside job. Since we are the women we have to do two types of work, the outside job and also the inside job. So staying healthy is a must for women.

Along with feelings of stress the women identified a number of negative feelings. Women spoke of feeling sad, depressed, lonely, anxious, and frustrated in response to

being asked about their health and what made them feel bad. Some of these feelings were associated with significant losses they experienced such as the loss of family and social support, loss of their financial and social status, loss of language and the need to adjust to a new culture and environment.

> I feel very sad, especially with the first year because I work all my life and I have to learn English and go to school and I felt depression.

The need to adapt and adjust to a new environment and culture was described as stressful and frustrating. The immediate period after migration was most often described as scary, angering, tiring, confusing, difficult and stressful. Women spoke of feeling sad, lonely and homesick during this time. At times worry was related to thoughts of the loved ones they left behind in their home country.

Emotional distress was sometimes related to the lasting effects of trauma experienced in the pre-migratory stage of migration. This stage is defined as the period in time during which the decision to migrate is made (Thurston & Vissandjée, 2005). Experiences during the pre-migratory stage are most often what lead to the decision to migrate. One woman specifically spoke about the trauma and violence she and her family endured in her home country. She continued to re-live this trauma after immigrating to Canada.

> Important health problem…. Sometimes I feeling depressed ya I want to cry especially when I think about the past and my life in my country because they killed my husband there.

For some women negative feelings surfaced during the interview and were evident through tears as they spoke. The significance of their emotional distress was evidenced by their description of sleep difficulties, fatigue and weight loss due to loss of appetite. These physical symptoms experienced in conjunction with prolonged feelings of sadness may be indicative of clinical depression (Canadian Mental Health Association, 2006).

The analysis revealed that immigrant women also experienced positive feelings after migration. Feelings of optimism, pride and hope were common among the women. Despite being faced with many challenges the women felt very optimistic and hopeful about their futures and the futures of their children and strongly believed that they made the right decision in migrating. The women's decision to migrate was most often based on the political instability of their country and government oppression. For many of the women immigration brought newfound freedoms, opportunities for their children to have a brighter future, pursue education and most importantly safety. Women spoke of feeling happy and proud because they were doing things they were unable to do or not allowed to do back home.

> I change here. Before I feel shy I can't talk with the people too much and now I change. I talk with the people, especially men. Before I feel very shy to look at

> the man or talk with him, now I change maybe because of the culture the life here is different. Now I'm working and I go outside for payments for school, sometimes for the children.

Overall, the women's definition of health included both physical and emotional aspects believing that one directly balanced the other. Feeling mentally healthy was deemed just as important as feeling physically healthy. Optimal health was also defined in the context of being able to fulfill their roles and responsibilities. Overall, the women's description of experiencing several negative feelings indicates that they perceive their mental health and well-being to be compromised to some extent. However, the women also described having positive feelings of optimism, pride and hope and strongly believed that migrating was the right decision.

4.2 Sources of Distress

The immigrant women in this study talked about many factors, experiences and challenges to their mental health and well-being. In their discussion they did not identify one sole factor but rather discussed the interplay of many and their overall impact on their mental health and well-being. The majority of the women were educated, motivated and determined yet they encountered various challenges in Canada that held them back from achieving their full potential.

With immigration came high expectations of employment and opportunity. However, for many these expectations were strongly tested. In response to questions concerning what

made them feel bad the majority of women spoke of the connection among their income and social status, employment status, education and the loss of their social support network. The majority of women spoke of financial strain as being a large cause of their distress.

> Yes I worried so much I worried sometimes I buy a ticket for a $1 dollar for lottery I hope to God…please…some money just for help everybody my family.

Much of the economic hardship they faced was due to being unemployed or underemployed. Their employment status was due to their lack of proficiency in English and due to Canadian employers not crediting or accepting the education they received in their home country. Some Canadian organizations also required Canadian experience for employment with them. The under-valuing of their education resulted in a downward shift in their career and standard of living upon immigrating to Canada. A majority of the women were educated and worked as teachers, secretaries, computer software engineers and laboratory assistants however, upon immigrating comparable work in Canada proved non-existent and many found themselves working in childcare and cleaning.

> I: You felt like you were losing your mind?
>
> R: Ya because everyday I am crying. I left my kids, I didn't care for them. They need at this time, they need more than me. I forget them because it was very bad here.
>
> I: Why do you think you were having all these health problems?

> R: Because you know I came here for better life you know because my brother-in-law says here is where the life comes. We have everything in my country I am teacher and my husband have a good job too, we have houses, car everything what we want you know. And we came here and my husband, we brought money too and we spend it in 8 months about $20,000 we spend it in 8 months and you know different culture and different language, I didn't know English too much and I needed doctor and I go here and here and nobody help me. You find yourself alone no friends no family and you came for better life and you find it no way, I rent house and have money like before I didn't have furniture it was hard for house, up and down
>
> I: So you say the changes you went through actually decreased the standard of living?
>
> R: Ya

One woman spoke of her difficulty in attaining satisfactory employment because of the discrimination she encountered.

> A lot that's what makes me feel mad because I think, like in Toronto I never experienced discrimination job wise but here in Calgary I have and I thought Calgary was supposed to be friendly.

The language barrier also posed difficulty for women in other aspects of their life. One woman described being unable to communicate with the nurse at her physician's office.

From that point on she had to rely on her son to translate for her during visits to their physician. The inability to communicate and relying on her son created a loss of independence and imposed greatly on her privacy.

> R: No, no this is my problem because I have to, I don't feel that my English is good for health problems I have to go with my son sometimes I feel shy
>
> I: But it's a problem for you?
>
> R: Ya for me it's a problem especially when I have some women's problems they have to listen everything.
>
> I: How does that make you feel?
>
> R: Very shy.

Feelings of loss related to their income and social status were difficult for the women to accept. For the majority of women their standard of living, changed significantly on both social and economic levels when they immigrated to Canada. They found themselves having to become accustomed to a lower standard of living due to unemployment and underemployment. Socially, they had limited social networks compared to back home and limited opportunities to socialize and pursue recreational activities. The hardship of having to start over to rebuild their lives financially and socially in Canada was something the women described vividly.

> Ya living a good life because my life back home is very good life but when I thinking about that I am coming from a good family and very rich family and

> when I compare my life now my life in the past I'm feeling very tired because here is change living like poor people, not very poor but not a good life, sick and I don't know what I do. I have many things in my country but I can't do anything here you know I have land and house and they took everything from us in my country and I coming and start from zero that makes me tired when I am thinking about that and I am not young to start from zero so I ask myself why all that happen to me I don't know actually I said to myself to start here I should work but I can't do that because my health is not good.

The downward shift in their income and social status, having their education rejected and not being able to achieve their employment goals produced a loss of identity for the women. Women went from being working professionals to settling for jobs in childcare and cleaning. The women continued to work on improving their English with the hope that the improvement would make a difference for them in finding well-paying, satisfactory employment. For some the loss of identity was also tied to their loss of independence due to being unable to communicate in English and thus having to rely on others, mainly their children for assistance.

The women's standard of living also changed in a gender specific way. Women took on additional roles and responsibilities upon immigrating to Canada to which they were not accustomed. Women were solely responsible for the children and maintaining the household as this was a role that was expected of them by their family. Although expectations for child rearing and domestic duties fell upon them in their home country

they had help with this responsibility then from hired help and extended family. Most women left their extended family behind upon immigrating to Canada and were therefore no longer able to count on that assistance. The additional work of completing all the household chores and duties along with paid employment proved to be a difficult adjustment for the women.

> Way back in the country I was working and I had my kids still small so I needed somebody to help out in the house, so I have this the nanny in the house every day to help me out and then when I came here I'm doing the job all of it already so this a big change I have to do everything on my own, cook my own food, do my own laundry and everything.

> It's more than full time, you go to work you come back and you're still not out of a job you finish one job and you're back home doing another job and then you feel you're going to do something for yourself but when you go to do something for yourself it's still part of a job so you never have time basically for yourself to do that you really enjoy like luxury just something nice for yourself.

Some of the women also spoke of a need to have more time and energy to dedicate to themselves as they most often expended their time and energy taking care of others. They spoke of always being mindful of other people's needs and happiness over their own and being unable to find the time to pursue interests and hobbies. This need

appeared to be related to the extensive responsibility the women carried such as being responsible for domestic labour, child rearing and working outside of the home.

> I'm happy I don't have anything to change, I sometimes I want to change myself because I put all my life for my children and my husband I don't think about myself too much this is not good for me.

Gender played a further role in that the women commonly identified their needs in relation to that of their children's. A concern for many of the women was their children's happiness in which their own was grounded. Being unable to provide their children with a higher standard of living that included the allowance to pursue leisure activities such as sports and hobbies was a concern for some of the women and resulted in feelings of guilt. Women connected the need to achieve a higher income and social status to improvements in the quality of life of their children which would then alleviate some of their distress.

> Ya I told you because you need it for kids to make them happy you know, to get them in sports group, or clubs, or to go for holiday or to go for dinners, you know we don't go outside for dinner I have to spend $100 if I want to eat outside I can't or toy if they want a toy I can't buy toys that's all.

Domestic violence was an issue faced by the women and affected their mental health and well-being in a very negative manner. These women spoke of living in constant fear of their husbands, being depressed and feeling helpless as a result of the violence. Some

women carried the after effects of the violence with them throughout their everyday lives describing being agitated and shaky when anyone raised a hand or their voice. They also spoke of the negative changes in their confidence and self-esteem.

> I: Has your husband ever really tried to kill you?
>
> R: Ya, he told me all the time I kill you, I kill you, I am one day dead, today, tomorrow maybe 20 years. Ya, I am before very strong and now I am very… (crying).

One woman described the effects of the abuse on her physical health along with her mental health having brought her to the point of suicide on a few occasions.

> Breathing, I couldn't breathe, I had a lot of asthma attacks, headaches, I lost a lot of weight I went almost to 68 pounds I ended up taking my life a few times overdosing on medications.

The effects of the abuse on their children were also a concern as some women feared that one day they might be killed by their husband and their children would be left as orphans. One woman perceived the violence as hindering her ability to properly nurture and mother her children causing feelings of guilt and shame. This hindrance was a result of depression and living in constant fear of being hit.

> Ya, couple of time he put knife here and blood come out, but Jesus I am dead you help me for my children. Jesus help me.

> I've never had a really married life it's always been abusive so it's always been his way and I've always worked so I can't really say I mean I've missed out on a lot I couldn't even say how I wanted to bring up my children I couldn't ever talk to them and I think since I was so young, I was really young when I got married and getting into this abusive relationship right away got me into this cocoon so I couldn't contribute or be a really good mom to the kids the way I wanted to be. I was always crying so when you are down and have lost your confidence how can you give confidence to somebody else.

Loss of their social support network further impacted women's mental health and well-being upon migration. Many of the women described heartache associated with missing the family they left behind. The emotional support that their extended family provided was non-replaceable. Contact with their family back home was often limited to telephone and letters. However, long distance telephone charges were very expensive and became a low priority, especially when they were struggling to put food on the table. Although letters sent by postal service was a less expensive means of staying in contact the service was neither reliable nor timely. Many women expressed a desire to visit or have their family brought to Canada, however most were resigned to the fact that this was never going to happen. The financial cost associated with this desire and/or the political turmoil

and danger they may encounter upon visiting their home country made this option nearly impossible.

Thoughts of the family they left behind also played a role determining the mental health and well-being of the women. The political state of their country and the everyday dangers of living back home caused the women to be in a constant state of worry and feel helpless that they could not do anything to guarantee the safety of their family.

> R: Ya I know I can't be back with my family you know because our country I know they kill us if we be back to our country and that make me sick because I don't know about my family my sister my brother.
>
> I: You have no information?
>
> R: Sometimes I send a letter and they send a letter but every 6 months because postal service is very bad and they send a letter to Jordan and from Jordan comes to another country and me too, ya so I receive a letter from them every 6 months and sometimes I'm feeling tired because I haven't had news from them.
>
> I: So would you say that leaving your family and country has affected your health right now?
>
> I: Ya, ya as soon as I wake in the midnight and my heart is pumping very fast
>
> I don't know I saw a dream that my aunt and sister was dead so I'm feeling very bad the phone it cost me a lot of money but I call them between 6 and 7 months my sister my brother and tells me and I call and spoke with them.

4.3 Minimizing Distress and Maximizing Resilience

This data analysis revealed the immense capacity of immigrant women to deal with adversity. The women demonstrated a great deal of resilience and strength when faced with challenges and were determined to not give up. They played an active role in minimizing their distress and in turn ensuring their mental health and well-being.

The women's resilience and strength was evidenced by their great determination to rebuild their lives in Canada. Rebuilding included pursuing classes in English to improve their proficiency and fluency with the language and actively seeking out employment opportunities. The majority of women were in the process of taking ESL courses with the hopes of pursuing the highest level course offered. Some women expressed a desire to take additional courses at learning institutions such as the Southern Alberta Institute of Technology (SAIT) to improve their chances of finding satisfactory work. Rebuilding also included ensuring their children received a good education so they would be able to lead successful lives in Canada.

Rebuilding their lives socially was also a focus of the women. Some women found themselves completely alone in Canada and actively found ways to meet new people. One woman secured a friendship with her doctor and sometimes would go see him to talk when she was upset. For the majority of the women friendships were made at their place of employment, at community agencies, through volunteer work and at places of worship.

The strength and resilience of the women became evident as the women described taking charge of their lives. For one woman this meant standing up to her abusive husband. For years she endured physical, emotional and financial abuse at the hands of her husband. She was under his direct control in every way. At one point she realized she could not rely on him and made the decision to build a life for herself and her children so that they would be financially secure in case her husband chose to leave her. She was able to do this by asking for help from friends she made at work.

> I: So before then what would happen with the money? You would come home and would just give him your cheque?
>
> R: No it would just go into the account.
>
> I: So it was a joint account?
>
> R: It was a joint account yeah, but it was a joint account in a way where I wasn't authorized. I didn't have the cheques or anything. I didn't have VISA and no nothing. At that time you could still say I was giving him the money, but the time it changed was when he finally sold the house and moved to Alberta invested that money into a motel without any sort of proper paperwork or anything and he left me high and dry in Toronto where I had to end up looking for an apartment for me because I didn't want to come right away with him. I had a good job there. I had no credit of my own because I didn't have VISA card, he didn't give me any VISA or anything and when I was looking for an apartment he didn't help me one bit. So I had to look for outside help. You could say I was pretty lucky because people at work and my boss was super, he gave me a letter saying that he would

take responsibility if anything went wrong and that's how I ended up getting an apartment. I realized I'm left nowhere so I started building up my credit and applied for a VISA. I got VISA cards, I got the bills in my name and I started putting my money into my own account and paid my rent so it's changed, since then it's changed. I've got my own credit.

The women played an active role in ensuring their mental health and well-being by recognizing the importance of minimizing their distress. The majority of women spoke of actively employing different strategies to help them to cope with the challenges they encountered proving their determination to maintain their health.

For many accessing their existing social support network was integral to coping with hardship. The women most often accessed their partners, children and close friends for social support. For some their social support network included their place of worship and the friends they made there. Social support usually consisted of talking about their difficulties and receiving emotional encouragement, support and practical advice. The women indicated they often felt “better” after being able to unload their worries and stresses and in turn receive empathy and support.

I: And if not who would you talk to? Who do you talk to?

R: You mean personal problem?

I: Yes.

R: Well we have the church, I would not go direct to pastor but we have a group of what we call brothers and sisters, people who know me well and I know them well so I can trust them and even though sometimes I accept advice but then I can confide something to someone who is close, trustworthy.

Moreover, women indicated that their religion and faith also provided them with spiritual guidance and comfort through the act of prayer. Worship and prayer was an important aspect of their everyday lives and was often incorporated into their daily routine. For example, some women rose very early in order to complete their prayers prior to beginning their day and made time for prayer throughout the day. They used prayer as a means to provide comfort, seek guidance and patience to deal with their struggles.

It gets you down if it affects your mental health it could affect your overall health but I mean I look at things in a positive way maybe there is something better waiting out there for me I don't know but it better come soon. I cry a lot but I pray a lot because I have a lot of faith and I think that's what keeps me going, have a lot of faith in God and I know he's going to look after me.

Attending religious service was so important to one woman she attended a Christian church despite being a follower of Islam.

I: Okay so you go to Mosque or church?

R: Sometimes I go to church but my government Muslim now I don't like them. I don't find any Mosque in here. I like go to church sometimes Sunday maybe Saturday I go to church near the C train I like so much singing.

I: It's Christian church you don't mind.

R: Yes, I know but I like just God's home. I like so much. I can't know the talk.

I: Right, you don't understand.

R: I don't understand all of them but I like that place, relaxed. I feeling relaxed but I think about good world about good life.

Participating in hobbies such as sewing, watching TV and talking walks were other common ways the women minimized their emotional distress. For some these hobbies provided a sense of relief in that they could release their worries and forget them for a while in order to concentrate on something else.

I: Do you have any hobbies, knitting, sewing?

R: Ya sewing. I sew lots clothes for my daughters for me.

I: Is that work or is it fun?

R: It feels good.

I: It does feel good?

R: I'm busy so forget

I: So you forget your worries and that helps

R: Ya.

Many of the women spoke of their positive attitude being specifically helpful in managing their stresses. Maintaining a sense of optimism and hope in their life proved to be uplifting when faced with obstacles that were particularly tough to endure.

> I think my belief is very important. I always think that there is hope no matter how troublesome how serious the problem is. I think that's not the end, there's always hope, even though sometimes you have to wait for long periods of time but then pray and ask God for the patience to wait.

For many their positive attitude was rooted in their self-esteem and confidence. They had the utmost confidence in themselves and were strong in their belief that they had a great amount to offer. They spoke of their self-esteem and confidence as very integral to the ability to cope with hardship. For example, when speaking of the rejection she faced when applying for a job one woman said:

> Yes, because that's how I look at it. If they don't want me then fine it's their loss, and the person who gets me it's their gain and they have to realize that you know.

In summary, immigrant women experienced a variety of negative feelings before and after migration. These negative feelings included sadness, anxiety, stress, loneliness, frustration and in the worst cases depression. For some women negative feelings were a result of the after effects of the trauma they endured in their home country prior to migrating. For the majority of women the experience of negative feelings was almost

always related to some form of loss. The women experienced a loss of their income and social status, education, employment and social support network upon immigrating to Canada. Together, these losses further produced a loss of identity for the women in that they were made to give up many of the characteristics that made them who they were such as their careers and education. Although income and social status, education, employment and social support network were discussed separately, it is important to note that these determinants of health are interconnected and work together to influence mental health and well-being. Immigrating to Canada brought many challenges for the women. Despite this the women showed their determination to rebuild their lives in Canada providing evidence of their resilience and immense capacity to deal with hardships.

Immigrant women also experienced positive feelings such as, optimism, pride and hope for the future. These positive feelings helped the women to maintain a positive attitude which was integral to their ability to cope. This positive attitude was often rooted in high self-esteem and confidence. Furthermore, the women actively engaged in a number of coping strategies such as leaning on their friends and family for support, practicing their faith and participating in hobbies. Overall, the women played an active role in minimizing their distress and ensuring their mental health and well-being.

CHAPTER FIVE: DISCUSSION

The conceptual framework adopted for this study is based on an ecological model for immigrant women's health developed by Thurston and Vissandjée (2005). Currently, the population health approach that guides Canadian program and policy development consists of a health determinants model that includes twelve determinants, all of which exercise a role in determining the health of Canadians. These twelve determinants include: 1) income and social status; 2) social support networks; 3) education and literacy; 4) employment/working conditions; 5) social environments; 6) physical environments; 7) personal health practices and coping skills; 8) healthy child development; 9) biology and genetic endowment; 10) health services; 11) gender and 12) culture. The ecological model by Thurston and Vissandjée (2005) maintains that the migratory experience acts as a determinant of health for immigrant women along with the aforementioned determinants of health.

The results of this analysis support this ecological model by demonstrating that migration does indeed act as a determinant of health for immigrant women. Some aspects of the model were not explored directly such as the institutions found at the meso-level. For instance, women were not asked about social and health service utilization nor were policies or the physical environment assessed directly. The subsequent sections of this paper will discuss how the conceptual framework for this study is supported. Particularly, health, gender and lastly migration will be discussed in the context of the mental health and well-being of immigrant women and their perception of it.

Immigrant women's definition of health included both physical and mental aspects with the majority of women indicating that one aspect influenced the other and vice versa. They did not tend to separate mental and physical health in a dualistic manner. Optimal mental health and well-being was perceived as important in attaining and maintaining overall health. This definition of health is supported by Wong & Tsang (2004). Wong & Tsang (2004) examined the way that immigrant women conceptualized mental health. Immigrant women from five ethnic-cultural communities participated in focus group interviews aimed at elucidating the women's perceptions and experiences with regard to mental health. Wong & Tsang (2004) found that the women did not conceptualize mental health as separate from physical health or overall well-being but rather saw their mind acting in conjunction with their body within a complex context that included domains such as work and relationships. Finding balance with all domains in life was deemed important to achieving optimal health.

Immigrant women's definition of health is in agreement with the definition of health promoted by WHO (2006) that states that optimum overall health includes aspects of mental health and general well-being. Interestingly, as stated previously immigrant women do not tend to separate physical health and mental health dualistically. Rather they view health in a holistic manner. Canada's health care system however, contradicts this definition of health by the way it is organized in a dual manner with treatment services specifically focused on either physical or mental health.

The WHO (2000) mental health definition was adopted for this study as a means to supplement the definition of health (WHO, 2006) and to provide a more detailed definition of mental health as this was the primary focus of this study. This mental health definition defines mental health as the capacity of the individual, group and environment to interact in a manner that promotes subjective well-being and the optimal development and use of one's cognitive, affective and relational abilities. This interaction leads to the achievement of individual and collective goals that are consistent with justice and fundamental equality. The basis of this definition removes sole responsibility from the individual and recognizes that mental health is determined by multiple factors, the individual, group and environment. It also highlights the role that social context plays and the importance of justice and fundamental equality in attaining and preserving optimal mental health (WHO, 2000).

The results of this study showed that immigrant women had pronounced cognitive, affective and relational abilities to interact with their surroundings. They had a healthy capacity to interact with surrounding groups and environment and hoped that in the long-term immigrating would bring prosperity and opportunities for more satisfying interactions. However, the capacity of the surrounding groups and environment to promote optimal mental health and well-being for the women was lacking. The women were met with many difficulties upon immigrating that were out of their control.

For example, the lack of acceptance of their education credentials and requirement of Canadian work experience by Canadian organizations disabled the women from using

their cognitive abilities to their full potential. Canadian employers and organizations were not willing to hire them based on their current credentials yet there did not exist avenues for the women to upgrade their education to Canadian standards that did not prove to be time consuming and expensive. One woman also described encountering discrimination in her quest to find employment and others may not have recognized this had happened. Ultimately, the achievement of the individual goals of immigrant women and the collective goals of Canadian employers were not consistent with justice and fundamental equality.

Difficulties with income and social status coupled with dealing with the loss of their social support network tested the women's affective ability. Emotional distress was experienced by the women in feelings of sadness, anxiety and stress. This emotional distress was also associated with the desire to provide their children with a comfortable and improved quality of life. A better future and greater opportunities for children were often cited as reasons for immigration by the women indicating that their mental health was partly determined by the health and happiness of their children. Their relational abilities then also were affected by the circumstances they faced upon immigration through their struggle with their perceived inability to provide their children with a comfortable standard of living.

The majority of the women in the present study spoke of feelings of sadness, anxiety, worry and loneliness. The women continued to experience emotional distress as long as the issues they perceived as problematic remained unresolved. Therefore, it appears that

the mental health and well-being of the women was not dependent upon length of time since migration. This finding is supported by international research conducted on the effect of time on the psychological distress experienced by immigrants (Lerner, Kertes, Zilber, 2005). Lerner, Kertes and Zilber (2005), carried out a nationwide study in Israel which included a sample of 600 men and women who immigrated to Israel from the former Soviet Union. These researchers found that variables such as age, income, employment and host language proficiency were strongly associated with psychological distress and that the psychological distress experienced by the participants did not significantly diminish over time. More specifically, it is the loss of financial and social status, loss of their social support network and non-recognition of their education and the difficulty associated with rebuilding these aspects of their lives that have made immigration a difficult and extended adjustment for them.

Loss of income and social status resulted in feelings of sadness, uncertainty, anxiety, and stress for women in this study. Some were resigned to working lower paying jobs and lower grade jobs compared to the jobs they held in their home country. Thus, they had given up hope of regaining their old identity, but held hope for their children's success. The results of the present study of the experiences of immigrant women are consistent with other research studies in immigrant health. Ahmad et al. (2004) found that mental health did not become a concern for the immigrant women in their study until after immigration. In their discussion of mental health they identified several stress inducing factors such as loss of social support, economic uncertainties and downward social mobility. Other factors included living a mechanistic lifestyle which they defined as

living very busy hectic lives without sufficient time for leisure activities and sometimes not having enough time to fulfill their expected gender roles such as wife, mother and homemaker. This finding is also in line with the present study. When immigrant women were asked what they would like to change in their lives many responded with wanting to change the amount of time and money they had so that they would be able to have more time for themselves and so that their family would be able to pursue leisure activities.

Likewise, in their study with Jordanian women in the United States Hattara-Pollara and Meleis (1995) found that feelings of loneliness, social isolation, loss of social status and the difficulties posed by a language barrier all persisted as stressors in the women's lives during the period of settlement after immigrating. The language barrier also posed difficulty for some women in the present study in being unable to communicate with physicians and nurses. This indicates that language potentially hinders immigrant women's ability to access appropriate and timely health care.

Surprisingly, in the present study only one woman described feeling bad when she perceived she was being discriminated against when applying for a job. This perceived discrimination caused feelings of anger and hurt. The single mention may be because the interview guide was largely based on health related questions. If the women in the present study had been asked directly about discrimination perhaps more incidents would have emerged. Furthermore, discrimination and racism tend to be very emotional and controversial topics thus influencing individual's openness to discuss it.

Similarly, Hattara-Pollara and Meleis (1995) found that the immigrant women in their study spoke of feeling unaccepted and marginalized by their neighbours disallowing them from establishing a sense of belonging and from truly becoming integrated into American society. This feeling was also identified by Thai immigrant women in Brisbane, Australia (Jirojwong & Manderson, 2001). In their study of immigration and health Jirojwong and Manderson (2001) found that Thai women in Brisbane, Australia experienced discrimination and racism by their employers and their neighbours which led to additional stress for these women. They described feelings of sadness and unacceptance when attempts to establish friendships with their neighbours were met by fear and anger.

There is evidence to show that racism and discrimination does indeed exist in Canada. For example, an Ethnic Diversity Survey conducted by Statistics Canada in 2002 revealed that 36% of visible minorities reported experiencing discrimination and unfair treatment in Canada. Furthermore, 74% of those surveyed indicated that they believed that discrimination and racism continued to be prevalent in today's society (Department of Canadian Heritage, 2005). Currently, the Department of Canadian Heritage, a division of the government of Canada, has developed and is implementing an action plan to combat racism and discrimination in Canada. The Department of Canadian Heritage is responsible for developing national policies and programs that promote Canadian content and foster cultural participation among its citizens. Its goals are to promote active citizenship and participation in Canada's civic life, and to strengthen connections among Canadians. This purpose of this action plan is to work with various partners and

organizations in Canada to combat and ultimately wipe out racism in Canadian society. The government of Canada showed its commitment to this action plan by including a total of $56 million in the 2005 Federal Budget for such initiatives (Department of Canadian Heritage, 2005).

Gender as a determinant of health was identified during the analysis in many ways. For instance, the results of the present study indicate that immigration may be experienced in gender specific ways. Throughout the analysis gender was observed in the roles and responsibilities of immigrant women, the role strain they experienced, gender-based violence and coping efforts.

The majority of the women in the present study were solely responsible for the child rearing and household duties. This gender ascribed role was also expected of them in their home country however, many of the women had additional help with their role in the form of hired help and extended family. Upon immigrating the expectation remained the same without the additional help. Furthermore, some women also worked outside the home to help support the family financially adding a great deal to their workload. This adjustment proved very difficult for many of the women as they were not accustomed to doing everything themselves.

Taking on multiple roles is something many women in Canada struggle with regardless of their immigration status. For example, Walters (1993) conducted a study with Canadian women to determine their perceptions of their mental health. During the

interviews the women were presented with a list of 67 physical, mental, social and economic problems and were asked whether they had experienced any of them in the last six months. The women reported experiencing mental health problems the most frequently. Among the mental health problems, stress, anxiety and depression were reported most often as persistent factors that influenced their mental health and were related to the extensive demands placed on the women. Feelings of stress, anxiety and depression associated with multiple roles were also found in the present study. A majority of the women in Walters (1993) study also reported tiredness, lack of time for themselves and sleep difficulties. In their discussion of their mental health these women spoke of the demands they faced everyday in regards to balancing work and their family responsibilities. For some the need to work outside of the home was based on financial need rather then a desire for career achievement. These multiple demands resulted in the women feeling overloaded and they expressed a great desire to be able to take a break and have time to dedicate to their own happiness. The results of the present study show that similar to Canadian born women immigrant women are often faced with the challenge of taking on multiple roles of mother, wife and paid worker. This gender ascribed role can cause a great deal of stress and anxiety for women.

Immigrant women also are exposed to gender-based physical and emotional abuse at the hands of their intimate partners. Some women described living in constant fear of their husbands and constant nervousness related to the trauma they experienced. Gender-based violence stems from the socially constructed power differential between men and women and the acceptance of aggression and violence as masculine and submissiveness as

feminine (Howard & Hollander, 1997; Nelson & Robinson, 2002). Violence against women by their intimate partner or men not known to them is a pervasive problem all over the world and is a prevalent cause of depression amongst women (WHO, 2000). Domestic violence is a phenomenon that does not discriminate by race or class. Research has shown that it is on the rise in all cultures, societies, and socio-economic groups (Nelson & Robinson, 2002; WHO, 2000). Therefore, one may speculate that the effects and consequences of domestic violence are the same for women regardless of their immigration status.

Research has shown that women who have experienced violence have increased rates of depression, anxiety, stress related conditions, addiction and medical symptoms (WHO, 2000). Similarly, the women in the present study who experienced violence at the hands of their husbands reported feelings of helplessness, anxiety and depression.

It may be that the effects and consequences of domestic violence is similar for immigrant and non-immigrant women however, they may differ in the way they respond and cope with violence. For example, their responses and coping strategies may be guided by their cultural beliefs and the cultural environment they live in (Yoshihama, 2002). Culture may also play a role in the way that immigrant and non-immigrant women experience domestic violence. Ayyub (2000) highlights some of the obstacles that Muslim women face in overcoming domestic violence such as their culture which is often dictated by religion. Muslim culture often shapes the roles men and women are expected to fulfill within the family unit. Women are expected to be patient, tolerant and sometimes

subservient with their husbands. Women are expected to be willing to make any and all sacrifices necessary to maintain a marriage even if it is to their detriment. Complying with the expectations of being a traditional wife within the culture offers Muslim women respect and status. Not complying with expectations and leaving their marriage brings shame to the family and brings outrage and ostracism from the Muslim community. Therefore many Muslim women stay in the marriage for fear of the consequences. Some Muslim women hold the belief of maintaining a marriage at all costs and being a patient and tolerant wife is their duty as a woman (Ayuub, 2000). Literature is scarce on the differences between immigrant and non-immigrant mental health among women experiencing domestic violence. Consequently, more research is required in order to ascertain whether a true difference in fact exists.

There is limited research on the factors that influence the mental health and well-being of immigration versus non-immigrant women. A question may be raised regarding whether a true difference between immigrant women and non-immigrant women in their experiences related to mental health and well-being in fact exists, or whether distress is caused by the experience of loss, gender and/or economics independent of one's immigration status. In this study immigration impacted the mental health and well-being of immigrant women by exposing them to circumstances they would have otherwise not experienced. A great deal of their emotional distress was brought on by the experience of loss in regards to their income and social status, employment, education and social support network. The stress and pressure of having to start over in every aspect of their lives proved to be overwhelming for the women. One can argue that non-immigrant

women may also experience distress if they experienced loss of their income and social status, social support network and were placed in a position of financial uncertainty.

When faced with adversity the women proved to be very resilient and had a great capacity to deal with the challenges they encountered. The majority of women spoke of utilizing different methods of coping in the presence of adversity. Most realized that actively using coping strategies was integral to moving forward with their lives and persevering. The most common coping strategy for the women was to access their existing social support network that most often consisted of their children, husbands, friends and their place of worship. Encouragement and support was sought from their social support network through talking out their feelings and problems. This finding is in line with current research in gender and coping. Research shows that men and women use problem-solving coping to the same extent however, they differ in their use of emotion-focused coping. A consistent finding is that women are more likely than men to seek out emotional support as a means of alleviating distress (Rao, Mridula & Subbakrishna, 2003). Other methods of coping included passing time with hobbies such as sewing, watching TV and taking walks. Similarly, research conducted with South Asian women by Ahmad et al. (2004), showed that this group of women recognized the importance of actively trying to ease and overcome their worries, stress, anxiety and feelings of depression. The women in the study actively engaged in similar forms of coping as the immigrant women in the present study (Ahmad et al., 2004). Particularly, they discussed making increased efforts to make friends and socialize as a means to relieve stress and to have friends to talk about their difficulties with.

Progress in recognizing that women and men may experience health and the health care system differently has been made in the recent past. Gender is a determinant of health that was only recently adopted into Canada's health policy, upon recognition that gendered norms of the dominant culture dictate and strongly influence the health risks faced by women and that there do exist gender differences in health (Public Health Agency, 2002). For example, research shows that women are more vulnerable then men to gender-based violence, low income, lone parenthood, and exposure to health risks such as smoking, suicide and substance abuse (Public Health Agency, 2002; WHO, 2000). For this reason and in order to ensure gender equality it is important for health program and policy makers to take gender into account in the development of health and social policies and programs. Gender-based analysis was introduced in 1995 by the federal government of Canada in an attempt to address the need for equality in all aspects of life between men and women (Status of Women Canada, 1998). Gender-based analysis is the assessment of existing policies, legislation and programs and those in development for the differential impacts that they might have on men and women. It brings forth the notion that men and women are not impacted by health policies and legislation the same way. It provides a base for the development of program and policies that promote equality and takes into account the difference between men and women and how they experience social and economic circumstances (Status of Women Canada, 1998).

In light of the fact that nearly half of Canada's citizens (47%) are of an ethnic origin other than British, French or native-born Canadian, research on immigrant health is integral to understanding the unique social and health needs of this growing population

(Department of Canadian Heritage, 2005). Migration is often a decision made by families that is based on the goals they might achieve and the perceived opportunities available in the host country. Often times the decision is based on the wants and desires of the parents for a wealthy and prosperous future for their children. Other times, migration may be an emergent need due to the political turmoil and safety issues prevalent in their home country and the desire for more freedom. Unfortunately, the positive expectations associated with the outcomes of immigration are not fulfilled for many immigrant families (Bhattacharya & Schoppelrey, 2004; Grimaud, 1993).

The mental health and well-being of the immigrant women in this study were impacted by being exposed to circumstances that they may have not been exposed to had they not immigrated. These circumstances had a negative influence on their mental health and well-being. Many women spoke of experiencing feelings of sadness, loneliness, anxiety, worry and stress related to a number of inter-related factors. Multiple role strain was experienced by the women after immigrating to Canada as many found themselves working outside the home in addition to fulfilling the traditional role of mother, homemaker and wife. Feelings of sadness and worry occurred as a result of unemployment and underemployment which consequently led to low income and financial strain. Their employment status was often determined by their education status. The majority of the women were educated in their home country and worked in careers such as, teaching, engineering and science prior to migrating. However, many Canadian employers did not recognize their education as equivalent to Canadian standards making obtaining comparable employment extremely difficult. Some women settled for jobs in

cleaning and childcare out of necessity. For these reasons, the majority of women were not able to maintain their income and social status in Canada. Many of the women described having a downward shift in all aspects of their standard of living upon immigrating to Canada invoking feelings of loss, frustration and stress around rebuilding their lives.

The importance of conducting research in immigrant women's health is evidenced by the limited amount of literature that currently exists. The amount of literature on the mental health and well-being of immigrant women is far scarcer (Hyman, 2004; Beiser, 2005). The present study adds to the current knowledge base on the stressors that immigrant women face post migration and their ways of coping. Utilizing a determinants of health framework that included migration as a determinant of health allowed for the development of a description of how immigrant women perceive their mental health and well-being in relation to the determinants of health and its connection to the experience of migration. Furthermore, the results of this study also add insight to understanding immigrant women's mental health and what is necessary to improve and maintain their health over time.

A major limitation of secondary data analyses includes the potential disparity between the purpose of the original research with that of the secondary. This problem with the fit of the data can lead to erroneous and invalid findings (Thorne, 1998: Hinds, Vogel, Clarke-Steffen, 1997). The fit of the purpose and research questions of this secondary data analysis was evaluated with the assistance of the primary investigator. The primary

investigator provided rich detail on the original study purpose, sampling strategy, data collection, target population and research questions and was confident the original research study was amenable to a secondary data analysis that focused on mental health. Therefore, the student is confident that this limitation was overcome. Another potential limitation of this study includes the use of an English interviewer. This has the potential of limiting the amount of information that the women were able to provide during the interview. Even though the women who participated in the study were recruited from ESL classes a few struggled during the interview in understanding the questions they were being asked and at times their responses were difficult to understand. The interviewers however did an exceptional job with clarification aiding in the understanding of the participants discussion. Although the use of translators or multilingual interviewers may minimize this problem it proves to be very costly and not feasible.

As previously discussed, discrimination and racism were not as evident as in the existing literature on the stressors faced by immigrant women. Perhaps it was not evident because the purpose of the original study and the secondary study was situated around health and thus the questions in the interview guide did not directly address experiences of racism or discrimination. This is an area where utilizing secondary data created tension between research question and available (secondary) data, and may have been explored if the student had the opportunity to go back to the field to address the issue of discrimination and racism with the women. Another possible explanation may be related to conducting the interviews in English. The woman that identified encountering discrimination

appeared to be quite fluent in English and was able to pursue a discussion with the interviewer at great length. Interviewing the women in their mother tongue may have allowed the women who were not completely fluent in English and perhaps still not comfortable in speaking English to be more forthcoming and detailed in their responses.

The purpose of this analysis was to explore and discover how midlife immigrant women residing in Alberta perceive their mental health and well-being. More specifically, the aim of this analysis was to identify 1) what issues of mental health were experienced by the immigrant women in this study; 2) what the women identified as their mental health needs; 3) what factors impacted their mental health and well-being; 4) what was the capacity of these women to overcome potential challenges encountered post immigration and 5) how immigration impacted their mental health and well-being.

This analysis revealed that the women in this study experienced a number of negative feelings. Most commonly, the women spoke of feelings of sadness, loneliness, anxiety, stress and worry and in the worst cases depression. Their distress also was evidenced throughout the interviews as some cried while they spoke. The women described the effect of these negative feelings on their physical health often describing physical symptoms of sleep difficulties, fatigue, headaches and weight loss due to loss of appetite. Feelings of optimism, pride and hope were also spoken of in the context of rebuilding their lives and their experiences with immigrating to Canada. These feelings were common among the women and carried great weight in their determination and motivation to establish themselves in Canada.

The identification of the feelings that immigrant women experienced required much reflection and thought. Further reflection on the student's background in mental health and psychiatry allowed the student to realize that there is a potential tendency to pathologize negative feelings such as sadness and depression as bad. This further reflection offered an alternate explanation for the existence of negative feelings. Although negative feelings experienced by immigrant women are individual and may be pathologized by those using a biomedical paradigm these negative feelings may be explained by looking outside the women at the factors that contribute to the experience of negative feelings. Upon immigrating to Canada immigrant women experienced a variety of losses induced by systemic factors that were outside of their control. Rather than pathologizing negative feelings as bad one could explain their existence as a healthy and appropriate reaction to the experience of loss. Perhaps these feelings served a function in the process of grieving by immigrant women allowing them to accept their losses and to incur the strength and determination to rebuild their lives in Canada.

Immigrant women identified their mental health needs in a practical sense indicating a need to be relieved from the stress caused by their income and employment status. Most commonly they claimed that they needed to increase their income so that they could lead comfortable lives and provide their children with an improved quality of life. An increase in income would relieve them of the financial strain they were under and would alleviate them of the stress and worry they experienced due to economic hardship. For some an increase income meant that they would be able to travel back home to the family they left behind and dearly missed. The women often spoke of experiencing sadness in

relation to missing the family they left behind. The need for balance was also something the women talked about. Balancing their home life with work was something the women found difficult. In relation to balancing their lives there was also a need for self-care. Many women found themselves acting as a caretaker to everyone around them except themselves and desired more time to dedicate to their own happiness.

Many factors influenced the mental health and well–being of the immigrant women in this study. These factors were primarily systemic and included determinants of health such as income and social status, education, employment, gender and social support network. The majority of women were capable, educated, knowledgeable and motivated yet they encountered policies that served as roadblocks preventing them from accomplishing their goals and functioning at their full potential. The results of this study support the view that determinants of health do not work in isolation but rather form complex interactions (Public Health Agency, 2002). The complex interactions between the determinants of health were evidenced by the women's description of their circumstances as each circumstance directly influenced the direction of another. For instance, income and social status were directly influenced by employment and education status. The results of this study lend evidence to suggest that in order to improve the health of the population that program and policy development must focus on addressing health at not only at an individual level but also at a broader systemic level.

Gender based issues such as multiple role strain and domestic violence also had a negative impact on immigrant women's mental health and well-being. Women found

themselves trying to balance their role and responsibilities as mother, wife and homemaker and paid employee. The difficulty in trying to attain a balance created stress for the women. Domestic violence was also an issue that immigrant woman faced causing feelings of sadness, fear and in the worst case suicide attempts. The violence had a detrimental effect on their self-esteem and confidence. They described incidents that included the use of weapons and comments that persisted to terrorize them even when the violence was over. Fears of how the violence impacted their children caused feelings of sadness and remorse.

The social support network of the women also impacted their mental health and well being. Firstly, feelings of sadness and loneliness for the women were related to the pain associated with sorely missing the family they left behind in their home country. The practical and emotional support they received from their family proved to be irreplaceable.

The capacity of the immigrant women in this study to overcome hardships and cope with the challenges they encountered was great. The women persevered through hardship and were determined to rebuild their lives in Canada. This determination was rooted in their positive attitude and sense of optimism and hope. High self-esteem and confidence also contributed to their resiliency and strength. The women played an active role in ensuring their mental health and well-being by actively engaging in coping strategies to minimize their distress. Coping strategies included utilizing their social support network, participating in hobbies and practicing religion.

This study shows that migration impacts the mental health and well-being of immigrant women by exposing them to circumstances they may not have otherwise experienced. A large majority experienced negative feelings associated with loss. Loss took many forms and included loss of their social support network, loss of income and social status, loss of education, loss of language, loss of their careers and in some cases loss of their independence. Consequently, the women incurred a loss of identity as a result of having the characteristics that made them who they were as individuals stripped away upon migrating. Many women were made to grieve their losses in the midst of trying to adapt to a new culture, social and physical environment.

Progress has been made in removing some roadblocks encountered by the immigrant population in recent years. One example is the Alberta International Medical Graduate Program (AIMG). The AIMG provides access to graduates of medical schools outside Canada or the United States to post graduate residency training in Family Medicine or Specialty disciplines. This program was set up in an effort to assist international graduates in establishing their careers in Canada (Alberta International Medical Graduate Program, 2005). Furthermore, programs have been developed specialized in the treatment for refugee survivors of torture (SOT). The SOT program was developed in Calgary in recognition that this population has unique physical and mental health needs. The SOT Program's primary goal was to facilitate access to community health services and establish services for survivors of torture that were competent, organized and readily available (Ramaliu & Thurston, 2003).

Immigrant women are capable, knowledgeable, educated and highly motivated and given the resources and opportunity they would be able to achieve their goals and work at their full potential. Evidence of immigrant women's high self esteem and confidence ran through the entirety of the analysis in their descriptions of themselves as having a lot to offer that could be readily demonstrated if given the opportunity. Women's perseverance and determination was evidenced by their relentless search for employment and educational opportunities in spite of being faced with many obstacles. These women's reactions of sadness were reasonable and they demonstrated what they really needed was access to gainful employment and education as a means to provide for their children.

Further progress needs to be made in removing the roadblocks encountered by immigrant women. Canadian polices and programs must be reviewed in order to facilitate immigrant women in rebuilding their lives in Canada and becoming productive members of Canadian society. The implementation of AIMG is one step towards the right direction. As much of immigrant women's negative feelings were directly associated with the non-recognition of their education more effort in creating programs such as AIMG in other professions should be made.

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APPENDIX A: INTERVIEW GUIDE

INTERVIEW GUIDE - WOMEN'S HEALTH STUDY IMMIGRANT WOMEN

Research Question:

What do mid-life Alberta women identify as their health issues and needs, the correlates of these issues, and the connection between the two?

IMPORTANT HEALTH ISSUES

Q). What does it mean to you to be healthy/ill?

Q). Where are you on a scale from 1 (ill) to 10 (healthy) ?

Q). Tell me about an important health problem you have ?

RELATED HEALTH FACTORS

Q). What do you do to stay healthy ?

Q). What makes you feel good ?

Q). What makes you feel bad ?

Q). What do you do when you are sick ?

FAMILY INFLUENCES

Q). Tell me about a typical day in your life from when you wake up to when you go to bed?

Q). Do you have children and/or other people you take care of in your home ?

Q). Do you have help to take care of them ?

Q). Do you have other relatives/friends that live close by ?

Q). How do you make major decisions (ie.money) in your family ?

Q). What is your role in your family ?

Q). How do you feel about your role ?

Q). Has your family, in past or now, ever been rigid or strict ?

Q). Has someone important (ie family member/partner) to you ever hurt you or made you feel bad ?

Q). Have you ever been in the past or now in an abusive or violent relationship ?

RESOURCES/COPING

Q). What do you do to cope with your health problems ?

Q). How did you decide who would be your family doctor?

Q). When do you go to your family doctor ?

Q). Would you talk to your family doctor/nurse about a personal/family problem ? If not who would you tell ?

Q). Where do you get your information about health, give me an example (source/type) ?

OCCUPATIONAL HEALTH CONCERNS

Q). What do you and your family do for money ?

Q). What do you like about your work ?

Q). What do you not like about your work ?

Q). What do you do when you have a big problem at your work ?

Q). Is money a problem for you and your family ?

Q). Demographic question on socioeconomic category and income.

IMMIGRATION

Q). What was it like immigrating to Canada?

Q). Tell about your health before you immigrated to Canada ?

Q). Were there major changes in your health after you immigrated?

Q). How has your life changed (ie. work, social status, family, education) after immigrating to Canada ?

Q). Do feel you like you belong to Canada ?

Q). Where do you feel most comfortable, in Canada, or in your home country ?

CLOSING QUESTIONS

Q). Have you had any major changes in your life (family, work, school) ?

Q). What you would like to change in your life ?

Begin Demographic Questions....

APPENDIX B: ETHICS APPROVAL

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

2006-01-12

OFFICE OF MEDICAL BIOETHICS

Room 95 Heritage Medical Research Bldg
3330 Hospital Drive NW
Calgary, AB, Canada T2N 4N1
Telephone: (403) 220-7990
Fax: (403) 783-8024
Email: omb@ucalgary.ca

Dr. W.P. Thurston
Community Health Sciences
University of Calgary
Calgary, Alberta

Dear Dr. Thurston:

RE: Perceived issues of mental health and well-being of mid-life immigrant women

Grant ID: 16956

Masters / PhD Student: Aparicio, Paola

The above-noted proposal, including the Thesis Proposal (Dated November 2005) has been submitted for Board review and found to be ethically acceptable.

Please note that this approval is subject to the following conditions:
(1) access to personal identifiable health information was not requested in this submission;
(2) a copy of the informed consent form must have been given to each research subject, if required for this study;
(3) a Progress Report must be submitted by 2007-01-12, containing the following information:
- i) the number of subjects recruited;
- ii) a description of any protocol modification;
- iii) any unusual and/or severe complications, adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, or complaints about the research;
- iv) a summary of any recent literature, funding, or other relevant information, especially information about risks associated with the research;
- v) a copy of the current informed consent form;
- vi) the expected date of termination of this project.

(4) a Final Report must be submitted at the conclusion of the project.

Please note that you have been named as the principal collaborator on this study because students are not permitted to serve as principal investigators. Please accept the Board's best wishes for success in your research.

Yours sincerely,

Gloria Gutwinski-Jeffreys, RPT, PhD

Chair, Conjoint Health Research Ethics Board

GG/ab

cc: Dr. L. Nieuwendyk (Information) Research Services Ms. P. Aparicio (Masters / PhD Student)
Office of Information & Privacy Commissioner

APPENDIX C: ORIGINAL CONSENT FORM

WHEALTH STUDY
INFORMED CONSENT FORM

PROJECT: The Perceived Health and Health-Related Experiences of Mid-Life Women
(The WHEALTH Study)

INVESTIGATOR: Lynn M. Meadows, Ph.D.
The University of Calgary
Depts. of Family Medicine and Community Health Sciences

FUNDING AGENCIES: Alberta Heritage Foundation for Medical Research,
Faculty of Medicine Endowment Fund, University of Calgary,
SEARLE,
Prairie Centre of Excellence for Research on Immigration and Integration

What is an informed consent form?

- This consent form, a copy of which has been given to you, is only a part of the process of informed consent.
- The informed consent form should give you a basic idea of what the research project is about, and what your participation will involve. Please take your time to read this carefully and to understand the accompanying information. Please feel free to ask if you would like more detail about something mentioned here or information not included here.

What is this study about?

- This study is investigating the perceived health and health-related experiences of mid-life women in Alberta. "Mid-life" is defined as between the ages of 40 and 65 inclusive.
- It is a descriptive and exploratory study, focusing on women's experiences and their reports of them. We are particularly interested in how social, cultural and physiological characteristics of women and their environment affect perceptions of health and wellness.
- The research questions that are being asked are:

  What do mid-life Alberta women identify as their health issues and needs?
  What factors affect these issues?
  What is the connection between the identified issues and the factors that affect them?

What does participation in the study involve?

- As a participant in this study, you will be asked to take part in a face-to-face interview with a member of the research team. The interview will be scheduled at your convenience at a location of your choice, and will take approximately 1-2 hours depending on the number of topics you wish to discuss. The interview will be audio recorded, and transcribed verbatim for analysis.
- Participants in the study may also be asked for permission for potential follow-up contact for a second interview, or to participate in a focus group discussion. You are free to decline further participation in the study at any time.
- At the conclusion of the study, a summary of the study will be provided to all participants upon request.

What are the rights of a participant?

- You have the right to know what this study is about, and what your participation will involve. Your continued participation in the study should be as informed as your initial consent, so you should feel free to ask for clarification or further information throughout your participation in the study.
- Your participation at one stage of the study carries with it no obligation for further participation in the study. You may withdraw from the study at any time without any jeopardy.
- You are guaranteed anonymity in this study. To ensure anonymity, all names of participants will be replaced by an identifying code which will be used throughout the duration of the study. Only the member of the research team actually conducting the interview will know your name, and the interviewer will keep this information confidential. At no time will your name be associated with the tape or the transcript of the tape.
- This study originates from the Departments of Family Medicine and Community Health Sciences; however, it has no bearing on your health care that may be associated with that department.
- Your participation in the study, and your signature on the informed consent form in no way waive your legal rights, nor release the investigators, sponsors or involved institutions from their legal and professional responsibilities.
- If you have any questions regarding the research study, you may contact:
  Dr. Lynn Meadows,
  Department of Family Medicine and Community Health Sciences
  Phone: (403) 220-2752.
- If you have any questions concerning your rights as a possible participant in this research, you may contact:
  Office of Biomedical Ethics, Faculty of Medicine, The University of Calgary
  Phone: (403) 220-7990.

Your signature on this form indicates that you have read and understood to your satisfaction the information provided above in this consent form regarding your participation in the research project, and that you agree to participate as a subject. Signing this form in no way waives your legal rights, nor releases the investigators, sponsors or involved institutions from their legal and professional responsibilities. You are free to request further information on the study throughout your participation, and you are free to withdraw from the study at any time you desire without any jeopardy.

_____

signature of Principal Investigator,
Lynn Meadows, Ph.D.

_____ _____

name of subject (print) name of witness (print)

_____ _____

signature of subject
(or responsibly proxy, if applicable) signature of witness

_____

date

A COPY OF THIS CONSENT FORM IS GIVEN TO YOU.
PLEASE KEEP IT FOR YOUR RECORDS AND FUTURE REFERENCE.