THE ORGANIZATION OF SOCIAL SERVICES AND ITS IMPLICATIONS FOR THE MENTAL HEALTH OF IMMIGRANT WOMEN

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Authors' Note

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Primary writing for Chapters I, II, and III was done by Marilee Reimer. Primary writing for Chapters IV and V was done by Ana Bodnar. Editing of the Report was done co-operatively.

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INTRODUCTION

The general concern of the study is with the accessibility and relevance of social services to immigrant women experiencing "mental health" problems. The research focuses on the delivery of services for the low income Spanish and Portuguese speaking woman. The study was initiated because community workers saw a serious inadequacy in the social service delivery system for immigrant women. They found that many non-English speaking women were going to community centres for help rather than using family services and health care agencies. The adequacy of the existing social services to meet the present needs of immigrant women is the central issue under investigation.

This study has revealed a wide gulf between the established social and health care services and the needs of immigrant women. The professional ideologies and working practices she encounters reformulates her problems according to the institutionalized definitions of reality. These do not accord with the ways women describe their own experiences in the Canadian context. The problems women face are handled by agencies in individual terms as problems of "mental illness" or cultural background. These approaches prevent a woman from seeing her difficulties in relation to the social contexts in which they occur. The individual becomes the problem: her cultural background, her mental state. The social matrix of her experience is not relevant. A disjuncture is created between the official explanations and the actual situations which created difficulties for her to begin with.

Many immigrant women experience distress and emotional upset accompanying their current difficulties in Canada. These women often come

into contact with formal agencies and professionals in seeking practical solutions to the dilemmas they face. From the women's discussions of their lives, a picture emerges of their common problems as non-English speaking immigrants and as women in an industrialized urban setting. In order to make this visible, it was necessary to portray the situation of the women clients themselves, from their perspectives.

The low income immigrant woman's life is organized in such a way that she is in a dependent status socially, in the labour force and in the home.* The institutional structure of her entry into Canada places her in a second class status as a sponsored immigrant. This is maintained in her contact with government agencies providing language and training skills for entry into the labour force. This dependency is a taken-for-granted condition of her situation in Canada and is preserved in the institutional contexts of government and the professions. A woman's inability to transcend these circumstances is taken as evidence of her lack of motivation to "adapt" to her new life in Canada.

Especially for the low income woman, the organization of her daily life creates problems for her which are a condition of her position in Canadian society. These arise in relation to the kinds of work she can find, the economic difficulties faced by low income families with few resources and her dependent status within the family. It is the social context of her everyday life which produces the crises, breakdowns and seeking of alternatives to unacceptable and intolerable living conditions.

When a woman comes into contact with the established settlement and family service agencies, the courts, etc., however, her situation as one which allows her few alternatives remains invisible. Along with many of

* Most women enter Canada as dependent immigrants, although there are a few who enter in the independent class. The "sponsored", "nominated" or "family class" immigrants are the categories of dependent status, i.e., for those who enter the country on the assistance of another family member who is defined as the "head of the house-hold" by the immigration act. Since the change of the act in 1976, the sponsored category has been replaced by "nominated" or "family class".

the health care agencies, institutionalized approaches to immigrant women focus on her as an individual and reformulate her problems as merely "emotional" or in terms of her cultural background. The 'givens' of her situation are not put into question, and therefore, her understanding of her situation is invalidated and attempts to change it are not supported. The psychiatric approaches to immigrant women are the most marked examples of this way of thinking and treating women. The practices of doctors and psychiatrists shift the focus from the external obstacles she faces to how she might better perform the traditional obligations of wife, mother, daughter, sister. The woman as an autonomous person with legitimate grievances is specifically invalidated.

From the perspective of the community workers* working exclusively or primarily with women, the inadequacy of services is a daily problem. Agencies with mandates to provide settlement services to the newly arrived immigrants are overloaded with women needing to discuss their situations in Canada and the possibilities for doing something to change them.

These agencies see mainly low income women who are experiencing various kinds of problems. For example,

a. She has been denied ESL benefits from Manpower three times but is unable to practice her profession without English.

b. She is trying to find a lawyer for a divorce and a job, because she has been beaten by her husband for ten years and can't take it any longer.

c. She is working shiftwork, her husband is having an affair with another woman and she never sees him at home.

d. She is daily harassed on the job by the foreman who is known to have forced other seamstresses to have sexual intercourse with him or get laid off.

* 'Community workers' will be used to denote those social service workers in agencies providing primarily settlement services, or the same services to people who have been here longer than the 36 month limit designated for the funding of such services.

e. She is having difficulties getting her children to obey her and the school has notified her that her son is failing first grade.

f. She has been denied workmen's compensation benefits because her foreman denies that she hurt her back at work.

g. She and her husband no longer communicate with each other, and he has had a series of girlfriends; she wants to leave, but she can't get welfare as a sponsored immigrant.

The list of difficulties faced by the low income immigrant woman is a long one, and she, like her Canadian counterpart, is very likely to go to social service agencies for help. However, for the majority of these women, who are non-English speaking, social services are not directly accessible as adequate interpreters are often not provided, nor are they necessarily supported to improve their situations. The agencies which attempt to provide settlement services are put in the position of counselling and supporting immigrants through their dealings with the government bureaucracies and the labyrinth of the labour market.

Since the difficulties faced in Canada do not end at the 36 months set by "settlement" funding criteria, community workers find themselves providing services for free.* And especially for the non-English speaking clientele, there are often few if any places to refer a person for individual or family counselling in their own language and by someone who is supportive. It also becomes questionable whether counselling or "therapy" per se are the most appropriate alternatives for women in the situations considered. For those who have been referred to mental health or other health professionals, women's reports suggest that their problems are ignored or misunderstood, and that pills are dispensed to maintain them in an unsatisfactory situation. Generally, this kind of feedback was made in

* The untenability of the 36 month funding limit was acknowledged by Joe Clark, Member of Parliament and leader of the Conservative party, in a letter to the Organization of Community Agencies Serving Immigrants, on May 15, 1979. The new government has not yet changed the criteria to fund services beyond the 36 month limit.

relation to doctors, psychiatrists and social workers.

Professional approaches to immigrant women's problems are institutionalized in the social and health care services. These are developed in the scientific discourses of social work, medicine and institutionalized psychiatry. They will be examined as professional modes of organization which articulate women's experiences to the available social service systems. Psychiatric and other professional approaches will be considered in the broader context of social relations of Canadian society. Of special interest is the use of psychiatric ideologies and practices in reinforcing and maintaining women in a subordinate, dependent relation in the family and on the labour market. The possibility of starting from the standpoint of women when talking about their problems is examined in this report as an alternative to these approaches.

From our study we came to the conclusion that those agencies which work closest to immigrants in the community were most effective in offering practical help to women. The provision of effective, practical solutions depends greatly on the ability of social service workers to understand the realities of immigrants' lives in Canadian society. The closer an agency's approach to the everyday realities of immigrant women, the greater its ability to respond to their concrete needs. We found that in the established health and social services, professional ideologies and practices create a distance between the official understandings and the actual situations of women. We have designed the format of this report in such a way as to illustrate how this distance is created in the organization of social services. Our discussion of alternative approaches in community services is oriented to seeing how services could be set up to provide the most effective forms of support. Specifically, we want

to view what kinds of services are most effective in helping immigrant women to help themselves, to become self reliant and eventually independent of the social service network as much as possible.

In Chapter II, The Immigrant Woman, the economic and social dependence imposed upon the working class women immigrant in Canada will be discussed. This dependence translates into an economic dependence on men; however, it doesn't begin or end there.[1] While examining the experiences of the non-English speaking women we have interviewed, we explore the role of the Manpower and Immigration policies in structuring their relation to the labour market, the society and the family. The organization of the labour market is also viewed as it is consequential for her life. The professional ideologies of "mental illness" and "ethnic difference" will be examined in light of the lives of these women in Canada, and of their consequences for the woman trying to better her situation as she sees it.

In Chapter III, women's experiences in the health care system are discussed. The approaches of doctors, psychiatrists and hospital workers in psychiatric units are examined from interviews with professionals. The delivery of homecare services by public health nurses and occupational therapists is discussed.

Family services, government agencies and community centres are the non-medical agencies which are involved in counselling and referring women for psychiatric attention. In Chapter IV, the provision of social services in these settings is examined in terms of their accessibility and relevance to immigrant women in Canada. Alternative programs which have recently been initiated are discussed in Chapter IV. Further programs and recommendations are posed based on the findings of this report.

1. Roxana Ng, The Social Organization of Family Violence: An Ethnography of Immigrant Experience in Vancouver, A report to the Non-Medical Use of Drugs Directorate, Health and Welfare Canada, Vancouver, 1978.

1) Method of Inquiry

The primary approach of the study is the focused ethnography. Central to our focus are the institutional processes in which "mental health" and "mental illness" are defined for the immigrant woman. We have viewed the administration of treatment, services and medical care in terms of their relevance and impact on women's lives.

The research began with in-depth accounts of women's experiences as told from their own perspectives. The women we spoke with became our major informants. We made use of their accounts in the way an anthropologist would treat them, i.e., as informants who are knowledgeable of a particular social organization. In this way we were able to learn from them aspects of the organization of services based on the women's experiences with the service agencies. Interpreters were used for the Portuguese women, and Bodnar interpreted for the Spanish speaking women. An often forgotten perspective, that of the client group themselves, provided accounts of the institutional processes under examination.[2]

It is centrally important to the study to portray accurately the situation of women clients themselves from their perspectives. Women's perspectives were of primary concern in this research because women are not usually allowed to speak authoritatively about their lives. Their perspectives and everyday experiences have not entered into the professional ideologies of medicine and psychiatry, or the formal scientific contexts where "reality" is defined.[3] Women are not generally located in positions within

2. In a study of welfare clients in a government agency in London, Mayer pointed out that social work researchers have rarely been interested in the client's perspectives and understanding of the nature of the service offer. See John C. Mayer and Noel Timms, The Client Speaks: Working Class Impressions of Casework, Routledge & Kegan Paul Ltd., London: 1970.

3. "Women and Psychiatry", Dorothy E. Smith, in Dorothy Smith & Sara David, editors, Women Look at Psychiatry, Vancouver: Press Gang, 1975.

management, administrations and the professions; women's consciousness is excluded from the formal, "objective" views of the world produced in these domains.[4] The non-English speaking, lower income women are even further deprived.

We address the practical organization of supportive services in relation to women's experiences with them. The interface between their experiences and the work processes of the hospital emergency, doctors' offices and social services will be discussed. The analysis of social services and health care delivery is informed by the interviews of those who work in these settings. Whenever possible, observations have been made of how the practical organization, available facilities and personnel affect the kinds of services available for women.

2) Research Design

The research was carried out on an in-depth, case history approach for 10 women, taking a total of 20 hours, and with a structured interview for community workers and health professionals. The women's interviews were taped, detailed notes were taken, and transcriptions were made in order to record the actual replies of the women. Six of the women were clients of a social service agency catering to immigrant women. Because of the difficulty in gaining access to women clients who had contact with the psychiatric profession and were willing to be interviewed, the "snowball" technique was used by interviewing women who were known to the community workers, but who were not clients themselves. This meant that four of the interviewees were not representative of the Centre's clients in that they had more education, spoke English as a second language

4. "Women's Perspective As a Radical Critique of Sociology", Dorothy E. Smith, Social Inquiry, v. 4, no. 1, 1974.

and worked in jobs such as child care worker, stenographer, wholesale sales agent and nursing student. The clients worked or are working as cleaners, factory workers or sewing machine operators. Two are currently unemployed with work related disabilities. They spoke little or no English and were in a low income bracket.

The second group of interviews was made with government, social service and community workers. We interviewed two workers in a government settlement service agency and three workers in two family service agencies. In looking at community-based agencies, we interviewed 13 workers in 6 agencies, two of which cater solely to immigrant women. Four agencies which provide family services and counselling to the larger public were also interviewed, and multilingual workers were seen whenever possible to assess service delivery to immigrant clientele. These agencies were chosen from the reported referral system of the workers and professionals who see Spanish and Portuguese speaking people.

The third group of interviews was made with health care professionals: doctors, psychiatrists, nurses, social workers and interpreters who work in hospital psychiatric services. Four doctors of Latin American, Spanish and Portuguese origin were interviewed; six psychiatrists, two of whom were Canadian born: four nurses; three social workers; two interpreters, one official and one unofficial. Interviews were also conducted with five public health nurses and two occupational therapists who work in public health and home care programs. All interviews were oriented to the delivery of services to the client group discussed. The interview schedules in the appendices were used as guides to allow for a more open ended inquiry. The interviews lasted between one and two and a half hours.

3) Social and Health Care Organizations and Referral Networks

Three major service delivery systems which orient to the needs of Spanish and Portuguese speaking immigrant women are considered: 1) agencies oriented to the provision of family services, 2) community-based agencies, and 3) health care services provided by general practitioners, psychiatrists, hospitals, and home care.

Family service agencies focus their work on the provision of individual and family counselling. Several counsellors in these agencies work with Spanish and Portuguese clients and report that they find themselves overloaded with demands for counselling. The agencies also provide group programs for battered women, isolated individuals, and parents of mentally retarded children, but none of these programs are presently available to Spanish and Portuguese speaking clients.

The majority of the Spanish and Portuguese speaking clients seen by these agencies are low-income and non-English speaking. The policy of the agencies is to gear fees to individual income, or to waive the fee where the client has limited means.

The services are available to any Canadian resident, irrespective of length of stay. This is an important funding and policy difference from that of community-based agencies, most of which are only funded to give service to immigrants who have been in Canada up to a period of 36 months.

Workers in these agencies reported an average caseload of 75-80 clients per months, approximately 60% of these being women. This heavy caseload reportedly prevents workers from initiating important group programs in Spanish and Portuguese.

The mandate of community-based agencies serving Spanish and Portuguese speaking immigrants is primarily one of providing settlement service. Most receive their primary funding from the Immigrant Settlement and Adaptation Program (under the Ministry of Employment and Immigration) to provide the following types of services: information, referral, translation, escort, advocacy and supportive counselling. Most community-based centres are only funded to provide services for those immigrants who have been in Canada up to 36 months, the time period deemed necessary for "adaptation". In contrast, one settlement service agency studied, one with direct government funding, has within its mandate the provision of service to all immigrants regardless of their length of stay in Canada. At the same time, community-based agencies continue to provide service to immigrants who have been in Canada longer than the stipulated 36 months.

The clientele of the community-based agencies is largely non-English speaking and low-income. Two of these agencies provide service solely to women and have historically or presently provided specialized job or health related services. A third agency is heavily oriented to women, has special programs for women, and also provides legal assistance. The remaining four agencies studied serve men, women and children, and have a range of counsellors including social workers, legal advisors, and workers specializing in information and referral.

As reported to us, there is some referral being done along horizontal lines among community-based agencies. Women, when they have multiple problems, or specialized needs in the areas of work and health, may be referred to an immigrant women's centre, where service will be provided in the areas of practical issues and supportive counselling.

Specifically in relation to mental health, one immigrant women's centre reported that 90% of clients received supportive counselling in a one-month period while seeking help in the following areas: job orientation, 60%; interpretation, 80%; general information, 70%; advocacy, 50%; translation, 30%; referrals, 15%; and escort, 12%. Supportive counselling was done around such issues as unemployment, economic difficulties, the language barrier, family problems, coping with stress, isolation, and health problems.

Health care workers in various areas come into contact with immigrant women in the context of mental health problems. It appears from our research that the bulk of counselling for this clientele is done by the general practitioner, who will refer to a psychiatrist if deemed necessary. Because some women are hospitalized on the advice of a psychiatrist, immigrant women come into contact with the Canadian hospital system and after-care workers such as public health nurses or community occupational therapists.

It is not the mandate of most general practitioners to provide on-going counselling services, but it was reported to us that many do in response to the needs of their clients. It appears that the Spanish and Portuguese speaking doctors we interviewed see, almost exclusively, patients of their own language groups, and that more than half of these are women. Counselling generally takes place in the context of a routine office visit, ranging from 10 to 30 minutes. In some cases, special arrangements will be made for a longer session, particularly if other family members are to be involved. As medical workers, general practitioners are in a position to prescribe drugs. It was reported to us that many do so routinely, primarily drugs that act as tranquilizers or anti-depressants. When a general practitioner feels that the needs of a client can't be met, due to time constraints or

what is judged as the "complexity" of the problem, referrals will be made to a psychiatrist. There are only a handful of Spanish or Portuguese speaking psychiatrists in Toronto. Some of these work primarily with clients of their own language groups, while others are based in hospitals and see a wider range of clientele. As psychiatrists, they can prescribe medication and ECT (Electro-Convulsive Therapy) to their clients. As reported to us, most routinely prescribe medication, while less than half are proponents of ECT. More than half of the clientele seen by the psychiatrists were reported to be female.

A hospitalized woman may be seen by community occupational therapists or public health nurses when she returns home. It is the mandate of these workers to help the patient reintegrate into the home and the community. This is done through education and support in regular home visits. Public health nurses also enter the homes of immigrant women on other occasions: they do so routinely after the birth of a first baby. As reported to us, in the downtown district, there are only a handful of public health nurses (and no community occupational therapists) who can speak Spanish or Portuguese. These few public health nurses are overloaded by the numbers of women they have to see. When the public health nurse cannot speak to a woman in her own language, a neighbour or family member may serve as interpreter. This situation can prove to be limited in its usefulness when a woman wants to discuss matters of an intimate nature.

The referral patterns of service agency systems are important in that they determine the type and quality of complete service a client will receive. They determine the extent to which her needs will or will not be met. For the non-English speaking woman, the particular referral that is made is important, because she often has only limited information

on what her alternatives may be in a given situation. The referral may be appropriate or inappropriate, it may lead her closer to getting her needs met, or it may gear her away from this and may even be harmful to her.

When looking at the referral systems among the three areas of service delivery--family services, community-based agencies, and health care services, some general patterns begin to emerge.

The general trend is for established agencies such as family service agencies and the health care system to make cross-referrals to each other, with only a small number of these making routine referrals to community-based agencies.

As reported, women generally go to community-based agencies on the advice of friends or family, or are drawn there through advertising made by various community centres. In contrast, women will be referred to family service agencies by government agencies (Welfare, Mother's Allowance, Ontario Housing), the Board of Education, the police, hospital social workers, and to a lesser extent, by community centres. While some community centres refer regularly to family service agencies, others have stopped doing so in response to the unsatisfactory nature of their clients' experiences with these services.

Family service agencies, in turn, refer primarily to family doctors, psychiatrists, and hospital programs (i.e., alcoholism, drug addiction, etc.). The health care service system also receives its clients through direct contact, as in the case of the general practitioner.

As reported, very few health care workers are aware of the services offered at community-based centres or make referrals to them. This is

significant because many health care workers, particularly general practitioners, see women with a variety of practical problems, which also have psychological concomitants, that could be appropriately dealt with by the community-based agencies.

A small number of general practitioners and psychiatrists, however, have begun to refer women to community agencies. Along with the routine referrals from agencies such as Children's Aid, the caseload of community agencies is increasing on this basis. This is especially intense for those community centres particularly oriented to women's needs. These centres take referrals from social service agencies with no provisions for the non-English speaking client, from a few health care professionals, and from other community centres which consider their services uniquely suited to help women. In this way, centres oriented to immigrant women become a "catch-all" for the social and health services which are not prepared to serve immigrant clients. The undesirability of referring women to established social agencies and health professionals has led to the perception by community workers that there is a "gap" in the service delivery system in the area of mental health. They are well aware that the needs of the non-English speaking woman go far beyond problems with mental health and require an understanding of her social situation in the Canadian context. We now turn to the situation of the immigrant woman, one which is not being addressed under the present organization of social and health care services.

THE IMMIGRANT WOMAN IN THE CANADIAN CONTEXT

Professional ideologies explain the experiences of immigrant women externally--that is, they are constructed from within a scientific and professional discourse which excludes the perspectives of women in this social class. The result is that attempts to understand the immigrant woman in the professional context rely largely on psychological attributions and cultural differences. The realities of how one lives one's life in a low income family or in a sex-segregated labour force are not emphasized in the professional modes of theorizing. But this is where the immigrant woman lives her life and where her experiences are socially located.

1) Second Class Status: The Labour Force

In order to understand the situation of low income immigrant women in Canada, it is necessary to look closely at what options are available to her in this country and how her status at entry conditions her experiences thereafter. If we begin from the women's experiences, it is possible to see some of her relations to the larger society.

There has been a lot of attention paid to the inherent difficulties which are caused by the "immigrant's" (backwards) culture in the Canadian context.* When these kinds of attributions are made, however, what is left unexamined are the policies of the federal government which place her in a second class, dependent status on arrival. The consequences for her extend not only to her relationship to her family, but to the labour force and her future opportunities in Canada. When the context of her situation as a "nominated" or

* The term "immigrant" will be used in this study in a common sense manner in order to explore the social practices which constitute women's problems in Canada as problems of cultural difference.

"family class" immigrant is understood, it can be seen that family relations are inseparable from her status in the larger society.

One common misconception is that "traditional family patterns" are responsible for the failure of immigrant women to "adjust" to Canadian ways of life. For example,

> traditional family patterns observed in immigrant families of various ethnic backgrounds, viz; the "sequestering" of the wife/mother primarily to home and church of ethnic originated activities...Classes in English or French offered at night school, or by various government or volunteer organizations have been, in great part, regarded as "out of bounds" for these women by family tradition.[1]

These "family traditions" are seen as responsible for strains in the family as the woman is increasingly isolated, distanced from her children, and experiences anxiety because of the changes in her role as the rest of the family becomes socially integrated.

By focusing on the consequences of her experiences, as they are portrayed in the family, the woman's relationship to the larger society is ignored. Whether the strains and conflicts in family life are generated within that sphere is open to some question. In particular, the conditions of the "nominated" or "family class" immigrant severely constrain the possibilities of low income women.*

The denial of language training and manpower training allowances to most immigrant women means that they will work in the lowest paying jobs, with the poorest working conditions, health and safety hazards, and often

1. "The Immigrant Experience: 'Who Cares'?", Alice Seylon, Professor of Social Work, Carleton University, Canada Mental Health, op. cit., p. 3.

* Recent changes in the immigration regulations now guarantee that all married women will suffer the disadvantages of being a dependent who has limited access to benefits.--From a community worker's discussion with a Canada Manpower & Immigration counsellor, August, 1979.

harassment and abuse. Even when a married woman is able to receive the allowances, her allotment is so minimal that she cannot even cover her transportation and lunch expenses; daycare is out of the question. Both the formal policies of distributing benefits and the discriminatory way in which they are allocated to women intensify her dependent status within the family.[2]

By denying the "family class" woman the language training allowance, her chances of learning English are small. For the low income family, the wife's economic contribution is usually a necessity, and it is quite unlikely that she will find time to study in addition to a "double day". Like most working women, she must also do the work of maintaining a household, children, husband, etc. For the woman with small children, she may not be able to find daycare facilities in her vicinity, and government subsidized care cannot meet the numbers of women who need it.[3]

The free classes provided by the government with daycare facilities only give her the most rudimentary, "survival" English, which is of little help on the labour market.

In all likelihood, the low income woman will be forced to work in an unskilled job with low wages and no opportunities to advance. In her study of problems faced by immigrant women in the labour force, Arnopolous points out that the concentration of immigrant women in the low wage sectors has made them the most disadvantaged group in the

2. D. Laing, The Immigrant Woman in Ontario: Some Suggested Issues for Further Research, Ontario Status of Women, April, 1979, p. 6.

3. "Metro Crisis Over Shortage of Daycare", Toronto Star, August 11, 1979.

overall labour force. She concludes:

> As a result of immigration policies in general, immigrant women are more than any other group concentrated in the poor paying work sectors where they are overworked and underpaid. Immigrant women tend to be unaware of their labour rights and fearful about complaining, and as a result abuses of labour in industry abound.[4]

The practices of the Manpower and Immigration offices have been criticized by many of the clients at the community centres, as their policies are not geared to giving full recognition of women's skills in particular. Women who have been skilled or semi-skilled workers in their countries of origin find that either their skills are not considered for upgrading and they are classified as unskilled workers, or they are not judged as "motivated" enough to merit a language allowance. The following examples illustrate these policies.

> Gladys E., a 33 year old assembly line worker in Canada for six years: My main problem is not knowing how to speak English... Manpower told my husband that I would be given an English allowance when I came to Canada. But when I went, they wouldn't give it to me. They said I had to work three years and then I could have a course. I worked before as a cosmetics demonstrator and they told me to get trained at Revlon, but I didn't speak any English.
>
> The counsellor wanted to know if I really had typed and wanted to know the name of the model I had typed on. I couldn't remember but saw a model that was similar and said it was like that. He said I was making up the whole story, that the model I identified was a new one, and I didn't get the course.
>
> (Interview with woman, Bodnar Journal: June 22, 1979.)

4. Sheila Arnopolous, Problems of Immigrant Women in the Canadian Labour Force, Canadian Advisory Council on the Status of Women, January, 1979.

> Isabel D., a 40 year old cleaner in Canada for four years; she worked as a legal secretary in Portugal for twelve years: I worked as a dish-washer and a hotel cleaner... and 2½ years in an insurance office as a cleaner until I had my operation (a masectomy). I'm not able to do heavy work because my arm is too weak. Three times before I applied for English as a Second Language benefits--finally they let me have a course.
>
> Note: After she and her husband separated and she had her second operation for cancer, she was given the benefits.
>
> (Interview with woman, Reimer Journal: May 29, 1979)

A counsellor at Manpower explained that ESL courses are given in order to place an individual in employment, when the barrier to employment is not being able to speak English. But non- English speaking women seem to be placed directly in the labour force in those jobs which require no English:

> Maria graduated in a two year course in dress design and went to an academy in her country for this course. Manpower told her she didn't need English and could work in a factory as a sewing machine operator.
>
> (Interview with woman, Bodnar Journal: June 15, 1979)

One of the community workers who accompanied a couple applying for allowances reported that the counsellor accepted the man's claim to a profession (without credentials) but cross-examined the woman as illustrated above. The worker also accompanied a woman who was denied a training course because she didn't know English and didn't make an impression of being a "motivated" worker as a result. After studying English on her own for a period of time, she reapplied, and was told that her English wasn't good enough for the training course; however,

she was told that her English was too good for an English allowance, so she couldn't have that either.

All of these examples suggest that immigrant women have been disadvantaged not only by the dependent status, but also by the value placed on the women's skills, and on the legitimacy of her claims to the skills she has. This practice of treating immigrant women as unskilled or "unmotivated" to improve their situations makes light of their actual work experience and skills, as well as the work performed in the home. It also overlooks the fact that the immigrant woman have a greater work force participation rate than her Canadian born peers, and, as a taxpayer, pays for Manpower benefits--and then doesn't qualify to receive them.[5]

The policies of the retraining programs are directly oriented, however, to the demand for labour in the work force. Griffith has identified the business practices which articulate skills to the Canadian labour market as the determinant factor producing class location within Canadian society.[6] The labour force is organized in such a way that certain groups of people--here, non-English speaking, "unskilled" immigrants--are segregated into jobs that are low paying, where English is not spoken, and where labour standards legislation is weakly enforced.[7] Without English, the immigrant woman will most often work in an unskilled, sex-typed job, e.g., sewing machine operator, cleaner, domestic, factory worker, where she will work with other non-English speaking immigrants.

5. Work We Will Not Do, Issue 7, Published by the Department of Church in Society, Mission in Canada, United Church of Canada, 1979.

6. Alison Boulter Griffith, Constituting Ethnic Difference: An Ethnography of the Portuguese Immigrant Experience in Vancouver, unpublished master's thesis, University of British Columbia, 1978, p. 100.

7. Sheila Arnopolous, Problems of Immigrant Women in the Canadian Labour Force, Canadian Advisory Council on the Status of Women, January, 1979, p. 9.

She may never be informed of her rights and may never receive overtime pay, workmen's compensation benefits if injured, or equal pay for equal work. Few of these jobs are unionized. If they are, for example, in the garment industry where 40% of the workers are unionized, most of the unions are weak, and some don't even translate the contract for the majority of non-English speaking workers.[8]

The work that women find places them in a most vulnerable position vis-a-vis the employer and the conditions on the job. Gladys E. described the working conditions at her assembly line job preceding her "nervous attack":

> In the places we have to work, due to speaking no English, they treat everyone like they are uneducated, stupid, idiotic. The foreman at my work is Czechoslovakian, and hard to understand. But he expects everyone to pick up what he teaches in 5 minutes when it took him years. Another woman is taking pills for her nervous condition. He makes people feel bad, and if they start crying, he laughs at them. I cried too. He expects me to operate an air-driven screwdriver without making any noise--I told him that I can't, that it is too heavy for me, but he doesn't care.
>
> The Canadian woman got laid off because she asked why he called everyone "shits" all the time. My sister-in-law told me not to talk about a union because they will fire you. Dr. ___ gave me some pills, but they put you right out--for night work on the machines you can't take sleeping pills. The weekend of my attack I couldn't get his face out of my mind...
>
> (Interview with woman, Bodnar Journal: June 22, 1979)

The conditions of work are often brutal for these women. There are often physical effects from pressures on the job and financial

8. ibid, p. 9.

insecurities, in addition to work related injuries. In several instances, these problems were brought to the attention of doctors, however, the nervousness or pain accompanying overwork and harassment is what seems to be addressed, rather than the situation itself.

One of women reported that after initially hurting her back on the job (cleaning), the doctor gave her pain-killing drugs and a note to lighten her workload. This woman went to work as a cleaner after separating from her husband to support herself and her three children.

> Julietta told her supervisor that she hurt her back and got help lifting. The doctor's report went to work so she didn't have to use the carpet cleaner. She was doing two 6-hour shifts of work in 8 hours, so they wanted her to stay. Then she worked overtime 5 more hours, and was paid $2.80 an hour with no overtime pay (over the legal 45 hour maximum). She worked 5 days a week.
>
> (Interview with woman, Bodnar Journal: May 25, 1979)

Julietta finally collapsed, was taken to emergency, and was told by a specialist that she required back surgery. A co-worker misinformed her that she would not receive medical coverage prior to working on the job 3 months, so due to an inconsistency in her Workmen's Compensation report, she has been denied benefits. She has applied for welfare, but feels depressed and that she will never work again.

In such a case where a woman is overworked, underpaid and pressured to accept abuse on the job, the "pain-killers" and valium reportedly administered by doctors appear to maintain a bad situation and can ultimately lead to severe consequences for the woman. Her problems on the job are compounded by her inability to speak English which

minimizes her access to information required to act independently on her rights.

A woman's economic dependency on her husband is reinforced by her inability to secure a decent income and working conditions through her own efforts. If she is dependent upon a man for economic security, she may have few options to an intolerable family situation should one develop. If she is also experiencing difficulties at work, the combined pressures can be intense.

2) Family Life and the Economic Dependency Cycle

The strains of immigrating are numerous, including relative isolation in a big city, difficulties in learning one's way around without the necessary language skills, and the high cost of living in Canada. While most of the women come to Canada for economic reasons, it was often not the woman's decision to immigrate.* In many cases the husband has sponsored the wife, or his family has, and the only people she may know are his relatives. Some of the husbands were also unwilling to sponsor the woman's family, and without the financial means she may not be able to sponsor them herself.

Although the expectation may have been to improve the family's economic status, many of the men experience downward mobility upon arriving, taking jobs which "anyone" could do until they learn English. Even then, many take on jobs which require less skill than they possess and pay such low wages that it becomes a necessity for the wife to work. The previous "contractual" nature of the marriage

* In four of the interviews, political reasons for leaving Latin American countries were given as one of the reasons for leaving for either the husband or wife. While none of these had experienced torture, rape, etc., which many refugees had, this underlines the lack of a chosen alternative to immigrate as one aspect of some women's situations.

begins to break down in these circumstances as it does for working class families in Canada.[9] That is, the previous division of labour, where the man is the economic provider and the woman maintains the household, raises the children and services the husband, begins to break down. With less income coming in, the authority which a man derived from his wife's dependence on him as the "provider" is decreased. The strain on her to work outside the home as well as inside it is more than simply a matter of overwork, although that is also very real for her. She is expected to take responsibility for the children, while he is able to go out socializing with his friends, meaning that she often experiences extreme isolation from adult companionship. At the same time, she begins to make money which provides for the possibility of independence, if she wants it. For several of the women, the ability to control their own money led to conflicts with their husbands.

For the low income couple, the isolation of the woman is compounded by the fact that there is no money available for entertainment or to pay for daycare if no family members are available to stay with the children. If both husband and wife work opposing shifts in order to look after the children, they may have very little time left to see each other. Practical difficulties also arise for the family living in cramped quarters, which often occurs in a flat, where the neighbours will not tolerate any noise from the children. A hospital interpreter pointed out that many families are forced to buy a house, as landlords are hesitant to rent to them if they have several children. This in itself increases the pressure to earn more money as well as the cost of living in Canada.

The pressures of living under these circumstances are also experienced by the children, who may be embarassed by their mothers who

9. "Women, the Family and Corporate Capitalism", Dorothy Smith, in Women in Canada, 2-35, Marylee Stephenson, Editor, Toronto: New Press, 1973, p. 22.

can't speak any English. Tensions also arise around their performance in school. The school problems of immigrant children are intensified by the inadequacies of the school system in orienting to low income students of any origin.[10] For many children, a role reversal occurs with their parents when the child learns English and is depended upon to take responsibility for practical transactions requiring English. The strains on the child are also increased if it is necessary to go to work to help support the family. Many mothers are concerned that their children will become involved with drugs or the law, and of course, some do.

Particularly when money is short, if the husband goes out drinking with his friends, the housewife's ability to manage a household financially is undermined. If the woman protests, as a study in family violence suggests, the husband may beat her in an attempt to reassert his authority.[11] Another alternative which is common is that he becomes the absent partner, as many of the men find other women to spend time with. Especially when the woman works a double day, she has less available time to spend with her husband and may be exhausted when she does. Under these circumstances, the contractual nature of their relationship breaks down.

There are many professionals who have the view that in this situation the problem for the couple is one of "role conflict" between the traditional roles of their country and that of Canada. However, women in urban settings are increasingly forced to work in the paid labour force, as the lowering of wages in relation to the cost of living is a growing reality in all industrial countries. In Canada

10. See "Meet the Myth Shatterers", Toronto Star, August 20, 1979, on The City Kids Book and The City Kids Teachers Book by Fran Endicott and Barb Thomas.

11. Roxana Ng, "The Social Organization of Family Violence: An Ethnography of Immigrant Experience in Vancouver, op. cit., p. 12.

and the United States, Europe and Latin America, an increasing proportion of the female population is working in paid labour. Moving from a less to a more advanced capitalist country may simply necessitate this change sooner. The women's movement in North America has arisen in this context. The ability to perform housework successfully as well as paid labour puts a strain on relations within the family. As well, an alternative to total economic dependence upon a man as the provider arises for the woman. However, receiving the lowest possible wages reduces the immigrant woman's options at the same time as strains on family relations increase. This bind demands more than "adjustment" to a new role.

Ng identifies an economic dependency cycle which exists for low income immigrant women who work solely in the home or are secondary earners in relation to their husbands.[12] Violence in these situations is common, although wife battering is by no means a class phenomenon. Regardless of cultural group, it was found that many husbands actively sought to maintain their wives' isolation and their authority over the family. The conflicts which existed over money, the man's consumption of alcohol and the wife's "nagging" about the lack of money, resulting in the man beating his wife and attempting to assert his position as "boss" in the household.

For the dependent woman who is expected to work solely at home, violence can escalate and she may know no one to whom she can turn for help. One such woman was being beaten by her husband, his father and brother, and was malnourished because they ate most of the food. She knew no one outside of the neighbours living on her street, and when her fahter-in-law attempted to rape her, she fled. Luckily a church was contacted and she was helped to "escape" with her

12. Ng, p. 19, op. cit.

children. However, no one informed her of her legal rights, her eligibility for child support, etc., and she lived in fear that her husband would come and take the children from her.

The dependent woman is also disadvantaged if she wants to move out on her own, but doesn't qualify for welfare. One woman wanted her husband to leave, after not communicating with each other for one year, but he refused. She was living in Ontario Housing and could not afford to move out. She wasn't eligible for welfare, being in Canada for less than five years as a dependent immigrant nor was she eligible for settlement benefits, because she had been here for three years. It was not until she and her husband separated that she was able to break her sponsorship relation and qualify for welfare benefits.

The 36 month limit on immigrant settlement services does not take cognizance of the realities of life in Canada for many immigrant families, and especially is not oriented to the situation of women. For when a family first arrives, for six months or even for many years, the predominant orientation to surviving--gaining economic stability, maintaining the family--takes precedence for many people over focusing on individual needs. With time, the difficulties experienced may multiply, and the frustrations then come out at a later period, after the initial settlement years. Sometimes couples separate after 5 years or more, and the wife is left in need of English training, of a job to support herself and the children, and is forced to take whatever she can get. When women find themselves laid off or unemployed, many feel individually responsible and blame themselves for not being able to find work. However, no consideration is given to the second class status a woman is in as a dependent

immigrant, as employment programs for women and immigrant settlement funds are continually cut back.

Many women, on the other hand, attempt to maintain their personal situations at some cost to themselves. This was particularly true for those women whose husbands had girlfriends. Women reported such reactions as various kinds of nervousness, accompanied by minor accidents, headaches, and in one case, epileptic seizures accompanying stress. For the woman who is isolated or speaks little English, she may find no one to give her support in times of crises. Because part of managing a household involves mediating relations within the family, women have been made to feel if their husbands are dissatisfied with them, have women friends, or beat them, that the responsibility rests with the wife: it is her fault. For the woman who is trapped in such a cycle of economic dependency, daily life may be fraught with frustration, physical abuse and despair. While the situations of women we interviewed did not always involve violence, they often felt powerless to change the way they are treated--at home or at work.

When women are depressed, exhausted, experiencing stomach pains, headaches, or having "nervous attacks" and epileptic seizures, their problem is not a failure to "adjust to the new way of life". Perhaps no individual ever adjusts to these circumstances, even though she must attempt to do so to keep the family together, to provide some economic security for her children, or out of lack of alternatives.

The second class status of a dependent immigrant woman in Canada creates problems for her which are shared by other low income, non-English speaking women. By starting from the accounts women have made of their experiences, we see that social and economic dependence

is imposed on women by their entry status upon immigrating. The institutionalized practices of Canada Manpower and Immigration ignore the economic realities of her life and family obligations, rendering her an unlikely candidate for language and upgrading benefits. The labour force is organized to take advantage of women without language skills and the knowledge to act on their rights and to secure protection from impoverished working conditions and pay.

The second class status she receives in Canadian society intensifies her dependency within the family. Her social dependency in the home as a non-English speaking immigrant often results in extreme social isolation. The stress of working in the kinds of jobs she can get, of financially managing a household and performing the work of a housewife are often intense. Her economic dependence on her husband and lack of social mobility make her vulnerable to violence in the home. It is these very real circumstances she encounters in Canada which create difficulties, particularly for low income immigrant women. These are not problems of "adaptation" or of "cultural background" but are features of the way Canadian society is organized. Professional approaches which attempt to individualize these problems do not provide a basis for addressing her situation and meeting her concrete needs.

III

PSYCHIATRY AND THE HEALTH CARE SYSTEM

1) Professional Approaches to Immigrants

Psychiatric and medical approaches to immigrant women are a part of a professional discourse in which "official" views of reality are produced. They share the inadequacies of professional services which are not oriented to the actual situations of the people they are to serve.[1] Characteristically the professional approach to problems of immigrants reformulates them, for example, as a problem of "cultural conflict", "culture shock" or as the difference between a woman's cultural background and her new setting. The problem is viewed as one of adjustment. Attributing a person's difficulties to problems associated with her background in this way specifically disattends how her life is organized in Canadian society.

An example of this approach comes from a study done in Vancouver using descriptions of family problems made by social workers of elderly parents who have immigrated from Portugal.[2] The parents have been sponsored by their family and are economically and socially dependent upon them. Many Portuguese immigrants are positioned in the labour force in such a way that steady well-paid employment is difficult to find. Families sometimes cannot carry the burden of elderly parents who cannot contribute financially. The old people are powerless because of their sponsored status. Sometimes serious conflicts arise which are brough to the social service agency. The social workers' descriptions did not orient to the dependency relation or to its economic context. Rather, difficulties were explained in terms of the immigrants' background and their country of origin,

1. John Mayer, op. cit., p. 18.

2. Alison Boulter Griffith, op.cit., p. 89. Also see "Immigrant Women", special issue of Multiculturalism, Vol II, No. 4, 1979, and Class Ethnicity: The Social Organization of Working Class East Indian Families, Marguerite Cassin, unpublished master's thesis, University of British Columbia, 1977.

e.g., the woman had a hard life in Portugal, a "typical in-law" problem. Griffith writes:

> The accounting which located the 'cause' as personal obscures the determinate organization of daily life in Vancouver in which these 'problems' arise. This view of the 'problems' is part of what organizes them as unsolvable.[3]

The approach which portrays women's problems as sex-role strain or cultural differences is a construction of women's experience from outside of it. Professional ideologies obscure the determinate organization of everyday life for immigrant women. They view a woman in terms of how well she is able to conform to the traditional female role and reinforce her in it. The practical material aspects of her situation are not considered as part of the problem and hence solutions for them are not sought. Shifts away from traditional roles are discouraged.

In the following section, the institutional perspectives on mental illness will be examined. The psychiatric definition of women's problems has a broader usage than that of the psychiatrist alone. Other health care and social work professionals work within this familiar mode of thinking when dealing with immigrant women--often their practical work requirements demand that they do.

2) The Psychiatric Approach to Mental Illness

The psychiatric profession is one of the many forms of administration, management and governing in highly industrialized societies. These are a part of a larger apparatus where the official definitions of reality are produced, e.g., in business, social work, newspapers and

3. Alison Boulter Griffith, ibid., p. 89.

royal commissions. This apparatus is part of a mode of action in government, business organizations, academia, etc., which is the locus of organization in our kind of society.[4] This is where the "official" views of reality are defined and acted upon.

In order for psychiatric models to have a general application, a conceptual system has been created which is independent of the local conditions and situations in which it functions and controls.[5] Ways must be developed to fit people who are not standardized into recognizable forms and types so that they may be acted upon in particular ways, e.g., therapy, tranquillizers, electro-shock treatment.[6] Immigrants are often treated by standard procedures which attend to more general attributes such as the fact of having immigrated, the

4. Dorothy Smith, "The Social Construction of a Documentary Reality" in Social Inquiry, Vol. 4, 1974.

5. According to the American Psychological Association Diagnostic and Statistical Manual, (1952), the system of classification originates in a nomenclature which had been in use since 1934. In response to the difficulties faced by the American Armed Forces during the war, there was an administrative need for diagnostic labelling of the increasing psychiatric caseload so that cases of "morbidity" could be dealt with. Ullman & Krasner explain, "Morbidity, operationally, was the inability to adapt to the army in a manner which was useful to that organization. The person did not perform in a manner considered desirable by the organization, and the organization decided that the cost of retraining him was not worth the outcome. The solution of labelling also implied that any failure of rapid adjustment to the service was an indication of 'sickness.'" Leonard Ullman and Leonard Krasner, A Psychological Approach to Abnormal Behaviour, New Jersey: Prentice Hall, Inc., 1969, p. 26.

6. Dorothy Smith, "A Sociology for Women", paper presented at The Prism of Sex: Towards An Equitable Pursuit of Knowledge, October 1977, Madison, Wisconsin, p. 25-36.

assumed culture of their country of origin, and their assumed personal traits.[7]

Psychiatric approaches to mental illness are familiar to most people, if only in a popularized version. In this way of thinking, mental illness is an individual state which can be identified and recognized in terms of symptoms. The symptoms are indicative of an underlying condition which an individual is assumed to have, some might say, like a disease.[8]

In this way of thinking, mental illness becomes identifiable once certain kinds of behaviour have come to the attention of one's friends, spouse, oneself, a doctor, etc. We have become familiar with how to detect these symptoms from from books on popular psychology, the media, women's magazines, etc. The process is completed once a person goes to a psychiatric agency or hospital, receives a diagnosis and becomes one of the statistics on mental illness.

The problem with this approach is that it assumes that illness exists apart from the social process of labelling by a psychiatric agency.

7. One psychiatrist suggested that a Greek woman might experience sexual relations with her father differently, because this was a more normal occurrence in the Greek culture. Also see Ethel Roskies, "Immigration and Mental Health", Canadian Mental Health Journal, Vol. 26, No. 6, June, 1978, and M.T.B. Ferreira, "Portuguese Patients as a part of the Canadian Mosaic", Canada Family Physician, Vol 23, August, 1977, p. 955.

8. This discussion of approaches to mental illness is from "The Statistics on Mental Illness (What They Will Not Tell Us About Women and Why)", Smith and David, op. cit., p. 72-120.

People do, of course, experience misery, acute anxiety and grief--and may even become severely psychologically disturbed. But in order for these experiences to be categorized and treated as illness, a person must first be entered into the social processes of psychiatric agencies.[9] The social context of psychiatric diagnoses is the institutionalized processes of management and control. These are applied in relation to people in their everyday lives and require a social judgement of someone's behaviour. This is quite different than the diagnosis of a physical illness--there are no objective measures or rules that must be broken in order to determine that someone is mentally ill. Once a person has been labelled in these processes, people react to her as if she didn't make sense, and no one expects her to.[10] This becomes a way of discrediting what a person says or does and can serve as a basis for courses of action that might not otherwise have been possible.

In viewing "mental illness" as the cause of someone's actions, the actual events and social context of her life are no longer in view.[11] Once her experiences are abstracted in this way, her actions are made manageable by the professional psychiatric institutions.[12] In the

9. ibid., p. 75

10. ibid., p. 92.

11. This "ideological" method is identified in Dorothy Smith, "The Ideological Practice of Sociology"; also see Roxana Ng, "Fieldwork as Ideological Practice", paper presented at the Canadian Sociology and Anthropology Association annual meeting, Saskatoon, June, 1979.

12. It is not known, however, what the practices of psychiatric agencies have been in relation to immigrant women because of an Ontario Ministry of Health decision not to compile statistics on the utilization of mental health services by immigrants. See F. Alodi, M.D., Transcultural Psychiatry Department, Toronto Western Hospital, "The Utilization of Mental Health Services by Immigrant Canadians", Canadian Mental Health Journal, Vol. 26, No. 2, June, 1978.

psychiatric "work up" of a patient, the social relations of her situation disappear.[13] The context of her everyday life becomes subordinated to the practices of identifying and treating the psychological state, i.e., one which has been identified as her problem. Deviations from the traditional female role, for example, are treated as symptoms of an underlying problem, and this behaviour becomes a focus for discussion.[14]

A wide range of factors enters into the process of "cleaning up" different behaviours and circumstances into distinct categories of illness. Statistics Canada lists some of these factors which include such things as the number of psychiatric beds available, the extent of O.H.I.P. coverage for the various mental disorders, the official and unofficial admissions policy for the psychiatric facilities.[15] In considering the experiences of immigrants in these processes, psychiatric professionals indicated such factors were indeed at play. For example, at a teaching hospital, one resident interviewed suggested that the non-English speaking person would be "wasting their time" entering the in-patients department in that hospital as there would be no one there who spoke their language. At another hospital in a highly populated immigrant area, the administration's policy is to keep the beds filled in psychiatry, so a patient in crisis would either be sent to the local psychiatric hospital or put on tranquillizers.

13. See Smith and David, Editors, "Women and Psychiatry", p. 5, for a discussion of how behaviour and situation are taken apart in order to focus on the psychological state.

14. Ibid., p. 6.

15. This description is from Statistics Canada, Mental Health Statistics, Vol. 1. Institutional Admissions and Separations, 1970, cited in Dorothy Smith, "The Statistics on Mental Illness: (What They Will Not Tell Us About Women and Why), Smith and David, op. cit., p. 94.

3) Psychiatric Views of Immigrant Women

From interviews of psychiatrists, doctors and other health care professionals, a general view of the immigrant's problems emerges. This is spoken of as problems of "adjustment", of the "immigrant syndrome", and of abandoning the old roles and having difficulties accepting a new culture. One psychiatrist explained:

> There is a tendency to become mentally ill--for everyone. More immigrants become mentally ill because they are under economic stress, they have to adapt to a new situation. For example, the wife has to work when there is not enough money and the husband assumes that he is the head of the house. The kids are raised here and there is a big gap between upbringing here and back home.
>
> (Interview with psychiatrist, Reimer Journal, June 25, 1979)

A nurse describes the kinds of complaints people had and was able to categorize illnesses on the basis of the observed symptoms:

> Illness is very prevalent in our society--Portuguese and Italians are more somatically inclined as opposed to the suicidal Scandinavians.
>
> (Interview with nurse, Reimer Journal, July 24, 1979)

When asked what kind of treatment would be given to an immigrant couple, when the wife was said to be "hysterical" and the husband very jealous, a psychiatrist replied:

> In this case you give symptomatic medical treatment: you try to work with the family situation and forget the rest of it. You have to know the religion, and cultural background, and what level you are working with; most are not (educated)--many are like five year old children and cannot do therapy.
>
> (Interview with psychiatrist, Reimer Journal, August 13, 1979)

While all health care professionals do not rely on the same sterotyped images of people, the general approach of attributing current difficulties to an individual's cultural background was widespread.* This focus of attention on cultural differences is a part of a routine procedure in producing psychiatric descriptions. It results in isolating the person's actions from the context in which they occur. Once this has been done, someone's behaviour can be "worked up" into a recognizable entity,[16] e.g., "depression", "hysterical mania", "manic depressive", etc: it can be identified for treatment.

The psychiatric approach to immigrant women's situations is used by doctors as well as psychiatrists. It differs greatly from the descriptions made by women of their own situations. Recent analyses of psychiatry made by women in Canada have identified a professional ideology which teaches women to "adjust" to their traditional roles, as subservient to the enterprises of men, as wives, mothers and daughters. From their own experiences they identify the neutralizing of their attempts to protest their subordination to their husbands and families:

> Women who are struggling to define themselves as autonomous are trained, instead, to believe that their unhappiness comes from within: it is only a symptom of their "illness".[17]

Immigrant women also reported this kind of opposition to their attempts to change their lives by psychiatrists.

* A few identified the difficulties experienced as problems with living--housing, low paying jobs, long hours; however, the onus rests with the individual or family members to change their actions, values, or to try to relax.

16. For a graphic description of how this procedure works, see Dorothy Smith, "K is Mentally Ill: An Ethnography of a Factual Account" in J.M. Atkinson and J. Coulter, Editors, Ethnographics, London: Martin Robertson Ltd., 1970.

17. Judy Chamberlan, "Women's Oppression and Psychiatric Oppression" in Smith and David, op. cit., p. 39-46.

The women we interviewed were not all labelled mentally ill: five of them were reportedly prescribed medications by doctors and psychiatrists which dealt with their undesirable symptoms of nervousness, headaches and stomach disorders; two of these were treated in hospital emergencies for their reactions to their situations, one a "nervous attack" and one an overdose of pills; two were hospitalized, one in a psychiatric unit of a general hospital and one in a mental hospital. Three of the women were not treated medically; however, they reported similar personal difficulties as the women who were. Of the two who were hospitalized, one reported that she was repeatedly given electroshock treatments and hospitalized over a nine year period; the other described being heavily sedated and told she would have to take medication for the rest of her life.

From the interviews of women who were treated by doctors and psychiatrists, a picture emerges of women who took steps towards greater autonomy or tried to change an oppressive situation. Their reactions were then treated "symptomatically", that is, they were defined variously as having psychosomatic, manic-depressive or nervous reactions and their symptoms treated.

The procedures of using symptomatic medicine are apparent in a description of a psychiatrist who uses this approach:

> Q: What are the kinds of problems you encounter?
> A: A common one was a South American couple--young. They had known each other a short time. To him, his mother was sacred, but he didn't treat his wife very well. They would have arguments and the wife lost. Finally they separated, and he came and beat her up. There's not much, again, you can do.
> Q: What kind of treatment could you give?
> A: If possible, you get the husband in. For her, you treat the symptoms--bring her out of her depression. Tell her--don't make any decisions until she is out of the depression. If this has been going on for many

> years, and they have children, you respect the family unit: I would never tell her to separate. It's a general rule, keeping the family unit together.
>
> (Interview with psychiatrist, Reimer Journal, August 13, 1979)

In this example, the woman had already acted and had suffered the consequences once. The next step is to "bring her out" of her reaction to being beaten, and concentrate on getting her together again with the man from whom she has just chosen to separate. This move to get a woman back into a role she has just rejected was a common theme in the women's interviews. The following is a description of a fifty year old Portuguese woman who began to protest the affairs of her husband and reported receiving shock therapy following this protest:

(From the notes of a community worker who interviewed her)

> She is very, very calm, as opposed to the other women who are full of energy and emotion. She said she didn't feel so hot and thinks the treatment at (hospital) killed part of the nerve endings in her brain--they gave her shocks. She says she has problems with her family and she gets nervous.
>
> She says it all started nine years ago when her sixteen year old son left the house. "It was my only son, I felt left all alone--how could he leave me and the family? Then he came back and I couldn't believe it: he was dirty and had a beard. I couldn't believe it. I started screaming and shaking; I had to be calmed down (with pills).
>
> "At that time my husband started to be interested in a woman who lived upstairs and was pregnant. We fought and he beat me. We took her everywhere--we took care of her. He had stopped having sex with me and I thought he was having an affair with her. I would start feeling electrified--full of energy--I wanted to cry and scream..."
>
> This was the first time she went into the hospital for a rest. They gave her shock treatments and drugs. I asked her if her doctor helped her: did he ask her about her life, how she was doing, what made her anxious? She said no, he never did anything--he just sat there and looked at me.

> The last of five doctors this woman saw over nine years was very tentative and treated her with respect. He was the first doctor to talk to her about her life, what she was doing during the week. She went to him every week and he said she didn't have to take shock treatments or pills or be hospitalized. He said the only thing that is going to help her is to understand her life.
>
> I asked her if she was angry but she didn't answer. I could see she was filled with rage as she told her story--she is very, very angry.
>
> (interview with woman, Reimer Journal, September 3, 1979)

The other women interviewed described similar experiences with psychiatrists, reporting that they received criticism or worse for stepping out of the role of the subordinate, obedient woman: a) the woman went to school and started to doubt her confidence; she said that the psychiatrist insisted that her problem was guilt over leaving her two daughters in day care; b) a husband was seeing another woman after the wife made friends at her new job and received a promotion; she stated that her guilt over making friends of her own increased after seeing a psychiatrist who advised her that she had made a mistake spending more time at work and less time with her husband; c) a working woman living with her family went on an expensive holiday following her father's death and put herself deeply into debt; her family, convinced that she was "out of control", encouraged her to go to a psychiatrist who reportedly admitted her to a mental hospital after one visit; d) a woman separated from her husband; she went to speak with his psychiatrist about his severe depression but refused to believe that was her fault for leaving him, and that he required electro-shock as a result.

Chamberlan addresses "freaking out" as a way of rejecting the limited choices offered by society and refusing to perform one's role:

> Rather than choose among a series of undesirable alternatives, one makes a non-choice--the unfocused rebellion of refusal. Because it is unfocused, it is unarticulated... By putting the stamp of mental illness on such protesters, their position is officially discredited.[18]

However, this is not the way a woman's experience is understood in the psychiatric profession. Women's consciousness is excluded from this "objective" mode of thought because women are generally excluded from those enterprises where "reality" and the "facts" are formally defined; if she does participate, she must enter on the terms of the profession.[19] Women generally stand in a subordinate relation to men in medicine (doctor-nurse), in business (manager-secretary) and in the intelligensia (professor-secretary).[20] Men in authoritative positions are then able to create the images, labels, concepts which define "reality" for us. This is particularly true for the psychiatrists we interviewed who viewed women in relation to the traditional roles.

From this position in the world, an "objective", impersonal mode of thought is constructed which becomes a part of management and administrative enterprises. The local and concrete settings, the personal and emotional dimensions of one's situations are specifically disallowed in the symbolic modes of theorizing. Those aspects of the world are suppressed, along with a woman's consciousness of her actual experiences in day-to-day living: she is constructed externally in a mode which defines her in relation to the enterprises of men.

For the immigrant woman, this lack of comprehension of her perspective is extreme. For she does not enter Canada on the same terms as a man, does not have the same relationship to the labour force, and lives under circumstances which are quite distant from the primarily male doctors who treat her. Her formal relationship to government and social services, the schools, her neighbours, reflect this relation:

18. Ibid., p. 41.

19. Dorothy Smith, "Women's Perspective as a Radical Critique of Sociology", op. cit., p. 10.

20. Dorothy Smith, "A Sociology for Women", op. cit., p.25-36.

however her concrete situation doesn't enter into the formal definitions of reality as a patient. As a consequence, she is more often acted upon, than able to speak authoritatively on her own behalf. How she is defined in these processes has a great significance for her own future and the likelihood that she will be treated as if she were mentally ill.

4) Mental Health Services

From interviews with doctors, psychiatrists and other health care professionals in four hospitals, it is evident that there is a lack of orientation to the counselling needs of the non-English speaking woman. Part of this assessment is based on the lack of training given to doctors and psychiatrists to understand the social context of low-income immigrants' lives in Toronto. Probably most important is the predominant orientation to social problems as an individual's "mental" problems which are treated as a form of illness. The lack of interpreters and professionals with language skills in the hospitals is another indication of the remoteness of health care administration from the needs of the immigrant population.

Doctors in private practice

The family doctors interviewed see a large number of women with symptoms of stress, overwork and nervousness. In the interviews they reported that no underlying medical explanations can be found for the symptoms of many of these women. When they ask their patients about their lives, they are told that there are problems at home, on the job, or other, which are causing them concern. The predominant approach is to administer pills--tranquillizers, sleeping pills or anti-depressants. Of the ten women clients interviewed, only two

had not received one of these types of medication.

One doctor interviewed described the common approach to such problems as "assembly line" medicine. This approach does not require the doctor to speak the language of the client--just a few sentences--because pills are given freely, or referrals to specialists are made without thoroughly exploring the problems at hand. This doctor described the example of a woman being administered pills without having her blood pressure checked, when she had a history of heart problems. Such a case was also recounted to us, e.g., a woman given tranquillizers and sleeping pills, who said she was not given a blood pressure check, after having a history of circulatory problems--and pain killers, when she actually had a more serious back injury. In those cases where it is assumed that non-medical "problems with daily life" are concerned, it appears that it is likely that a doctor will assume that her problem is with her "nerves" and to treat that with medication.

However, even when doctors take time to talk to a woman, women reported that they nonetheless communicated a lack of interest in their situations, e.g., by looking at his watch or walking in and out of the office while she explains why she is so nervous. Women are also aware when there is a waiting room full of patients that the doctor may not have much time to give her personalized attention. Only one doctor spoken to had counselling hours set aside for patients.

On the basis of doctors' own reports, the majority of patients seen do not have serious mental problems, but are experiencing the "normal" problems immigrant women have. These are treated symptomatically, and only one doctor stated that pills were not the answer to their problems, and should be avoided as much as possible.

In Let's Take Care, the Ontario Nurses Association points out that the training doctors receive is not oriented to preventative measures or education, but to illness and the possible medical cures which he can administer.[21] This speaks well to the routine practices of administering pills in an "assembly line" fashion. It also raises questions about the medical model of the 1970's which appears to be oriented less and less to the social aspects surrounding physical illnesses.[22] Doctors and nurses alike have stated the belief that very little can be changed for these women, e.g., it is all right to give a woman valium, because how else can she cope with a job and five children?

This bland acceptence of problems as normal, considering the difficulties experienced in "adjusting" to a different culture, necessarily leaves very few alternatives to medication. Only one mentioned the possibility of finding help through a community agency, but since the working wife is so busy, she is more likely to take pills than to follow up on such a referral. So it appears she is often given drugs. The approach of administering pills to calm women down assumes that what she needs to do is "cope" better with the situation as it is. Once the symptom is gone--be it heart palpitations, "paranoid talk", abdominal pain or pain with intercourse--then the patient is cured. The actual practicalities of managing her life--being informed of her legal rights, decreasing her isolation or "in-law" problems--are considered by many doctors to be incurable or "chronic".

While doctors expressed sympathy for some women's situations, two of them compared these women's problems to those of their own wives. Holding down a job and managing a family is understood as a problem of overwork, a task that would be very difficult to imagine their wives doing without suffering hardship. Comparing the situation of

21. Let's Take Care: A Report to the People of Ontario, Ontario Nurses Association, 1978, p. 2.

22. Bodnar Journal, June 15, 1979. The same remark has been made in relation to the social work profession by a family services counsellor.

a low-income immigrant woman to that of a doctor's wife, however, obscures the class differences between the two positions. In making this kind of comparison, women's difficulties are seen in light of the differences between their cultural background and the "Canadian way of life"--which, presumably, the doctor and his family have already achieved. This approach suggests that if only the husbands would help the wife or stop drinking, she wouldn't be so tired and would feel free to better perform her wifely role. The problems then are reduced to "role conflicts" between the old culture and learning to adapt to Canadian society.

This focus on symptoms places the responsibility for adjustment on individuals and leaves unquestioned the underlying problems in immigrant women's lives. It also constructs a woman's problems from the vantage point of an external authority--her consciousness is excluded. In one case, a woman described what happened when she refused to take her medicine, and thus challenged the doctor's authority to make a diagnosis. She reported that she was told by her doctor to take a pill which made her "numb, absent minded all day and sleepy" for her headaches. She finally told him she wouldn't take it any longer, and he insisted she would have to go to a psychiatrist or he wouldn't be her family doctor any more. She later discovered an abscessed tooth at the dentist which was causing her headaches. This whole experience was repeated again for a pain in her foot--which turned out to be a wart.[23] Another woman reported that her doctor threatened to hospitalize her if she did not follow his advice to take medication.

Seeing the distress a woman expresses as problems with her "nerves" or psychosomatic reactions to day-to-day stresses trivializes her difficulties and suggests she is overreacting to the problem in her life. This lack of comprehension of the seriousness of her complaints is even more obvious when she has reached a crisis which doctors cannot

23. Interview with woman, Bodnar Journal, August 28, 1979.

categorize as day-to-day, normal difficulties.[24] The most cited example was that of the "paranoid" woman, who was described as out of touch with reality for thinking that people were deliberately treating her badly.

A diagnostic category such as "paranoid" treats the individual's life very selectively, recognizing only those aspects which can fit the persecution formula, e.g., "people are staring at me in the streetcar", "I'm not being treated well by the school authorities because I'm an immigrant", etc. It is a very different way of understanding what is happening to a woman than a description beginning with "her husband is drinking and beating her and not coming home at night..." or "she went to the school to talk to the teacher and she was told her son is mentally retarded". If a doctor does not have an understanding of a woman's situation and her difficulties, it is easy to see how her anger would be seen by him as hysteria, paranoia, etc.

The protest which accompanies a woman's complaints and anger are not recognized as expressing resistance to the treatment she receives. It is described as "hysterical". Her consciousness is not a part of the formula for a "reasonable" response to beatings, isolation, intimidation on the job, overwork. One doctor reported that he gave this kind of advice to a woman who was depressed over her husband's extra-marital activities: she simply had to make herself more competitive - to get more educated and make herself attractive like the models on television.[25]

24. Cooperstock cites findings from a family clinic setting that a disproportionately high rate of mood altering drugs were prescribed to women for the same symptoms and complaints made by men. She suggests that doctors' propensity to view women's health problems as psychosomatic rests on a view that woman's illness is often rooted in emotional instability, which is seen as intrinsic to her sex. This approach to women's ailments likely underlies the disproportionately high rate of prescriptions for mood-modifying drugs given to women. See Ruth Cooperstock, "Sex Differences in the Use of Mood-Modifying Drugs: An Explanatory Model", Journal of Health and Social Behavior 12, 1971, p. 238-244, and "A Review of Women's Psychotropic Drug Use", Canadian Journal of Psychiatry, Vol. 24, 1979, p. 29-34.

25. Interview with doctor, Reimer Journal, August 17, 1979.

Defining a problem as a failure to sufficiently please her husband reformulates her anger and turns it against herself: she is supposed to feel guilty (or even guiltier) for not being an attractive enough sex object. It defines a woman as an object, and reproduces her usual position of subordination to the enterprises of others. And if she cannot calmly accept such advice as a cure for what she is feeling, she will stand the chance of being judged "mentally ill" and entering the psychiatric labeling process. Her refusal to accept a reasonable solution evidences the diagnosis.

Those doctors whose offices were not part of a larger clinic seemed less likely to send people to psychiatrists. One explained that if the person is hospitalized, especially the older person, this would be quite a stress in itself. He also pointed out that women patients came into his office who had been administered electro-shock in the hospital but didn't know why and were afraid to go back to a hospital.[26] One doctor also mentioned that he wouldn't send his patients to the local family services because he considered their counselling too middle class and not oriented to his kind of clients.

Several doctors we interviewed did indicate that referrals to psychiatrists were commonplace, and that many women were hospitalized by psychiatrists for mental reasons. When these doctors are unable to deal with a woman's symptoms with medication, then a referral is made to a psychiatrist.

The role of doctors in identifying "mental illness" cannot be minimized. This is not only a question of shuffling a patient on to another specialist: three doctors reported that patients are admitted to hospital psychiatric units based on the requests of the family doctor. That is, in some cases the psychiatric assessment is nothing more than a formality and in others dispensed with altogether.

26. Interview with doctor, Reimer Journal, July 18, 1979.

The doctor's position as a medical practicianer qualifies him to label and categorize people in this mode of operating. This labelling and categorizing is consequential for women as it goes on their records and may be carried for life. In this way the doctor communicates to a woman that there is nothing basically wrong with the way people treat her, but the way she responds is inappropriate. If she complains too loudly and forcefully, then she is suffering a mental or emotional disturbance, has lost touch with reality and her response is out of proportion to the severity of her situation, as he sees it. If she is beginning to question and speak out about her feelings, she will come to see this as a symptom of her illness, e.g., as a part of the "nervous reaction" she is suffering.

If the difficulties women experience are organized for them by their limited and oppressive life circumstances, a medical practicioner would need to understand what that is about before he could help her. Silencing a woman with medical technologies is a perpetuation of the kind of experience she is subjected to in the Canadian context. Acknowledging that these problems are occurring and finding support for solving them seems to be a crucial beginning in reversing the "trap" which many immigrant women are forced into when they come to Canada. Unfortunately, many of the doctors who prescribe drugs are unaware of the conditions they are perpetuating with their professional ideologies and practices.

Psychiatrists and Hospitalization

Of the six interviews with psychiatrists, there was a range of approaches to women's problems. At one extreme, we found a psychiatrist who focused heavily on women's "hysterical" psychoses and neuroses, which explained anything from being "cold in bed" to calling her husband a "criminal", displaying "coquettish" behavior, etc. On the socially oriented side, one psychiatrist saw people's problems as related to their economic and work situations, family problems in handling the lower status of employ-

ment of the couple, etc. There are exceptions to the predominant orientation of doctors and psychiatrists to the "cultural" or role strain formulation of a women's problems. We mentioned earlier that some doctors are aware of the social and economic factors which create problems for immigrant women. Among psychiatrists, one did orient to the organization of women's lives in Canada, and this suggests that psychiatrists might work differently in relation to the immigrant patient. He commented on how different his treatment was from that of the general practicioner:

> Sometimes not at all -- it doesn't always require training and expertise. But some general practicioners don't have the time. This requires an understanding ear, common sense and support to restore the coping mechanisms and self esteem. These people don't necessarily need a psychiatrist. But some g.p.'s operate on a very strict medical model: pills are very important and are self-perpetuating. A woman asking for pills is really asking for someone to talk to. Pills don't really work and then she asks for a greater dose.
>
> (Interview with psychiatrist, Reimer Journal, August 23, 1979)

Such a socially oriented approach was truly an exception for the psychiatrists we interviewed who regularly see immigrant clients. Far more common was the symptomatic orientation to an individual's mental state. The focus on family relations very much utilized cultural or personality types of explanation as discussed earlier. For example, one psychiatrist pointed out that many of the older women are paranoid, and a typical hospitalized elderly woman has fears that her children won't take care of her. These descriptions of individual responses are not anchored in the economic and social relations of formal dependency and obligation, or economic difficulties arising from the extended family. A judgement is being made by the psychiatrist simply on the basis of "her problem" as it has come to be seen. Her family arrangements may be the source of difficulty, and the dependent relationship she has

to them; but this is not a topic -- she is the topic and her life is not present in the formal psychiatric "work up" of herself.

in that a woman's
These processes are striking/consciousness can be so insignificant in deciding what course of treatment she will receive. In some hospitals, the psychiatrist meets with the husband and wife before administering medication or electroshock to the woman. However, this seems to be an extraordinary basis on which to decide treatment, as one doctor described, the husband usually does the answering and she is powerless because he makes all the decisions. In such cases, a psychiatrist explained, the woman is not a good candidate for psychotherapy: she somatizes, it is said, because she can't use the language, or due to a lack of consciousness which makes therapy very difficult. Given that she is not amenable to therapy, a custodial form of care like medication is given or electroshock is administered.

The actual care a woman receives under these circumstances depends in part on where she is hospitalized. However, for those women we interviewed who had not been hospitalized, but merely spoke to a psychiatrist, an interesting pattern emerges. These two women had learned to speak English, were educated and could communicate well with the psychiatrist. Both were entered into therapy. The less educated, less articulate women were far less successful in defending their actions when confronted with a psychiatric reformulation of their lives. These two women who were hospitalized were both from working class, Portuguese families. This difference in the kind of care they received is in agreement with the findings of Hollingshead and Redlich, who found a definite class difference between the private, theraputic approach to the middle class patients and a bias towards custodial forms of care for the low income, manual workers.[27]

What also affects the kind of psychiatric care a woman receives is the

27. A.B. Hollingshead and F.C. Redlich, Social Class and Mental Illness, John Wiley & Sons, New York, 1958, cited in Smith & David, op. cit., p. 111.

cost-cutting measures being made in Toronto hospitals:

> The nurse to patient ratio has changed so that each nurse is responsible for more patients and less time can be spent with each. Increasingly, the way to cope with this situation is the more liberal use of tranquilizing drugs instead of the personal contact needed.[28]

There are basically two types of general hospitals which admit non-English speaking patients to inpatients psychiatric units: Hospital "A" will refer to a more community oriented type of hospital which immigrant women use; Hospital "B" to a teaching hospital which is located in an immigrant area.* In Hospital "A" a woman will have difficulty being admitted if her situation is deemed an "emergency" because the beds are usually filled as a policy of hospital administration. She may then be sustained on tranquilizers or be admitted to a mental hospital. The care she receives in the psychiatric unit will be more in the order of "custodial" care, although some of the staff will speak to her in her language. She will be given several forms of medication simultaneously and stands at least a 33% chance of having electro-shock applied to her brain. Since 66% of the patients were estimated by one nurse to be in hospital for depression, and half of the depressed receive shock, she will very likely receive it. Depression was the most commonly cited female disorder by psychiatrists and doctors.

Electro-shock treatment ("E.C.T.") described by hospital workers as the "treatment of choice" is still commonly used in Canada. One hospital worker described a case where a woman resisted being shocked:

> The woman cried for two days in a row. She had a two year old child, and stays at home alone. She has no relatives, no friends and wants to go back home. She is also very lonely and wants to talk to someone in her own language.

28. Let Us Take Care, op. cit., p. 15. Dr. T. J. McCann, chief of chronic care services at Queen Elizabeth Hospital, reported to the Ontario Psychogeriatric Association that the too liberal prescription of drugs and oversedation can precipatate acute psychiatric illness in the elderly. See Pat McNenly, "Drugs used to quiet aged made them worse, M.D. says" Toronto Star, September 12, 1979.

* These two types may not exist in the pure form and throughout metropolitan Toronto variations on these exist. These are not meant to refer to actual hospitals, but are a composite picture of different kinds of care.

> She refused ECT and was afraid of what the doctors and nurses thought of her. Everything was arranged in the operating room. But someone had told her that ECT was no good. She saw 10 to 20 people in the room and started crying and saying she didn't want it.
>
> She felt quite guilty and thought her husband was quite upset about it. He told her to do what the doctor wants her to do. Most people just do what the doctor says.
>
> She finally agreed to have it to please her husband and doctor.
>
> (Interview with hospital worker, Reimer Journal, July 23, 1979)

A chaplin intern who sees patients in this hospital suggested that what some of the Portuguese women actually need is a job (and to get out of the house), otherwise they will come back four or five times and their problems will never be solved. Once in the hospital, the chaplin interns will see a patient and speak to her in her language, if she chooses to see one, and they are "perhaps the only ones she sees who are not hurried like the doctors and nurses". One wonders if a more liberal use of tranquilizing drugs is used instead of personal contact which requires a larger staff to patient ratio.

In the psychiatric unit of Hospital "A", the staff-patient ratio is low, as compared to the teaching hospitals where resident psychiatrists and more specialists are working in psychiatry. As a consequence, there isn't "time or space" to conduct group therapy, and the language barriers between Portuguese, Italian and Spanish patients are said to prevent such groups. The patients here can participate in recreational activities, such as exercise and Bingo. However, these activities are not very useful to many of the Portuguese and Spanish-speaking women. While it is possible to talk to the doctor when he makes his rounds, communication is still restricted for the large numbers of Portuguese and Spanish-speaking patients, because the nurse who speaks the language has to be on the shift in question. They can also see the interpreter for the hospital and can speak

with her if she is not busy elsewhere in the hospital.

Hospital "A" might be considered in some ways to be a "poor man's" hospital compared to the well financed, teaching hospital, Hospital "B". In Hospital "A", an immigrant woman will have someone, sporadically at least, to speak her language. While she may be more likely to initially go to such a hospital, the restrictions on the kind and availability of care suggest that the fiscal priorities of the government were clearly not set to meet her needs. Although this hospital serves a low income, immigrant community, there is not even an outpatients psychiatric service or "drop in" centre where a working person could be seen without having to be hospitalized.

In the well financed, teaching hospital, Hospital "B", the use of custodial type care like electro-shock is said to be minimal (5%). The problems a non-English speaking woman will have in this hospital share some similarities with the first, however, even though they are organized quite differently. Here, as an inpatient, she will have no one to speak to if her language is Portuguese or Spanish. Her family may have to serve as interpreters at a point in time when they are least sympathetic to her, e.g., the case where a woman was called a "moaner and a groaner" by her doctor, and admitted in order to give her family a rest.

This practice of using family members to interpret may minimize the chances that a woman will speak freely and be able to define for herself what she is experiencing. A hospital cleaner who doubles as interpreter explained what can happen to a woman when her family members are the only source of interpretation:

> Three months ago a girl from Brazil came to the hospital drugged. She had a problem with her husband -- he told her she couldn't go home to Brazil. They fought all night. She told me he was forcing her to stay -- but her husband told the doctor something different. She asked me where she could get money for a ticket ... her daughter and family

> are in Brazil. Her husband, a Canadian, told the doctor that he hadn't refused to give her money for a ticket. Her arms and legs were bruised -- she said she had been thrown downstairs.
>
> Q: What would have happened if there had been no interpreter?
>
> She would have been in trouble. But after I talked to her, the doctor didn't ask what she had said. I gave her the address of (a community centre).
>
> (Interview with cleaner, Reimer Journal, August 23, 1979)

In the inpatients department of the teaching hospital, with 25 beds, it is not uncommon that the entire staff will be English speaking. While the staff may make many attempts to get a trained interpreter, the administration is said to not want to be known as a community hospital, because then less money could be allocated to teaching, research and expensive machinery. Psychiatry and social work are two areas which need to be oriented to the immigrant population, but are not because of the priorities of the administration.

The financial commitment of a hospital administration to providing such services has important implications for the availability of quality care versus custodial type care or a referral to a mental hospital. A trained interpreter explained how significant this is for the kind of care a psychiatric patient might receive:

> If you don't understand what a person's problem is, you can't treat them for it. This is very important in psychiatry because the problems people have often even can't be understood in their own language.
>
> (Interview with interpreter, Reimer Journal, July 23, 1979)

Among the problems identified by this interpreter was the use that is made of immigrant support staff who are not trained in interpreting or in medicine. Often a cleaner, for example, doesn't make the interpretation required but says what he thinks is appropriate. In one instance, a patient said that her husband never comes home at

night and has been running around, but the cleaner's translation was that the husband was lazy.

In another teaching hospital in an immigrant area, a doctor recorded that 50% of the patients assessed for psychiatric care were immigrants, out of a sample of 200, however, only 2 actually received care in a unit where the dominant foreign languages in Toronto are not spoken by the staff.[29] This hospital very clearly is oriented to a more middle class clientele, to the extent that one nurse described it as a place which is known for catering to people with money when they need to go for a rest.[30]

In the better financed teaching hospital, an array of activities are provided for the patients: art therapy, activity groups, patient outings, tea parties, community and exercise groups. The non-English speaking woman, however, is very isolated in this setting, and doesn't get involved in the activities. At the same time, these women are said to be failures in their communities for entering the hospital; their three to six week stay in hospital may likely be the first in a series.

The outpatients department of the teaching hospital (Hospital "B") does have a psychiatrist who speaks the languages of the major immigrant groups in Toronto. However, the ability of one person to provide all of the services which are available to the English speaking patient is doubtful, e.g., social work services, occupational therapy, nursing support, social groups and programmes.

The provision of homecare services by occupational therapists and public health nurses is another area where the non-English speaking person's health needs are inadequately met. The Community Occupational Therapists Association arranges for occupational therapists to visit patients needing help in adjusting to a life style change, often associated with

29. Interview with psychiatrist, Reimer Journal, June 25, 1979.
30. Interview with nurse, Reimer Journal, August 20, 1979.

injury on the job, or other health related problems. This organization has no Portuguese or Spanish speaking therapists whatsoever. They are called upon in conjunction with public health nurses to care for people who have previously been hospitalized or who require services at home.

In both forms of care, counselling and education are often an integral part of the services provided. Particularly the work of the public health nurses introduces a rare component of preventative care in the sense that a future crisis may be prevented by such a direct, localized service. In the case of her visits to women following the birth of a child, her services could be invaluable to the woman isolated in the home. The public health nurse as well as the occupational therapist bridge the transition a patient experiences moving from hospital to their home, with ailments of both a physical and a mental nature.

The language barrier is not the only factor preventing homecare services delivery to immigrant women. Home care services depend, for a patient in the hospital, upon a referral being made from within the hospital. Two of the non-English speaking women we interviewed for this study who had undergone major surgery were not assigned homecare until a community worker intervened on her behalf. The small number of public health nurses who speak Portuguese or Spanish suggests that the non-English speaking psychiatric patient will not likely receive homecare, that is, unless a nurse with her language happens to cover her area. The possible care provided to a mental patient with a limited use of English (or none at all) will be minimized by the problems of communicating under these circumstances. Several public health nurses complained of their difficulties in making contact with mental patients while in hospital, due to the psychiatrists' policies of excluding them from the mental health "team" in psychiatry. Before leaving hospital, the patient by law may choose to see a public health

nurse; however, this likelihood is lessened by the restrictions placed on her contact with patients while in hospital. This is particularly unfortunate because she is one of the few professionals who is familiar with the home settings and might provide concrete information on a woman's situation not utilized in the professionalized approaches.

This organization of homecare and the lack of language training for nurses in heavily populated immigrant areas underscores the inaccessibility of services to this segment of the population. The quality of counselling services provided to the non-English speaking woman is also questionable when she is required to discuss highly personal issues with a mimimum of English. While in some cases the nurses may help such a woman, others may be unnecessarily referred to a psychiatrist or hospital because they were unable to receive homecare in their own language. Once again, health services delivery appears not to be organized to satisfy the needs of the immigrant population. For women isolated in the home, or simply socially isolated, this means that crisis oriented solutions are the only ones offered.

The lack of cooperation by the hospital administration and government agencies to meet the needs of the immigrant population is yet another example of the second class status afforded immigrant women -- as immigrants -- in Canada. Although it is difficult to know the actual patterns of utilization of hospital services without records of immigrant use, some preliminary observations can be recorded nonetheless. It appears that Portuguese and Spanish speaking women less frequently become patients in the teaching hospitals where few if any staff speak other than English. She is either maintained on medication, referred to another hospital or counselling service, for the most part, or to the local mental hospital.

It appears that older Portuguese women who are non-English speaking are the most frequently admitted group of immigrant women we are discussing. They are least likely to have alternatives or options to a dependent, subordinate status, and most easily scapegoated should conflict arise

in a family. Portuguese women who are married and having difficulties at home, work, etc., seem to be the second most frequently cited group for either the teaching or community hospital. A third group would be the daughters of immigrants who are English speaking and most likely to receive some verbal therapy. While the frenquency of Spanish speaking women who are hospitalized is proportionately less, so are their numbers in the population.* The care most of these women receive in psychiatric units can only approach the most custodial when communication is minimized, and may likely enter a woman into a cycle of hospitalization and medication. Non-English speaking women who are not helped at a teaching hospital or one with an all English speaking staff will likely to to the mental hospital where admittance may not be denied as it is at general hospitals.

If she enters a hospital where the languages are spoken, she will be heard in her native tongue and will have some chance of communicating with someone. However, she will find little other than informal talks with a few staff members, and may be medicated and unable to receive formal therapy. In such cases more medication and ECT will likely be applied until some visible change occurs.

Clearly the care immigrant women receive in the health care system reinforces her dependence on medication and her definition of her situation as one of "sickness". Professionals who work with hospitalized women describe them in terms of how their reactions fit the psychiatric definitions of mental illness. The illness is seen as the problem rather than the social conditions of her life. Due to the lack of trained interpreters and staff with languages, the experience of being put on medication with no one to talk to only reinforces the view of a woman as sick, and unable to speak authoritatively about her life. The experience of hospitalization can only serve to reinforce this inability to speak. Non-English speaking women were described repeatedly

* However, the Portuguese immigration occurred earlier than the large wave of Latin Americans in the 1970's, so that similar patterns of utilization might occur once the Latin American group is in Canada longer.

as poor candidates for therapy, resulting in a custodial approach of medication and electro-shock. Even for in-patient units with multilingual staff, the chances were high that she would receive these same forms of treatment. More socially oriented approaches to immigrants cost money, and from the interviews with hospital workers, it appears that administrations place a low priority on investing in the immigrant patient (particularly teaching hospitals, which comprise the majority of downtown hospitals). This generalization holds true for the extension of relevant services in the area of homecare, where the non-English speaking woman will likely not receive the same care provided to her English speaking counterpart.

What is not understood in the psychiatric approach to illness is that the organization of an immigrant woman's daily life in Canada creates problems for her. The medication-hospitalization cycle fails to recognize the social basis of her problems and reformulates them as mental illness. The low priority on providing service to the immigrant populations results in non-English speaking women receiving the most primitive and custodial care, which will impress upon her the individual nature of her mental problems.

IV

SOCIAL SERVICE DELIVERY SYSTEMS

In order to understand the manner in which services both meet and fail to meet the mental health needs of Spanish and Portuguese speaking immigrant women, three service delivery systems are examined. The health care system was described in the previous chapter. The purpose of this chapter is to look at the ways in which government agencies, family service and community-based agencies, and alternative programs orient to the needs of immigrant women.

In a previous section, we described in detail the experience and the situation of the immigrant women in Canada. This has been done on the basis of in-depth interviews with the immigrant women where they talked of their lives and of their experiences with particular service delivery systems. We have also provided a more general analysis of the situation of the immigrant woman in Canadian economic life, of her secondary status in relation to government benefits, and of her dependent position in relation to the family. The situations in which many immigrant women live are exploitative and stressful. Women respond to these stresses by becoming anxious and depressed, or by protesting their situations by refusing to continue living their lives in the same manner. These reactions, be they of depression or of active protest, are dealt with in different ways by different service delivery systems. There is also variability among agencies within a particular service delivery system.

Our focus is to look at the ways in which agencies deal with the women's reactions to stress, as well as to understand the way, if any, in which they attempt to help the women take action to change

the oppressive situations they may face.

In examining government, family service, community-based agencies and alternative programs, we are looking at the orientation and practice agencies may have ir the following areas:

1. The immigrant woman's experience and the practical realities of her life.
2. The place of the immigrant woman within the larger Canadian and institutional context.
3. The nature and practice of sexist as opposed to non-sexist counselling.
4. The information and support given to a woman in her attempt to take an active role in changing her situation.

By looking at these issues we are trying to determine in what manner the agencies are meeting the women's needs, based on their own experiences and attempts to improve their lives.

In our research, we found considerable variability in how the immigrant women's needs were being met, both among service delivery systems and within them. Generally, the appropriateness of service provided ranged along a continuum from most inappropriate at the level of government and family service agencies, to most appropriate at the level of community-based agencies and alternative programs. In looking at appropriateness, we are looking at the ways in which services meet the needs of immigrant women, based on their own definitions of their needs and on the concrete realities of their lives.

The nature of this continuum is not simply a matter of chance. Service delivery systems that are highly bureaucratized and

professionalized require that their workers take on a particular professional approach and modus operandi. This approach is an individualized one which tends to see problems the individual is having in terms of cultural background or emotional make-up. The adoption of these assumptions by professionals remove the service provided from the context in which the problems arise in Canada, and lessen the likelihood that effective and concrete help will be provided.

The professional approach acts to put distance between the agency and its clients, a distance that allows for reinterpretation and misunderstanding of a client's situation. In looking at the various service delivery systems, there appears to be a degree-of-distance continuum running from government agencies at one end to community-based agencies and alternative programs at the other. Government agencies appear to be the most removed from a woman's life experience, while community-based agencies and alternative programs in their provision of service, appear to be the closest to the actual life of the immigrant woman and its practical organization.

From our findings, it has become clear that those services that hold the least distance from the immigrant woman are the most effective in meeting her needs. In response to this finding, we provide a rather extensive description of the nature of services as they are provided by community-based agencies and alternative programs.

The organization and mandate of particular agencies determine, to a great extent, the nature of the counselling practice that takes place. In every agency, there are particular ways in which clients and their situations are perceived, and particular procedures that are to be followed. At the same time, there is some degree of

flexibility in how individual workers approach their clients. This accounts for the variability encountered among workers in the same agency or service delivery system.

In outlining the agencies within the various service delivery systems we have examined the mandate and organization of the agency, the nature of their funding, the practice of the agency as reported to us by workers interviewed, and experiences with these agencies as reported to us by women interviewed. Some of the information included also comes from the experience of community workers as reported to us in our interviews with them.

In general, we found that all agencies reported a very heavy demand for counselling services on the part of Spanish and Portuguese speaking women. In some agencies, particularly family service agencies, there were not enough workers who speak Spanish or Portuguese to meet this demand. In other agencies, particularly the community-based, workers reported that they were overloaded with counselling needs, especially because these agencies are neither set up nor significantly funded to provide counselling services.

1) Government Service Agencies

Our comments on government services provided to immigrant families are based on several sources of information: reports from community workers who accompany their clients to these agencies, reports from women on their experiences, and interviews with two workers at a government settlement service agency.

Our investigations into the overall services provided to immigrants by government is necessarily limited. This is due to the fact that we have focused primarily on those agencies where immigrants receive social and counselling services. In addition, time constraints precluded a more thorough investigation of government services in this study.

On the basis of the information we gathered on government services, it appears that the professional approaches adopted in these agencies are not effective in meeting the needs of immigrant women. The most extreme approach emphasized the importance of the family unit and traditional female roles over the most basic needs of women. Also, women's problems were seen in the context of "adapting" to Canadian life, rather than in the context of the actual realities of their lives in Canada.

Women and community workers repeatedly reported negative experiences in their contact with some agencies in particular: government workers did not allow women to explain their situations and their desires for taking action, community workers were prevented from carrying out their advocacy and translation role, and women tended to be blamed for their problems, particularly in the case of marital conflict.

Overall, government agency workers did not make use of information about a client that would be available to them if their approach took seriously the realities of women's lives. In addition, they were not adequately prepared, in terms of their understanding of the immigrant woman's situation in Canada, and their knowledge and use of other community resources, to be effective in providing service. This lack of information and preparation, coupled with the adoption of a particular professional orientation, creates a distance between the agency's approach and the woman's experience and needs. This

distance lessens the possibility of providing adequate service.

In terms of referral patterns, it appears that government agencies make routine referrals to family service agencies when they judge that more in-depth counselling is needed. From our investigation of family service agencies, it appears that women will be dealt with in a similar professional manner.*

On the basis of reports from women and community workers, Family Court was one example of a government institution where unsatisfactory service was being provided. In the case of Family Court, the agency's commitment to family unity, even when a woman voices a different desire, is well illustrated. If a woman wants to leave her husband, she is discouraged from doing so by the Family Court worker, even though she may clearly be asking for a divorce. Family Court workers generally refer a woman who is seeking a separation from her husband to a family service agency for reconciliatory counselling. In this situation, the non-English speaking woman has more difficulty than her English speaking counterpart. It is more difficult for her to voice her opinions and to be aware of alternative services that could be useful to her in helping her carry out her decision.

In one case, a community worker reported that she accompanied a client to speak with a Family Court worker. The client was seeking a divorce from her husband: he had transmitted venereal disease to her and she was under doctor's orders to stop having intercourse with him. The Family Court worker would not let the community worker interpret the woman's account of her situation, only allowing her to answer "yes" or "no" to the questions put to her. The Court worker went on to tell the woman that she was in fact frustrating

* For further discussion, see Section 2 of this chapter.

her husband by not having intercourse with him.[1]

This woman was attempting to make a change in her life that she considered appropriate. The response of the Family Court worker was to negate the woman's experience of her situation, as well as laying the blame for her marital situation entirely on her shoulders. In addition, the community worker was not permitted to interpret fully or carry out an advocacy role. Following this encounter, the woman abandoned her attempt to separate from her husband.

Another example of government services with which immigrants have contact is that of a government settlement service agency. This agency is a major point of contact for immigrants to Canada and has permanent funding to provide settlement service to immigrants.

The services provided by workers in this agency include orientation, information, translation, and referral to other appropriate services. This agency also provides sponsored English classes and day care for the children of students. The basic services of the agency (not including English classes) are offered to any immigrant to Canada without restriction as to the length of time the client has been in the country. This is in clear contrast to the mandate of community centres which are only funded to give service to clients who have been in Canada up to a period of 36 months. The workers we interviewed in this government agency stated that many of their clients have been in Canada for 10 or 15 years. This point serves as one useful illustration of the fact that individuals do not automatically stop needing specialized services after 36 months in Canada.

In addition to having specific issues that need to be resolved, many immigrant women bring their problems with their families, their work, and their physical and emotional health to the counsellors in this

1. Interview with community worker, Reimer Journal, August 15, 1979.

agency. In fact, the workers reported that a great deal of informal counselling is provided to clients.

Since this agency is well known and a major contact point for immigrants, the quality of the counselling provided is important to examine. As reported to us, there appears to be no systematic understanding of the situation of the immigrant woman: her desire to talk about her situation is seen as a need to "ventilate" rather than as a desire to problem-solve and take action; her problems are seen in the light of problems of "adaptation" to Canadian life. Due to the limited understanding of the woman's life on the part of the workers, difficult issues tended to be avoided. For example, the issue of family violence was one that was often avoided. As one worker stated:

> Maybe this is a cowardly way out. I try not to get involved in these types of situations...I'm speechless when I have one of these situations. I try to find out why it happened, what caused it, and tell her to try not to let it happen again.
>
> (Interview with government worker, Reimer Journal: June 12, 1979)

This worker went on to say that:

> If the woman is really determined to leave, I'll tell her about Nellie's or Women in Transition, I'll tell her about legal aid, a lawyer who can speak her language, I'll even call for her.
>
> (Interview with government worker, Reimer Journal: June 12, 1979)

As reported by this worker, referrals to legal aid or hostels occurred only very rarely.

For a woman who is being beaten regularly it is often difficult enough to even consider leaving her home. This woman needs to be supported

in her struggle; at the very least she needs to be listened to. When faced with a worker who is unable to talk about the subject, a worker who may be her only contact outside her own family, and her only possible resource for the practical information she needs, the possibility of getting any help from this worker is slim.

A woman in the same situation would receive far more effective service from community workers who accept wife-battering as a reality and are trained to help a woman find a solution.* But if the worker the woman sees in this government agency does not refer women to community centres, her access to groups of women who are addressing these issues is severely limited if not completely denied. As has been mentioned, this agency is used as a primary contact point by many immigrants. For this reason the role of its workers is an important one. Some of the workers refer women to other family service agencies when they judge that a woman needs a more ongoing in-depth counselling process. However, there are problems with this referral system. Many women who have gone to family service agencies return to these workers telling them of unsatisfactory or negative experiences. As stated by these workers, women recount that the counsellor at the family service agency did not really understand even though the counsellor spoke the same language.+

In summary, our examination of government agencies that provide services to immigrant women has led us to several conclusions. What is most marked is a lack of preparation on the part of the workers to work effectively with the women.

* See Section 3 of this chapter. Community workers also run into many problems in trying to help a battered woman. Women's transition houses often isolate immigrant women further because they are geared to English speaking women. Also, there are no support groups presently in existence for battered immigrant women.

\+ For more discussion on family service agencies, see Section 2 of this chapter.

It is not possible to meet the needs of an immigrant woman with only a limited or incorrect understanding of her life situation and a practice of avoidance in dealing with her real concerns. In addition, if counselling is to be carried out in a serious manner, government workers must become informed about existing referral networks and resources.

2) Family Service Agencies

For the purposes of this study, we looked at two family service agencies. The workers we interviewed in these agencies see almost exclusively Spanish and Portuguese working class clients, many of whom are women coming in alone for counselling. Out of their total caseloads, the percentage of individual female clients ranged from 40-60%. Caseloads were reported as heavy, ranging from 75-80 clients per month. These very heavy caseloads impose time limitations that make it difficult for the workers to implement group programs for Spanish and Portuguese speaking women. We also found some limitations as to the quality of counselling that women were receiving. This point was reinforced by some accounts of women's own experiences with these agencies.

The agencies in question are well established in Toronto, both historically and financially. They have several branches throughout the city. Aside from their counselling focus, one of the agencies also provides groups for single parents, children of divorce, and battered women. To date, all of these groups are conducted in English, although there is a recognition for a need to establish groups in Spanish and Portuguese.

Family service agencies are, whenever possible, staffed by professional

social workers. These are public agencies that provide counselling for immigrants no matter what their length of residence in Canada. Out of all the numerous branches throughout the city, there are only a handful of workers who speak the languages of a large proportion of the clientele. As a result, these workers find themselves with very heavy caseloads.

The agencies we examined presented some general common orientations in terms of the ways in which women were perceived and the extent to which counselling of a supportive nature was provided. The agencies generally hold a specific professional mode of dealing with their clients, a mode that reflects considerable distance from the experience and needs of the immigrant woman as she defines these. This distance, in turn, limits the effectiveness with which service is provided.

The workers we interviewed generally had an approach to counselling that situated the problem as an individual one, i.e., there was something wrong with the individual's coping skills. Even when the social causes of a problem were recognized, the general orientation of the agencies was to see a woman as having an individual problem and to give her help to better cope with this problem. Although there was some range among workers interviewed in their adherence to this individualistic model, even the minority who displayed a clearer understanding of working class immigrant women were limited in their counselling practice. This is because their agencies do not prioritize alternatives to one-to-one counselling or programs for non-English speaking clients.

The workers we interviewed in these agencies stated that the problems women come with are largely in the areas of their home and work lives. They cited some common situations they see in the following way: wife-beating, infidelity on the husband's part, an unwillingness of the

husband to allow the wife to control the money she earns, and strain on the woman where she has to serve as mediator in parent-child conflicts. In the area of their work lives, women are referred to these agencies when they experience stresses due to working a double day, getting harassed on the job, and having to put up with abusive working conditions in factory jobs. Workers stated that many women have somatic complaints such as headaches, dizziness, backaches--resulting from situations that are assumed to be stress-related. It is important to realize that women are referred to these agencies and do not simply go on their own initiative. They are sent by the church, the school, the police, Family Court, hospital social workers, public health nurses or community centres. The referral agent has already made some determination that the woman has a "problem" and needs "more specialized" attention. These also often suggest specific solutions, which may or may not reflect her situation as a woman defines it.

Generally, the agencies have a family orientation: it is deemed important to keep a family united whenever possible. Divorce may be seen as a viable alternative in a situation where a woman is being beaten repeatedly and wants to leave her marriage. In this situation, a woman would receive supportive counselling and be presented with practical alternatives and her legal rights. Otherwise, it would be hard for a woman to get the information and support she needs to decide on divorce as a possible course of action.

Indications are that women coming to such an agency will be discouraged from thinking of leaving their husbands, and that they will be encouraged to view themselves as responsible for the problem. As well, they may be given advice on how to be a better wife. Such was the experience of one woman who went to one of these agencies and later visited an immigrant women's community centre. She expressed anger and frustration at the

type of counselling she received at this agency.[2] Community workers report that this is a common experience women have with family service agencies.[3] In this situation the traditional female role model of good wife is being reinforced, while her own struggles to break away from this model are negated.

The workers we interviewed stated that they attempt to involve the husband in the counselling process when he is willing to do so. In one case, the husband did not understand what it meant for his wife to work a double day, and was not willing to be practically and emotionally supportive of her. In this situation the worker tried to make the husband see his wife's situation.

So much hinges on the personal volition of the husband, on his choice to first come for counselling and then to change his behaviour, that in the common situation where a wife is economically dependent on him, she may feel she has little recourse but to accept his behaviour if he has no desire to change it. There are alternatives for her, both within and without her marriage, but she needs to gain access to information about these alternatives. Since she is commonly isolated and most probably does not speak much English, her chances of getting this needed information and support are slim. If this same woman visited an immigrant women's community centre for help, her chances would be far greater for gaining access to the information and support that would allow her to change her life.

It is of interest to note that there are only two existing support groups oriented to battered women in Toronto, although there is a general public recognition (on the part of doctors, social workers, community workers and the press) of the extent of wife-battering across culture and class lines, and a recognition of the lack of support

2. Interview with woman, Bodnar Journal, July 6, 1979.

3. Interviews with community workers, Bodnar and Reimer Journals, July, 1979.

services available to these women. Both of these groups are conducted in English. Most immigrant women do not have sufficient facility in English to join these groups. Many obstacles are put in the way of learning English, even for the woman whose motivation is very high.*

One of the workers we interviewed expressed an interest in initiating a Portuguese or Spanish speaking battered women's group. His caseload was such, however, that it absorbed all of his time. There was also some concern on his part on the suitability of a male leading such a group.

In family service agencies, many of the same kinds of practices are at play as described in the section on psychiatry, although a minority of workers interviewed stated critical attitudes toward the psychiatric model. The implications of adhering to this model of mental illness in counselling may do more harm than good to a woman needing support. When workers are faced with a woman they cannot understand or cope with, they report that she is "having" a distinct psychiatric illness (paranoia, schizophrenia, etc.) and refer her to a psychiatrist. Once under psychiatric care, the diagnostic and labelling process can be formalized, the woman may be medicated and hospitalized, and suffer the consequences of this entire process, as well as suffering the stigma of being labelled "mentally ill".

Thus, the type of view that an agency has of what is meant by "normal" or "mentally ill" is of great importance because it determines the type of referral that is made. At the same time, workers we interviewed stated that they had only limited knowledge of mental illnesses and were not "experts" in the field. Nonetheless, these same workers are in a position to make judgements and referrals that can be ultimately

* The majority of immigrant women arrive in Canada as sponsored immigrants, and as such, are not eligible for Manpower English classes. Refer to Chapter II of this report for further discussion.

damaging to the individual client. It is paradoxical that these same workers have received very negative reports from some of their clients who have been to psychiatrists or who have been hospitalized. Nonetheless, the referrals to psychiatrists go on because there exist few alternative modes of working with women who are breaking down in response to their stressful lives.

A minority of the workers we interviewed were critical of the very individualistic, therapeutic approach adopted by the social work profession over the last decade. This "therapeutic" social work model is very similar to the medical model in that it focuses on the individual as the primary cause of his/her problems and neglects the social structures in which people live and face real day-to-day problems. In the words of one worker:

> The therapeutic approach does not serve the ethnic community because it does not recognize the real problems that people have.
>
> (Reimer Journal, July, 1979)

This worker found it important in his work to help his clients "consolidate their economic base and advise them on how to use the system". (Bodnar Journal, July, 1979). This was done through referring his clients to community centres that could give them practical help and to existing group programs that would provide a supportive atmosphere in which to discuss their situations.

Summary

These family service agencies are staffed almost exclusively by professional social workers who have been trained to see the problems of their clients as primarily internal and individual, and only secondarily as having any relation to the social structure. When this professional analysis is joined with the psychiatric approach to mental illness, a woman whom the worker cannot comprehend or cope with is labelled and referred to a psychiatrist.

At the same time, a minority of workers in these agencies do not adhere to this model. In their approach they attempt to provide support to her for the concrete issues she has defined and consider the larger social context of which she is part. In an agency geared to a professional social work approach in counselling, an individual with a critical approach to this mode is an exception rather than the rule, and is constrained in actual practice by the procedures adopted by the agency.

These two approaches to counselling are clearly reflected in the recommendations made by workers having these differing frames of reference. When asked about perceived limitations in their work and perceived gaps in services for immigrant women, one worker, who supported a medical model of mental illness and referred clients to a psychiatrist on a regular basis, stated:

> There is a desperate need for workers, for professional social workers, in Spanish and Portuguese.
>
> (Interview with family service worker, Reimer Journal, July 18, 1979)

Another worker, this one critical of the individualistic, therapeutic mode of counselling, responded to the same question in this way:

> There are not enough women's support groups in Spanish and Portuguese. These would be very helpful. What we also need is a more verbal, vocal ethnic community to protest cuts in services and to demand services... the community centres can play an important role in determining gaps and in lobbying for services.
>
> (Interview with family service worker, Bodnar Journal: July 23, 1979)

In conclusion, our examination of these family service agencies illustrate two important points: first, that there is a clear need on the part of Spanish and Portuguese speaking women for counselling services as evidenced by the overly heavy caseload of the workers--a caseload that impedes the establishment of necessary group programs for this clientele; second, that the professional approach adopted by these agencies, by reinterpreting women's situations and not attending to the practical issues in their lives, serves to put distance between the agency's approach and the real issues for the woman. This distance inhibits the provision of effective service.

3) Community-Based Agencies

Community workers who provide settlement services at all of the centres surveyed recognize the need for further service to be provided for immigrant women. Because of the many unsatisfactory experiences of women clients, workers who solely or primarily see women feel they

cannot make referrals to the few family services and mental health professionals who can speak to the woman in her own language. As a consequence, the immigrant women's centres are overloaded with women needing someone to talk to and support them in the changes they are making.

Many of the women have already seen doctors, family counsellors and psychiatrists who have not understood their difficulties and have provided them with few or no alternatives.

Community-based agencies tend to be less professionalized and thus have a greater understanding of the realities of immigrant women's lives than do other service delivery systems described. This proximity to women's experiences minimizes the possibility of misinterpreting a woman, and maximizes the possibility of providing practical solutions to her problems.

Even though community centres are not set up to provide counselling services, the approach of the women's centres in particular provides validation to many women who were previously pushed back into the home or given pills.

It would make sense for the government to not only finance the expansion of counselling services at community centres, but also to create ongoing viable programs in these centres where women are already going for help.

The community centres that we studied are primarily funded to provide settlement services for immigrants throughout the "adaptation" process or up to 36 months. In practice, however, community centres serve many people who have been here over the prescribed time limit.

Several of the workers we interviewed stated that the problems faced by immigrant women do not automatically end at the three year limit. As one worker commented:

> There are two stages in the entry period. At first, there is a great concern with material stability. Emotional problems come later, three or four years after arrival. Women have more problems than men, men settle more quickly, while women are more isolated. They have to internalize their problems for a few years and then they explode.
>
> (Interview with community worker, Bodnar Journal: July 15, 1979)

When one considers the living and working conditions of low-income immigrant women in Canada, it is not difficult to comprehend why services provided by community centres continue to be essential over periods exceeding 36 months.

As related by community workers, immigrants arrive at these centres with a range of problems in the areas of dealing with the government agencies, social services, their home lives and their work lives.

We found that the services provided by the community centres, as reflected by the workers we interviewed, varied in the degree to which they provided supportive counselling services to their female clients. They ranged from being supportive and validating of her experience and desire to take action, to negating her by not taking her seriously when she questioned what was happening to her. In the extreme, she was blamed for creating the problems which arose without looking at the larger context of her life. Generally, however, services of a more supportive nature were provided in centres catering solely to women.

Routes to the Community Centre

Women may follow a number of routes to contact a community centre. In some cases they are referred directly by a government settlement service agency or by other social service agencies. Although many women go to their doctors with a variety of physical and practical problems, only a few doctors refer them to community centres. Most women find out about the services provided at community centres through advertising and through their own informal networks.

Overload in the Community Centre

All of the workers who were interviewed stated that a significant portion of their time is spent in providing counselling services to women clients. One immigrant women's centre provided supportive counselling to 90% of their clients over a one-month period. This demand for counselling, since it is not within their mandate to fulfill, puts these centres into the position of being overloaded. This is aggravated by the fact that at some centres, particularly those catering to women, workers do not feel that they can refer their clients elsewhere because of the negative experiences that have been reported to them by their clients.

In 1978, one of the immigrant women's centres initiated a publicity campaign in the ethnic radio and press. Women who wanted to talk over their problems with someone were asked to call in to the centre. Many of the women who called were isolated and had none of their own family members in Canada. They had a need to talk to other women. The response was so overwhelming that it was more than the workers could handle. It became necessary to end the publicity campaign. Nonetheless, this experience clearly demonstrated the need of Portuguese and Spanish speaking women to discuss their situations with

another woman who understands the realities of her life in Canada.

Even without publicity campaigns such as this one, many women regularly use the services provided by community centres. If we understand the subordinate position of the low-income immigrant woman in society, then it is easy to see why she would need the services of a community centre. These centres play an important role in providing advocacy and supportive counselling to the immigrant woman.

Contact with the Community Centre

Women come to a community centre with a wide range of problems that need attention. The most common problems, as stated by community workers interviewed, are in the following areas:

1. Documentation and interpretation
2. Help in getting government benefits, including sponsored English classes and Manpower training courses
3. Family problems, mainly with husbands and children
4. Being beaten by their husbands
5. Getting needed services for their children: day care, appropriate schools
6. Looking for a job
7. Work related problems: harassment on the job (verbal or sexual), problems in receiving UIC and Workmen's Compensation benefits
8. Legal help: for separations, custody suits.

The first contact a woman has with these community centres will almost invariably be for help with a practical problem. In the

process of working on these problems, other ones, of a practical or personal situation, will emerge. She will talk to the worker about the particular situation she is in that has led her to seek practical help in solving her problems. After her initial contact, she will often return with other practical problems or come to discuss her personal situation with a counsellor. If a woman is satisfied with the services provided by a particular centre, she will send to it other women she knows who may need help.

Case study: getting legal help

The following is the history of a client who came to an immigrant women's community centre to get a lawyer. The history is taken from an in-depth interview.

After several years living in a continually deteriorating marriage, Matilde decided to seek a separation from her husband. She first approached a counsellor she knew at a government settlement service agency.

> He sent me to a legal clinic - but they weren't able to help... I needed immediate action, someone to take over my case, but they could only give me a referral. He then sent me to an immigrant women's centre. I came to the centre to find a lawyer. Marcela was very helpful. She went with me to the lawyer and translated. Any problem I had, I would phone the centre. The first time I came in, I spoke for two hours with Marcela and felt better... I also came here to find out if I could get into an English class. When I went to Portugal when my father died, she still called my son to see how he was... After my operation, Rosa (another worker) arranged for a visiting homemaker. She also told me I could go to a special society where they help people with my kind of physical problem.
>
> (Interview with woman, Reimer Journal, May 26, 1979)

Matilde went on to comment that she found the services at this particular centre useful:

> Here, I get direct results versus referrals.
>
> (Interview with woman, Reimer Journal: May 26, 1979)

Matilde had had contact with this centre for over a year at the time she was interviewed. Her contact with the centre became an ongoing one and involved several facets: she was helped to acquire a lawyer and accompanied by an interpreter to effect her separation, she received ongoing emotional support following her decision to leave her marriage, and the centre played an important advocacy role in helping her to receive Manpower ESL training and Welfare following the separation.

Case study: work-related problems

Women also come to the community centres we examined for help when they were being verbally or sexually harassed on the job. The harassment can take the form of pushing a woman to learn a skill more quickly than she is able, or intimidating her into working faster and faster.[4] Older women also have difficulties at work and may receive no support from the union. One woman in this situation was shifted from a job she had competently performed for many years to one where she had to use technical skills in which she had not been trained. This woman suffered a nervous collapse. In response to the intervention of a community worker, she was reinstated to her original job and returned to work.[5]

The following is taken from a history of a woman who suffered severe emotional stress due to harassment on the job.[6] Alicia

4. Interview with woman, Bodnar Journal, August 15, 1979.
5. Interview with community worker, Reimer Journal, July 22, 1979.
6. Bodnar Journal, August 19, 1979.

became increasingly nervous as she was continually pushed to learn a new skill more quickly and to work at a faster pace. She began to have difficulty in coping with both her work and home life. These stresses culminated in a nervous attack that required medical treatment. This woman asked one of the immigrant women's centres to intervene on her behalf with her supervisor. This intervention led to action taken in her work situation. She also expressed that she was having some problems with her husband and would re-contact the worker at this centre to discuss this situation. In her own words:

> Although I don't know Margarita (the worker at this this centre) very well, I like and trust her as a woman and as someone from my own country. I feel understood with her and comfortable enough to speak about intimate matters.
>
> (Interview with woman, Bodnar Journal: August 19, 1979)

Working with Battered Women

All of the workers interviewed told us that many women are coming in for counselling in response to situations where they are being beaten by their husbands.

A worker in a women's centre stated that:

> Over half of my clients have let me know that they are being beaten by their husbands. My guess is that there are other women among them who are in the same situation but hesitate to talk about it.
>
> (Interview with community worker, Bodnar Journal: June 12, 1979)

Discussions of battering situations take place primarily with women workers at the centres surveyed. We found that female workers in five of the six centres surveyed, including the immigrant women's centres, work with battered women. The other centre is a busy information and interpretation service, catering to the entire family and staffed primarily by men.

One worker at a women's centre described her approach in working with battered women in the following way:

> When I first talk to her about a practical issue, she may also tell me that her husband is beating her and she has thought about leaving. I tell her that if she wants to change her situation to come back and talk to us.
>
> (Interview with community worker, Reimer Journal: August 6, 1979)

Once a woman has decided to take action in this situation, to try to leave her husband, she returns to the worker she knows to get practical advice and support during the difficult transition phase. The worker will tell her about her legal rights here in Canada.[7] Often, a woman believes that the law is the same as in her home country, where she is seen as her husband's property and he can easily get custody of the children. The worker will also inform her of the type of social service resources she can get. A woman can go to a transition house until she re-establishes herself, but several women reported that at the transition houses they were so isolated without English, and often became so upset that they decided to return to their husbands. Since there is seldom anyone at the transition house who can talk to her, community workers will be called in to interpret, or women will be referred back to the

community centre. When a woman is in the process of leaving a bad marriage, female community workers reported that they give her emotional support. They would remain in contact through the whole process: before she leaves, in her transition period, and when she is re-establishing herself on her own.

Workers in five of the six centres surveyed have reported that they have contact with battered women and give them as much service and support as they can within their limits of capacity. However, they are being faced with situations that are complex and require more viable solutions besides emotional support. Representatives of these agencies have begun meeting in relation to this problem and are in the process of planning a program of workshops to educate women on their legal rights. This group has also identified a need for a transition house for immigrant women. One worker stated that even a transition house with twenty beds would not be adequate for the number of women she sees.[8]

Case studies: Summary

These are only a few examples of the types of situations immigrant women bring to these community centres, of the ways in which they are handled by the workers and of the responses that clients have to their experiences with the community centres. They serve to illustrate the nature of the contact a woman has with some centres: she receives practical help within the context of emotional support for her own decision to act.

8. Interview with community worker, Reimer Journal, July 22, 1979.

Community Centres: Responding to the Immigrant Woman

Not all workers in community centres are supportive of a woman's efforts to take action and move towards increased autonomy. In our survey we found some degree of correlation between the type of service provided and the type of community centre. Generally, less supportive services were being given in centres run by men, staffed by men, and open to all members of the immigrant family. In one situation, when a woman left her husband to move into a transition with her children, the husband was able to enlist an agency worker to try to take the children from his wife as a means of persuading her to come back. Services of a more supportive nature were being provided by centres staffed by women and catering only to the immigrant woman. At the same time, we recognize that women (and some men) working in centres open to the whole family also provide services of a supportive nature to the immigrant woman.

There are many modes in which a working-class immigrant woman can be served. These modes are shaped by the setting in which the interaction takes place (hospital, doctor's office, formal social agency, community centre, home), the work organization of the particular agency, the resources available to the agency, and the orientation of the particular worker.

In those centres that do not cater specifically to women's needs, both men and women have access to service, and family counselling is often attempted. The general pattern seems to be that it is first the woman who approaches the community worker with her situation. Depending on the specific case, the husband and the children will be asked to come in, to join in the counselling process. In the case of one of these centres, the worker reported that 75% of the husbands in question were willing to come in and join in the counselling process. The rate of success of these ventures was more

difficult to estimate by the worker at this centre.[9] Because of the family orientation of these centres, attempts will be made to reconcile the family when possible, rather than to focus solely on the woman's experience and on her attempts to change her situation.

It is our belief that centres staffed by immigrant women, who are of a similar cultural and linguistic background as their clients and have gone through the experiences of immigration themselves, are in the best position to give good service to their clients. Many of these women workers have given critical thought to their roles as women and as immigrants in Canada, and have developed an understanding and a sensitivity to the situation of their clients, as well as having knowledge of various aspects of the Canadian bureaucracy. In our estimation, workers who are knowledgeable about the situation of immigrant women and are oriented to working in a supportive manner are in the best position to be helpful and supportive of them.

Community Centres: Referral Systems

All of the community centres we interviewed have a referral component in their work. Referrals will be made to appropriate government agencies, lawyers, family doctors, day care, English classes, programs at other centres, and so on. Our focus here, however, is on the referrals made in the area of counselling.

Referrals are made to agencies whose principal mandate is to provide counselling, called "Family Service Agencies", family doctors who do counselling, psychologists and psychiatrists. Among the six centres studied, there was some variability in the amount and type of referrals made. Some referred regularly, others not at all. In two of the centres, referrals are made when an individual's problems are judged

9. Interview with community worker, Reimer Journal, July 24, 1979.

as being too complex to handle at the community centre, or when it is evaluated that ongoing and regular counselling is required for a client. Referrals are made to particular workers in family service agencies who speak the appropriate language. Two family-oriented centres make regular referrals to family services agencies on the basis of previous personal contact with the agency worker, which included some evaluation on the effectiveness of the particular counsellor. At a third family oriented centre, referrals were also made to family service workers as well as to Spanish and Portuguese speaking psychologists.

In cases where women repeatedly reported negative experiences with these agencies and psychologists, referrals were no longer made. The three remaining centres, including the two catering specifically to women, make very few referrals, or none at all. Referrals were made when the centres were first established. However, the repeated negative feedback they received from their clients, and their own contact with these workers, have led workers at these community centres to stop making referrals to family service agencies or professional mental health workers.

It is of importance to note that many clients of community centres are hesitant to go to formal counselling agencies or professional mental health workers. Once a referral has been made to a formal counselling service, there has already been a judgement made that the client is "sick" and needs "help". This very process identifies the woman in a way that reformulates her experience and usually discourages her from following up on the referral.

A woman does not see herself as "sick" to go to a community centre for help. The community centre provides a variety of practical services that she needs, and is staffed by individuals who share her

language and cultural background, and with whom she can discuss her situation in an informal physical and emotional setting.

Workers in these centres find themselves in a difficult position: they recognize the need for counselling services for their clients, they cannot meet these needs comprehensively because it is not their mandate to do so, but they have very few agencies or individuals to whom they can send their clients.

Firstly, there are severe limitations in the actual number of workers in agencies or in the professional mental health care system who can speak to the woman in her own language. Those that do exist have extremely heavy caseloads. Secondly, there is a question as to the limitations that these agencies and professional mental health care workers have in the quality of supportive service that they are providing to the immigrant woman.

Community Centres: Working in Co-operation with Doctors

Two workers interviewed at two separate centres have been working in co-operation with family doctors and psychiatrists for a number of years. In both cases, the doctors contacted these workers to enlist their help in working with their immigrant women clients. These doctors felt that they did not have sufficient time or expertise in working with these women. In one situation a psychiatrist approached the community worker to enlist her assistance. The client continued her visits to the psychiatrist in order to monitor her medication and her overall situation while the worker met with this woman over a period of two years[10] to discuss various aspects of her life: her feelings, her home situation and possible work situations. The worker arranged English classes for this woman, contacted the teacher, and accompanied her to the class. The counselling process with this woman

10. Interview with community worker, Bodnar Journal, August 15, 1979.

went on in the office over the phone, and in the community setting.

In another situation, a doctor approached one of the workers with the situation of a woman who was having severe marital problems and had been hospitalized briefly. This woman would contact the worker in crisis situations over a period of several years.

In the cases of these workers, there is ongoing contact and feedback between themselves and the doctors in question. One worker stated that on some occasions, when she is asked by doctors to work with them, she has to refuse. She felt she did not have the time within her job situation to take on these clients.[11]

The co-operative relationship that exists between doctors and community workers has been established on a personal, ad hoc, basis, and there are clear limitations to it in its present form. Since this work is done largely outside of the formal mandate of the community centres, there are limitations on the amount of time and energy that can be devoted to this work.

Since it is essential to provide support for immigrant women whose situations have led to a need for medical intervention and who are presently attempting to establish themselves as independent and competent individuals, it would be of great benefit to establish a more formalized working relationship between professional mental health workers and community workers.

Conclusions

Community centres serving Spanish and Portuguese speaking women are overloaded by the demands on them by their clients. Women generally make initial contact with a community centre to get help in dealing

11. Interview with community worker, Bodnar Journal, July 10, 1979.

with a practical problem. In the process of working out this problem, the personal situations that have led her to take some practical action often come to light. Many immigrant women are isolated and thus have a need to discuss their situations with other women. Generally, community-based agencies are far less professionalized in their approach than other service delivery systems. This allows the agencies to understand the women's experiences and lives and to provide them with more effective, practical service.

Not all the workers in community centres respond in a supportive manner to a woman who is trying to take action to better her situation. Generally, we found that the most supportive workers were to be found in centres catering specifically to women. At the same time, some workers in family-oriented centres also provided services of a supportive nature to their women clients.

Although there was variability among the centres in terms of referring their clients to other agencies or to mental health professionals, many workers do not refer clients for counselling because of the negative feedback they have received from clients who have had contact with these other services. Since the needs of immigrant women cannot be met simply through individual counselling, the solution lies in creating programs for women, programs that would give needed information and support to a woman who is attempting to make changes in her life.

4) Alternative Programs

It is out of recognition of this need that a handful of programs have been created. These programs are organized on the basis of the needs of immigrant women as a group. There is recognition of the fact that many problems that immigrant women have arise out of their situation as a group, and their place in Canadian society, rather than being seen as problems of an individual nature. The programs attempt

to speak to the needs of immigrant women as they define them. The programs tend to be informal in style as well as location. The approach of the alternative programs is oriented to the direct needs that women have, and thus can be most effective in addressing their practical difficulties and their needs for information and support.

The existing programs, though they may differ in the focus of their content, have in common a desire to provide education and information that an immigrant woman needs to take more control of her life. This information is passed on in the context of a supportive environment, provided by the group facilitator and the group members.

Most of the existing programs have to struggle for their very existence, not knowing if their funding will be renewed and constantly on the lookout for new funding sources. This type of situation constitutes a problem: much time that could be given to program development is spent on funding issues and in some programs, there is a heavy reliance on volunteers who have many other commitments.

Existing programs are in the following areas: to provide social contact, programs supportive of women who are isolated and depressed, job orientation and training courses, and teaching English in the workplace in the context of worker education.

In addition, a network of community workers are presently co-operating to initiate a course for Spanish speaking battered women within the confines of existing funding available to community centres.

Social groups for immigrants were established by the YWCA several years ago. There are several of these groups in existence throughout the city, catering to West Indian and other ethnic groups. These groups are aimed at bringing together isolated women to provide

them with support and orientation to Canadian life. At the present time, all of these groups are being conducted in English.

Social groups also exist at the Centre for Spanish-speaking People (where a group has been running for several years), and another one was recently initiated at Scadding Court Community Centre. This group meets under the title of the "International Cooking Club".

In recognition of the lack of services to immigrant women in the suburbs, several workers in Rexdale initiated a pilot outreach program in December 1978, to bring together immigrant women in the area who were experiencing social and psychological isolation. The aim of this program was to "help these women overcome their fears and frustrations by linking them with a small group of sympathetic neighbours, using trained volunteers as facilitators".[12] Groups have been established for West Indian, East Indian and Italian women. A group for Spanish speaking women may be organized in the fall of 1979.

This group uses the self-help concept as a model for working with isolated women. There is only one paid staff person, who acts as co-ordinator of the program. Home visits and group facilitation are being carried out by trained volunteers. This program relies very heavily on volunteers, and this can be difficult in a situation where the volunteers are also part of the salaried work force, as well as having commitments to their own families. This program has a large outreach component. It is important to remember that the outreach process is a long and labourious one, though very important in the process of bringing isolated women together. Another aim of the Rexdale project has been to make contact with immigrant women to find out the types of programs that would be useful to them. It was found out that women of different cultural and class affiliations had

12. Rexdale Immigrant Women's Project, May 1978.

different needs and different styles of interacting: some shared problems with other women more easily than others. At the same time, all of the women in the groups expressed a desire for more content-oriented, structured programs.[13] This is useful information to have for the planning of future programs for immigrant women. The Rexdale Immigrant Women's Project has funding for one more year--after that, its future is uncertain.

There are a few group programs that have as their focus immigrant women who are isolated and depressed and who may have had contact with the psychiatric profession. Two years ago, one such program entitled "Breakthrough" was started for Italian women by a worker at the Canadian Mental Health Association. Although this program is an established one, only a very small number of women is involved with it at any given time because referrals to the program are few.

A non-clinical therapy group for Italian women is also in existence at COSTI's Women's Centre. The women's centre also provides recreational programs and personal, educational counselling to Italian women and to a lesser extent, Latin American women.

The Canadian Mental Health Association recently (summer 1979) initiated a support group for West Indian women who are experiencing emotional difficulties. Although the program worker is contacting many agencies, psychiatrists and hospitals, referrals to this program have thus far been very few.

There are two programs geared to women in difficult emotional and practical situations presently at the planning stage for Spanish and Portuguese speaking women. One of the groups will be formed at Scadding Court Community Centre and will focus on women who need a supportive environment in which to discuss their problems. It is possible that

13. As reported by the co-ordinator and volunteer worker in this program. (Bodnar Journal, August 1979)

this group will also include women who are having or have had contact with psychiatrists. The only other program for Spanish speaking women will focus directly on battered women in the Spanish speaking community. This program is being organized through the co-operation of various community centres and will be based in the Centre for Spanish-speaking People. It will provide much-needed information on legal rights, social services and housing to the battered woman, as well as emotional support. This will be the first group of this nature oriented to immigrant women, although there has been long-standing recognition of the large numbers of battered immigrant women on the part of community centres, family service agencies and medical professionals. This program has no funding and will be made available by existing funding and staff at this Centre.

There are many Canadian women who are also subject to family violence, and at the present there are only two support groups available to them: one in the downtown area and one in Scarborough. The problem of battered women of any class or ethnic group is at last being discussed openly and some action is being initiated to provide information and support to these women.

Other existing programs focus on job orientation and training. The "Making Changes" Program, an eight week course for (a maximum of twelve) women is presently being offered for the second time at the Cross-Cultural Communication Centre. This course aims to help the immigrant woman to improve their situations by giving them job preparation, career counselling and familiarizing them with various educational and social resources. The program worker we interviewed who is involved in "Making Changes" sees all aspects of a woman's life as interconnected: her job situation, her difficulty in getting day care, her family life. In addition to getting information and counselling, the women are given assertiveness training as related to

the job situation. As the course continued, women would also talk about their overall life situations with each other. In addition, they often had contact with the two group facilitators outside formal group time--mostly to discuss particular issues around job situations and returning to school.

Although the focus of this group was not geared primarily to giving emotional support for the women, this support emerged through contact with each other and with the group facilitators. The course was given in English, although many women who participated spoke English only with difficulty. These women expressed to the facilitators that their English skills improved as the course progressed, because of the opportunity to practice their English skills in a comfortable environment. The "Making Changes" worker we interviewed was pleased with the progress and outcome of this particular program, because it was helpful to a certain number of women. She, however, went on to state: "...but it is only a drop in the ocean. This type of program is useful for women in terms of finding out about resources and in giving them more faith in themselves. But there is a lot expected from individual women in terms of personal change in order to fit into the system... it expects a lot of women in terms of battling institutions... what is needed is more advocacy to support women all along the way..." (Interview with program worker, Bodnar Journal, August 29, 1979)

Many program workers and community workers share this opinion: they support the creation of programs to meet the needs of the immigrant woman while at the same time, they are aware of all the difficulties she faces in the larger context of Canadian society.

Another program that focuses on aiding the immigrant woman in the labour force was created through the Working Skills Centre. This program provides a six-month program for women, where they are trained

in mail-room techniques, and provided with life skills and English as a Second Language classes.

In an attempt to move immigrant women out of the factory and cleaning sectors of the labour market, another skill was chosen in which to provide training. After careful market research, it was decided that mail-room techniques was a useful skill to have in terms of future employment possibilities. This program is in its second year, at the end of which it will have to re-apply for funding. The women who are involved in the program benefit from its various components, but in the context of the large numbers of immigrant women who need job training and accessible English classes, one such program reaches only a small percentage of women.

Another program that is work-related is the "English in the Workplace" program, which has benefited some immigrant women in the factories. Unfortunately, this program is at present only available to women who work in unionized shops, and only to a small percentage of these. Ongoing work is being done to introduce English as a Second Language in the Workplace to additional unionized shops. In this program, the content of the classes is made relevant to the needs of immigrants working in these settings. This form of teaching English has several short and long-term benefits. Firstly, women who come together in the class have the opportunity of forming a supportive environment through their contact with each other. Secondly, English is being taught in a manner relevant to their own situations as immigrants, as women, and as workers. The curriculum material is one that is functional to their needs and as such will facilitate the acquisition of English skills. Thirdly, women will become more aware of their rights as workers, and the role of the union in their workplace. All this will allow them to be better able to make use of their union when they need it and to take a larger participatory role in union matters and decisions.

Although the programs that are geared to job orientation and training, worker education and the teaching of ESL do not focus specifically on "mental health" issues, it is clear that they are serving the purpose of promoting mental health, especially if mental health is understood in the context of being a product of all of the factors affecting the life of the immigrant woman.

More important, these programs can be seen in the light of preventative mental health. By better arming the immigrant woman to cope with the difficult position she finds herself in, and by giving her some skills to change her situation, these programs are lessening the probability that she will break down and come into contact with counsellors, psychiatrists and hospitals.

Other programs that have been discussed here also serve preventative functions, one example being the programs that bring women together breaking down their isolation. Other programs give support to women who already suffered the consequences of stressful lives: COSTI's group program, the groups initiated by the Canadian Mental Association, and the course for battered women that will be offered in Spanish are of this nature.

Although all of these programs are valuable in beginning to meet the information and support needs of immigrant women, we must keep in mind that these are only a few programs for a very large number of women. In addition, many of these exist only from month to month because of their precarious funding situations. Some are being created in existing community centres without special funding and as such tax the already heavy load of community workers. Other programs rely heavily on the support of volunteer workers and as such have limitations.

Over the last few years, several groups providing services to English speaking women have taken an interest in the immigrant women's

community. For various reasons, solid links have never been made; workers in (Canadian oriented) women's programs may not have the necessary understanding of the situation of the immigrant woman to effectively meet her needs. This was the case in one course designed for women who do counselling work with immigrant women: the course was oriented to teaching therapy techniques that could be useful to middle-class Canadian women but did not meet the needs of working-class immigrant women. More important, however, is the funding crisis that all women's services have been in for the last few years. It has been difficult enough for services like Nellie's transition house, Times Change employment centre and the Women's Counselling Referral and Education Centre (WCREC) to meet their operating costs to maintain existing services--to expect them to develop new programs for immigrant women is unrealistic. Before its own severe funding cuts, WCREC was developing programs to work with low-income and immigrant women. When its staff was reduced from six full-time workers to one full-time and two half-time, it became impossible to continue in these new directions. Unfortunately, it is likely that WCREC itself will shortly be forced to close its doors due to a lack of funds.

Summary

In our view, those agencies which are oriented to the experience of immigrant women and the practical realities of their lives are in the best position to understand a woman's situation and offer practical solutions to her problems. We feel that if people are given support and practical help, and the means to help themselves, then they are receiving the most effective type of service.

In looking at the social service delivery systems, we can see a general continuum from ineffective to effective service ranging from government and family services at one end to community-based agencies

and alternative programs at the other. At one end of the continuum we find government and family service agencies which are highly professionalized in their approach and distant from the experiences and practical needs of their clients. Following this continuum we find some community-based agencies, particularly immigrant women's centres, to be less professionalized, less distant from women's experiences, and thus, more effective in meeting their needs. At the other end of this continuum, we find a handful of alternative programs which are the most oriented to the actual experiences of immigrant women. They use a group approach which focuses on problems as these arise in a social context rather than on individual weakness or illness.

V

CONCLUSIONS

Low income immigrant women are disadvantaged and experience a second class stuatus: this is created by the practices of government and business institutions that condition her entry into the labour force. Her disadvantageous economic and social status reinforces her dependency in the home and limits her options in attempting to improve her life.

Social services adhere to professional ideologies that maintain her subordination in the labour market and in the home. The professional appraches in social work, medicine, and psychiatry are not rooted in an understanding of the processes which define a woman's experiences in Canada. Their reliance on assumptions of individual motivation and of problems created by the culture of origin obscure the significance of what is happening to an immigrant woman in Canada. Particularly the psychiatric approach to women's problmes reinforces a preconceived image of good mental health for women who conform to traditional female roles. Rather than question the world around her and to expect the same benefits and opportunities others receive, immigrant women are encouraged to look inward for the sources of dissatisfaction in their lives.

Our findings reveal a gap between the way immigrant women experience their lives and the ways these have come to be understood professionally. We have attempted to present a sketch of some of the service networks which most frequently come into contact with women in crises and the services that are provided for women in need.

The most general conclusion is that the health care and social service delivery systems are not functioning in a manner to serve the needs of

low income immigrant women. At one extreme, most medical and psychiatric services are largely inaccessible to a woman in crisis when she cannot speak to someone in her own language about her pressing concerns. At the level of crisis intervention, the traditional approaches are often invalidating of the individual who has suffered the humiliation and exploitation many of these women have, as individuals with minimal social power in a new country. The sexist and professional orientations which pervade many of the health care and social agencies reinforce this subordination in the home, the labour market, and the larger Canadian context.

As long as the actual circumstances faced by the low income immigrant woman remain a mystery to social and health care workers, the services which are available will individualize and deny her reality.

The experience of the low income immigrant woman in Canada is often one of exploitation in the workplace, conflict in the home, and isolation. Her situation is reinforced by government policies that deny her subsidized English classes, day care for her children, recognition of her skills, and access to training and other benefits. The lack of options this imposes on her increases the difficulties she already faces in attempting to maintain a household with very few financial resources. The pressures experienced by many immigrant men as minimal wage earners, with lack of control in the workplace and little social status are transmitted to the woman in the home. In this social context, many low income immigrant women live in oppressive situations over which they have little or no control. Their responses to these situations include depression, breakdowns, and/or physical ailments. Whatever the reaction of the woman, she often has a need to share her situation with other women and receive support and validation.

The majority of existing health care and social sercices treat the problems women have as individual in nature. They try to help her cope and adapt to her situation, rather than focusing on the context in which the problems arise. Because the approach held by most agencies that work with immigrant women is one that is distant from the ex-

periences and lives of the women, it is not surprising that they are not effective in meeting her needs. This view is part of an approach to understanding society which has been termed "blame the victim": it is the individual who is at fault, not the social system in which she lives. If the individual is seen to be at fault, then it follows that the kind of help give will be to correct this fault, or illness. Thus, the approach is the individualistic one adopted by most existing health care and social services that sees a woman as being 'ill' or 'unable to cope' and tries to help her 'adapt'.

A common complaint that is made about immigrant women is their "lack of motivation" to learn English. This complaint is often heard from Manpower counsellors and other government workers. There appears to be a general belief that if a woman learned English, then she could work at better jobs and also use the social and health care services that exist for English-speaking Canadians. There are several problems with this analysis. First, by seeing the issue of learning English in the context of personal motivation, the organizational aspects of a woman's life are ignored. Since the entry status of an immigrant woman is most often one of a dependent immigrant, her access to subsidized English classes is automatically denied. The belief that immigrants should take advantage of free English classes in the evening ignores the fact that these women have to work at tiring jobs, and in addition, have to look after their families. The jobs that most immigrant women have access to are those where they will have contact with other immigrants, and thus, the possibility of learning English is minimal. The expectation that immigrant women, if they are motivated, can learn English in their free time is an unrealistic one: the structure of her life simply works against this outcome. The learning of English is often seen as the magical solution that will assure "adaptation" for the immigrant woman. In addition, it is often believed by the public at large that the English speaking immigrant woman no longer needs special services because she now has access to all of the services that English speaking Canadians use. What this position fails to take into account, however, is that most

existing health care and counselling services are inappropriate for all women in that they do not take into account women's experiences from their point of view and tend to reinforce women's traditional roles as wives and mothers. Women have begun to question and critique these practices and attempts have been made to establish alternative services for English-speaking women.

Although the low income immigrant woman shares many of the same problems as her English-speaking counterpart, her situation is more difficult. Because she cannot speak English and has less control over her life, it is more difficult for her to protest her situation and to speak authoro-tatively on her own behalf. It is more difficult for her protests to be taken seriously by the professionals with whom she comes into contact. Most of these professionals are men, particularly in the health care fields. The professional orientations which they both follow and help to formulate have the effect of maintaining these women in the traditional roles rather then supporting their attempts to break out of them.

As contributors to society and the economy as mothers, workers, and tax-payers, immigrant women have the right to services that meet their needs. The picture that emerges from this study is that the majority of existing services are inaccessible to the low income immigrant woman and do not begin to meet her needs. We found this to be true throughout the health care and social service systems, with the exception of a few community centres and alternative programs.

There are concrete gaps in accessibility due to language: for example, in the various services provided by the health care system, particularly hospital interpreters, public health nurses and psychiatrists. There are also language-related limitations in service delivery systems such as family service agencies: the few workers who speak Spanish or Por-tuguese carry very heavy caseloads which prevent them from establishing important group programs for immigrant women.

Services that are supportive to women are being provided by some community-based agencies, but these agencies find themselves overloaded by the

demands for counselling. In addition, they are not funded to provide counselling and are only funded to provide service to immigrants who have been in Canada for a period up to 36 months. Our findings suggest that there is very little relation between the arbitrary 36 month limit and the needs of immigrant women for these services. In fact, community based agencies do provide services to these clients without being reimbursed for them. Also of importance is the fact that the very existence of these agencies is precarious in terms of ongoing funding.

There are also gaps and limitations on the level of the quality of service that is being provided by all service delivery systems. These limitations are clearly seen when service delivery is analysed in terms of its orientation and practice in the following areas:

1) Knowledge of the low income immigrant woman's experience and practical realities of her life,
2) The place of the immigrant woman within the larger Canadian bureacratic and socio-economic context,
3) The provision of sexist as opposed to non-sexist counselling,
4) The provision of information and support to help a woman take an active role in changing her situation.

In the health care system, the responses that women have to stressful lives are generally seen as symptoms of individual illness. These symptoms are dealt with through medication, Electro Convulsive Therapy, and psychotherapy. In this context, she is seen as "sick" and her contact with the health care system may serve to label her as "having a psychiatric illness" and initiate her career as a mental patient. The actual concrete issues in her life that led her to experience emotional stress will often be left behind, unexamined and unresolved. Of the few psychiatrists who speak Spanish or Portuguese, the majority do not appear to deviate from this approach.

In the government and family service delivery systems, there are similar gaps and limitations in meeting the needs of immigrant women. Workers in government service agencies will negate a woman's stated desires for making changes in her life and interfere with the work of community

advocates interpreting for and representing their clients. One government settlement service agency provides counselling of an informal nature, even though it is not within the formal mandate of this agency to do so. Workers in this agency tend to see the problems of immigrant women in terms of "adaptation", again putting the burden and blame on the indvidual rather than looking at alternatives to an oppressive situation. In addition, the agency workers are not sufficiently familiar with the services available at the community-based agencies and do not make appropriate referrals to these agencies when needed.

Family service agencies are largely staffed by social workers who have been trained to see the proglems of their clients as individual ones and carry out their counselling practice within this frame of reference. Even those workers who have some understanding of the immigrant woman's expereince and of the concrete socio-economic forces in her life are limited in meeting her needs because of the mandate and practices of the agencies in which they work.

If a client's problems are seen as too complex for the family service agencies to handle, a referral will be made to a psychiatrist or hospital, where a woman will be treated as if she were "sick", will be medicated, and could begin her career as a mental patient. As in the case of government service delivery systems, workers in family service agencies have limited knowledge and make limited use of more relevant services provided by community-based agencies.

Community-based agencies are overloaded by counselling needs of immigrant women. Among these agencies, there is variability in the extent to which a woman will receive counselling that meets her needs. Generally, less supportive counselling is provided in agencies that are run by men and serve men, women, and children, while more supportive counselling is provided in centres that are staffed by women and cater solely to women. At the same time, there are some centres that serve the immigrant family that provide legal assistance and useful programs for women.

At an immigrant women's centre, the experiences and social context of the life of the immigrant woman is understood and validated, counselling takes the form of providing information and support to help a woman change her life. The woman will not be seen as "sick".

Although services that are beginning to meet the needs of immigrant women are being provided in some community-based agencies, these are largely on the level of individual counselling and as such are limited in their effectiveness and reach very few women. Because of these limitation, the the gaps and limitations that exist in all service delivery systems, there is aneed to initiate programs for immigrant women. These programs would serve to give needed information and support to a woman who is attempting to improve her life. The programs would also serve a preventative function in that they would better equip the women to deal with the difficult situations they encounter in their subordinate position in society.

Though few at this time, existing alternative programs are an illustration of an alternative mode of working with immigrant women. Their approach, by focusing on the actual needs and experiences of immigrant women as a group, is in clear contrast to the professional individualized approaches often adopted by the health care, government, and family service delivery systems. In these, women's experiences are often not understood, and their situations are reinterpreted to fit a framework not of the clients' making.

Thus, alternative ways of working with immigrant women are possible, and effective.

The overall picture of immigrant women in Canadian society is a disturbing one. Many of these women are not provided with even a minimum of support until they have experienced a severe crisis and must turn to the service delivery system out of desperation. If the government is serious about providing access to health care and social services for the immigrant population, its most disadvantaged sectors cannot be eliminated from receiving such benefits.

Concrete measures must be taken to provide funding for programs for this sector of the population.

RECOMMENDATIONS

Introduction

On the basis of our investigation as reflected in this report, we have come to the conclusion that those services which are closest to the immigrant woman's experiences are the most effective in meeting her practical needs. We also believe that services that are geared to a group rather than an individual are most effective because they recognize that similar problems are shared by many low-income immigrant women because of the context in which they live in Canada. Programs geared to groups are also more effective because they reach larger numbers of women.

In addition, there is action that can be taken within existing health care and social services that would make them more accessible and effective for immigrant women.

Program Recommendations

Programs should be funded at an immigrant women's centre that would provide women with information that will be useful to them in becoming aware of their rights, and to provide them with with the tools to exercise these rights in finding alternatives to their present living and working conditions.

The programs will have several functions:

1) Social: to break down the isolation experienced by immigrant women by bringing them together in a relaxed setting where they can voice their common concerns.

2) Educational:

   a) Information on women's legal rights in Canada: in the areas of immigration, family law, landlord and tenant rights, etc.
   b) Information on resources that are available to them: social services, medical services, consumer information, etc.
   c) Information on labour rights and eligibility for benefits.
   d) Facilitation of community projects, e.g. organizing day care facilties or other community needs.
   e) English as a Second Language training.

This series of workshops will give support and information to immigrant women so that they may evolve from their passive role to a committed role as initiators of change in their lives and in their communities.

General Recommendations

1) Funding criteria for community services should be expanded to cover those services provided to immigrants who have been in Canada for over 36 months. Services continue to be needed past this stipulated time period and social services in their present form are not accessible to immigrant tax-payers.

2) Firm funding for Mental Health programs for immigrant women to be run by community agencies.

3) Make health care services more accessible to immigrant women in terms of language through
   a) the provision of trained interpreters in hospitals
   b) more public health nurses, occupational therapists and Home Care services that speak Spanish and Portuguese or have interpreters available to them.

4) A series of educational workshops for social workers, health care workers and community workers, and other professionals working with immigrants, including education in the following areas:
   a) the situation of immigrant women in Canada and providing services relevant to them
   b) education in the area of mental health for community workers, including workers in the suburbs
   c) education for all workers on the services available in the community centres, particularly for health care workers
   d) education of doctors and psychiatrists to alternatives to drug dependency for women in crisis

Potentially, these workshops could be sponsored by Women Working With Immigrant Women.

5) The health and social work training institutions should take responsibility for training their students to become aware of the immigrants' situation in Canada in order to provide relevant services and health care to this segment of the population.

6) The establishment of a community-based referral network on types of counselling that are alternatives to the medical model.

7) The establishment of more hostels for women. The establishment of a hostel geared specifically to immigrant women. The addition of staff with language skills in existing hostels.

8) That support groups by the Canadian Mental Health Association be extended to include Spanish and Portuguese speaking women with past or current experiences with psychiatric agencies. These groups would follow the model of those existing presently for Italian and West Indian women.

9) Expansion of classes in the English as a Second Language in the Workplace Program.

10) The establishment of a support group or network for front-line workers to deal with burn-out.

APPENDIX I

INTERVIEW SCHEDULE FOR CASE HISTORIES OF WOMEN

This basic format was used as a guide for the case histories with all the women. Not all parts of it were relevant to all the women. Where a woman had a particular situation she wished to discuss more extensively (such as divorce, hospitalization, problems at work, etc.) we allowed for sufficient flexibility in our format to accomodate this.

I. General Information

Age:
Marital Status:
Age of marriage:
Place of Birth:
Citizenship:
Education and Special Training:

II. Immigration History

Time in Canada:
Why did you immigrate?
How economic situation in home country affected decision to immigrate?
Was immigration your decision?
In what order did you and your family, husband's family arrive here?
What did you know about Canada? (from friends, relatives, books?)
What were your expectations, concretely, in coming here?
What is the relationship between these expectations and the realities you have encountered here?
Who made the legal intervention to bring you to Canada? (sponsorship, nomination, etc.)
Who of your family was here before or has come since?

III. Home Life

Household: Who lives in your house?
How many people work?
Who began to work first?
Who makes decisions around money, buying things, children, social activities?
When you initially came, how did you shop, cook, clean, get around? Alone? Did husband go with you?
What were your problems with English when you first came?
Did you take ESL and/or Manpower Training when you arrived? If not, why not?
Does husband speak English? Did he take courses? If not, why not?

Children:

How many?
Ages?
Day care? School?
Do children speak English?
Do they help you when you have to do things that need English?
Problems with children? (and you)
Problems children may be having at school?
Who takes care of the children when you work?
Who helps you with the housework?
Is housework different here than in home country?

Relationship with Husband:

Did you have problems with your husband in your home country?
What kind?
Did these problems or your relationship change once in Canada? Why?
What were the decision-making patterns in home country? How did these change in Canada?
Does your husband go out on his own?
On what kinds of occasions do you go out together?
What kinds of things does he do when he goes out?
Does he drink with his friends? Is alcohol a problem?

If wife has left husband:
How long ago?
Why?
Process of deciding to leave: events, who was consulted? Who was understanding and supportive? Who was opposed to this move?
What changed in your situation that prompted you to move?
What is the reaction of your friends and community to your separation?

If husband left wife, ask similar questions as those above.

Social Life:

Do you have contact with your extended family? (outside of nuclear)
How often?
On what kinds of occasions?
Do you go alone or always with your husband?

Do you visit people outside of your family circle?
Are they from your own country?
Do you know people outside from other countries?
How did you meet the friends you have here?
Do you ever visit or go out with your friends alone?
What kinds of things do you talk about with your friends? (practical issues, emotional issues)
Have they told you about people or services that you could go to for the solution of problems, or for advice?
Who? Have you gone?
What are your reactions to the service given?

IV. English

Do you speak English?
Did you want to go to classes but were denied them? Or didn't have the time or money to go?
Would you like to learn English?

Does your husband want you to?
Under what conditions could you attend English classes?
In what situations do you find your lack of English the most problematic?

V. Work History

Did you work in your home country?
Type of work? Special training for work?
Why? (did you have to work?)

Do you work here in Canada?
Why did you first go to work here?
Was it your decision to go to work?
How many jobs have you had?
What kinds of jobs?
How did you find these jobs? (friends, family, Manpower, community services, etc.)
Who was most helpful in your job search? Least helpful? Why?

Description of present or most recent job:

Treatment by supervisors and co-workers?
Training on the job?
Possibilities for advancement?
English training at work?
Presence of union?
Language spoken by workers?
Satisfactions and dissatisfactions with job?

Who do you talk to about your job:

In the workplace? Is there conversation with co-workers?
Outside of the workplace?
Who at work do you go to regarding sick leave, salary, working conditions, etc.?

How does your husband and family respond to you being at work?
What happens to your salary? Who has control over it? Is it used for a specific purpose every time, i.e., household expenses, clothes for the children, etc.?
Do you put any of the money aside for your own personal use?

Unemployment:

Have you been unemployed? (or are you now?)
How long have your periods of unemployment been?
Problems with UIC? Where have you gone to try to get help? Were you satisfied with the service you got?
Did you talk about other things when you went for help? Were the conversations useful to you?

What do you do when you are unemployed? Activities? Friends?
How do you feel when you are unemployed?
How do your husband and family react to you being unemployed?

If unhappy about being unemployed, who have you talked to about it?
What was their response?

Is your husband unemployed? For how long? What is your reaction to this?

Husband's Employment:

Does husband work?
Type of job?
Salary?
Hours?
Shifts?
Number and types of jobs since in Canada?
Impact of husband's work on family life? (i.e. lacking enough money, shifts, working conditions, frustrations on the job?)

VI. Contact with services

What community centres have you visited?
What kinds of problems did you take there?
Were you satisfied with the help you got? Why? Why not?
How did you first connect with these agencies? (friends, referrals from other agencies, etc.)

Contact with Working Women:

What are the problems that brought you to this centre?
History of your route to this centre and contact with other agencies or individuals through this centre?
How long have you been coming to this centre?

Who do you take your problems to? (when you feel upset, unhappy?)

Friends? Family? Church? Community centres? Doctors? Family services? Other "professionals"?
Do they have time to talk to you?
Is their attitude supportive to you?
What types of service have they given you?
Have they referred you to other services or individuals?
Which ones?
Did you go?
Why not, if not?
What was your experience with these secondary contacts?

Do you have friends or family who have had problems here and have been upset, depressed, nervous?
What types of problems have they had?
What have they done?
Where have they gone?
What have their experiences been?
Where would you send a friend who was upset?
Do you know anyone who has been in the hospital for "emotional" problems? What have their experiences been?

Would you participate in a women's recreational/educational/discussion group?
What activities would you be interested in doing or issue would you be interested in discussing?
What kind of practical arrangements would have to be made in order for you to attend? (i.e. location, time of group)

APPENDIX II

INTERVIEW SCHEDULE FOR HEALTH CARE PROFESSIONALS

Introduction: The purpose of this study. Note: The following interview schedule was designed for doctors and was modified to apply to psychiatrists, nurses, social workers, other hospital workers.

1. Where do you work? Do you have a private practice, work in a clinic or hospital? Where do you spend most of your time?

2. What proportion of your patients are Spanish or Portuguese speaking women? Do most of them speak English?

3. If not, how do you communicate?

4. Do you have counselling hours or would that be a part of the regular visit? Do you counsel people on a long term or short term basis? For what kinds of problems?

5. Where do most of the referrals come from? How else do women happen to come in, e.g., for physical problems, on the suggestion of family members, accidents on the job?

6. Are most of the women low or middle income? Do they work away from home? What types of jobs do they have?

7. Are most of the women's problems related to marital problems, e.g., wife beating, tension at home, difficulties with children, work related. Do many of the women have nervous breakdowns, problems sleeping, etc.?

8. What do you do for the different kinds of problems? (talking, therapy, medication, etc.)

9. When would you decide to give medication or to recommend hospitalization? How severe are cases which you have to refer to psychiatrists or hospital care?

10. Hospital Care:

    Are most of the patients referred by a private doctor, or do they come in off the street?

    What are the primary reasons that a woman would enter the hospital? (for a rest, family pressure to go in, nervous breakdown?) Who else is involved in such cases? Does the husband accompany her to the doctor? Children?

    When women are in the hospital, who do they see on the first day?

10. Hospital Care - continued

Are they usually on medication?

How often does the doctor see the patient?

Are there interpreters available at other times?

11. To whom do you refer women you cannot deal with be it for limitations of time, language or lack of communication - or due to the severity of the problem?

12. Have you worked in conjunction with or received referrals from community agencies? e.g., Catholic Family Services, Portuguese Free Interpreters, the Centre for Spanish Speaking People? The Working Women's Community Centre? What about government agencies, e.g., Family Services, Children's Aid, Workman's Compensation Board, Welfare, Family Court? Do you follow up on or have an ongoing role in such cases?

13. How do you see the difficulties these women have with the various mental health services?

Do you have any suggestions for alternatives or expansion of services?

14. Would you like to refer us to anyone else who sees immigrant women in the medical profession? In your hospital? others?

At what stage of a problem do you receive a request for intervention? (i.e. slight stress as opposed to a violent or crisis situation)
If your agency is not set up to do counselling, how do you provide counselling along with the other services in your mandate?
Do you see any limitations to your counselling service? (i.e. lack of training to provide counselling, lack of interpreters, time constraints, lack of space, etc.)

V. Referral Patterns

If overloaded by requests for counselling, where do you refer the clients you cannot see?

Where do you refer clients who you feel need counselling (and other) services that you cannot provide in this agency?
Do you follow up on referrals?
Have you had any feedback about referrals from your clients?
If so, of what nature has the feedback been?

Have the clients you see gone to other agencies for counselling?
Have they talked to you about the kinds of experiences they had with these agencies?

VI. Comments and Suggestions

Do you perceive any gaps or limitations in existing (counselling) services for immigrant women? If so, what are these gaps or limitations?
What suggestions do you have about how to effectively fill this gap?

What would be helpful within your agency to meet the needs of immigrant women more effectively?

APPENDIX III

INTERVIEW SCHEDULE FOR SOCIAL SERVICE WORKERS

The basic format of this schedule was used for interviews with government, family service and community-based agency workers. The format was tailored to the particular agency that was being studied.

I. General Information

What is the mandate and organization of your agency?
What services do you provide?
What is your funding situation?
Do you have limitations on whom you can serve?

II. Target Population

Do you have clients who are Spanish or Portuguese speaking women?
What proportion of your clientele are women? What proportion are married? Single?
What income group is your clientele?
What kinds of work did your clients do in their home countries?
What kind of work do they do in Canada?

III. Referral to Agency

How do your clients come to your agency? (Direct referral, publicity, word of mouth, etc.)
If referred, by whom?

IV. Counselling practice

Do you provide counselling to your clients?
What form does this take?
What kinds of issues or problems do your clients come to you with?
Can you cite some specific examples of the kinds of problems your clients have had and how you have worked with them?

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