

Addressing Factors Related to Depression & Mental Health in  
Elderly Chinese Immigrant Women in Ontario

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## **Abstract**

This is a qualitative research centred on factors related to depressing and mental health among elderly Chinese immigrant women living in Ontario, Canada. The purpose of this qualitative research study was to examine those social factors that affect or contribute to depression or other forms of mental illness among elderly Chinese immigrant women. Qualitative content analysis was used. Reports of organisations concerned with elderly Chinese immigrants, qualitative research articles on elderly Chinese immigrant women, and government reports and publications were analysed based on their content. From the data, three main categories were developed. These are pre-migration, settlement experiences and health promotion. Some of the themes or sub-categories under these three main categories include the following: separation, isolation and loneliness, family and economic dependence, communication barriers, physical and psychological illness, transportation and food challenges, and empowerment. These themes or sub-categories were presented alongside the general conditions affecting elderly immigrant women as reported by other literature. From these findings several recommendations with regards to feminist health promotion were discussed. These include empowerment, making health social support accessible, family connectedness and others.

Key words: depression, mental illness, isolation, loneliness, family, empowerment, feminist health promotion, elderly Chinese women immigrants

## Dedication

My lovely family

## **Acknowledgements**

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## **Introduction**

In recent decades, there has been a renewed interest in better understanding the effects of social factors in relation to health in specific populations (Benoit et al 2009). One such group is the elderly Chinese female immigrant population in Canada, which has been growing significantly in recent years. Elderly immigrants are generally more vulnerable, and therefore require more care and support in order to optimally readjust into an environment different from their country of origin.

The process of immigration brings with itself a host of challenges unique to resettlement, readjustment and adaptation. It is known that immigration in general is highly correlated with depression and anxiety due to factors such as post-immigration stress (O'Mahony & Donnelly 2007). The importance of understanding the roots of compromised mental health in the elderly Chinese immigrant women is a key factor in the prevention approaches or mental wellbeing promotion. Furthermore, it is known that there are serious mental health risks and problems, and yet access to services to provide adequate care is limited by various factors (O'Mahony & Donnelly 2007). Women are at a disadvantage due to unequal gender-based differences in access to health care (O'Mahony & Donnelly 2007) when compared to their male counterparts, making women who are both elderly and immigrant even more vulnerable.

Feminist scholars have termed the idea of a “triple jeopardy” of gender, age and sex that negatively affect social processes for this population in ways that may be sustained over time (Chundamala et. al, 2006). These women face a complex set of barriers that they must overcome due to their gender, sex and age before they can be able to access health care or social services and supports effectively and work towards healthy readjustment. In this sense elderly

Chinese immigrant women are especially at risk of depression and face mental health struggles caused by immigrating at an older age.

Although a great deal of research and study has been dedicated to the overall health of elderly immigrants, the body of research dedicated to elderly Chinese immigrant women and their mental health is lacking. This Master's thesis seeks to contribute to the body of research that is still emerging. In order to reach this objective I employ qualitative content analysis to examine the factors that influence mental health of elderly Chinese immigrant women in Ontario in order to understand the possible social support that could be given to them.

Elderly immigrants in Ontario come from a range of countries and cultural backgrounds. The Citizenship and Immigration data from 2010 lists the following regional origins for immigrants 65 years of age and above: Africa and the Middle East (23.8%), Asia and Pacific (48.1%), South and Central America (10.1%), United States (3.3%), Europe and the United Kingdom (14.7%), (Citizenship and Immigration Canada, 2009). In Canada, Asian immigrants, particularly those who are Chinese, have been the source of over half of all immigrants since the early 1980s (Fung & Wong, 2007). The Chinese community in Canada has a lengthy settlement history (Lai, 2004) and belongs to the largest ethnocultural group (Statistics Canada, 2006; Wong & Tsang, 2004).

Elderly Chinese immigrant women's mental health requires a thorough understanding of the ways in which cultural diversity plays a role. Chong (2012) explains that Confucianism, Taoism and Buddhism are philosophical and religious constructs on which the values of the Chinese people are grounded. Therefore, these further shape the perception of the Chinese people regarding mental illness. For example, Confucianism discriminates against

mental illness, Taoism considers mental illness as a pattern of disharmony while Buddhism stigmatises mental illness (Chong, 2012). This example highlights the possibility of elderly immigrant Chinese women's refusal to access treatment for their mental health conditions due to these values. Arguing further, Chong explains that:

Chinese culture emphasizes harmonious personal relationships (Lam et al., 2010; Lin, 1983). Harmony, interdependence and loyalty is key to survival, peace and happiness (Lin). Chinese familism is a system of cognitions, affects, intentions and behaviours focused on harmony, solidarity, family prosperity and sentiments (Lin et al., 1995). Many Chinese people have been influenced by these teachings of being group orientated, non-assertive and conflict avoidant and as such many Chinese behave and act in certain ways (Chong 2012: 8).

These together reveal the peculiarity of the case of Chinese immigrants and the prospect of these values and cultural difference affecting their mental health as well as their access to health support in Canada. This study, therefore, tries to find answers to the following questions. What are the unique settlement challenges faced by elderly Chinese immigrant women? How are these challenges impeding their access to social support and health care? What systems can address these unique challenges to help overcome obstacles working against them? How can we aid them in terms of their resettlement and in what ways can we open avenues to health care for these women who are otherwise left out? Finally, how can our understanding of the case of elderly women in Ontario contribute to the development of policies towards addressing the social challenges causing mental health issues among elderly immigrant women in Canada?

An Immigrant's entry into the Canadian context is not without its challenges and struggles. In spite of the rapidly increasing diversity of elderly immigrants, there is limited research that addresses the specific cultural and multicultural factors involved in elderly mental health (O'Mahony & Donnelly, 2007). This study therefore contributes to the general understanding of the health conditions of elderly immigrant women. Finally, it creates the

opportunity for governments and policy makers to develop policies and programs that incorporate the peculiar needs and issues affecting elderly immigrant women.

This study is organized into five chapters. The first chapter discusses the contextual background and states the problem examined. The second chapter talks about the theoretical considerations. In chapter three I discuss my methodology, that is, qualitative content analysis. In Chapters four I discuss my findings, and in chapter five I discuss my recommendations drawing on my findings and other literature through the lens of feminist health promotion.

## **Chapter One**

### **Contextual background and statement of problem**

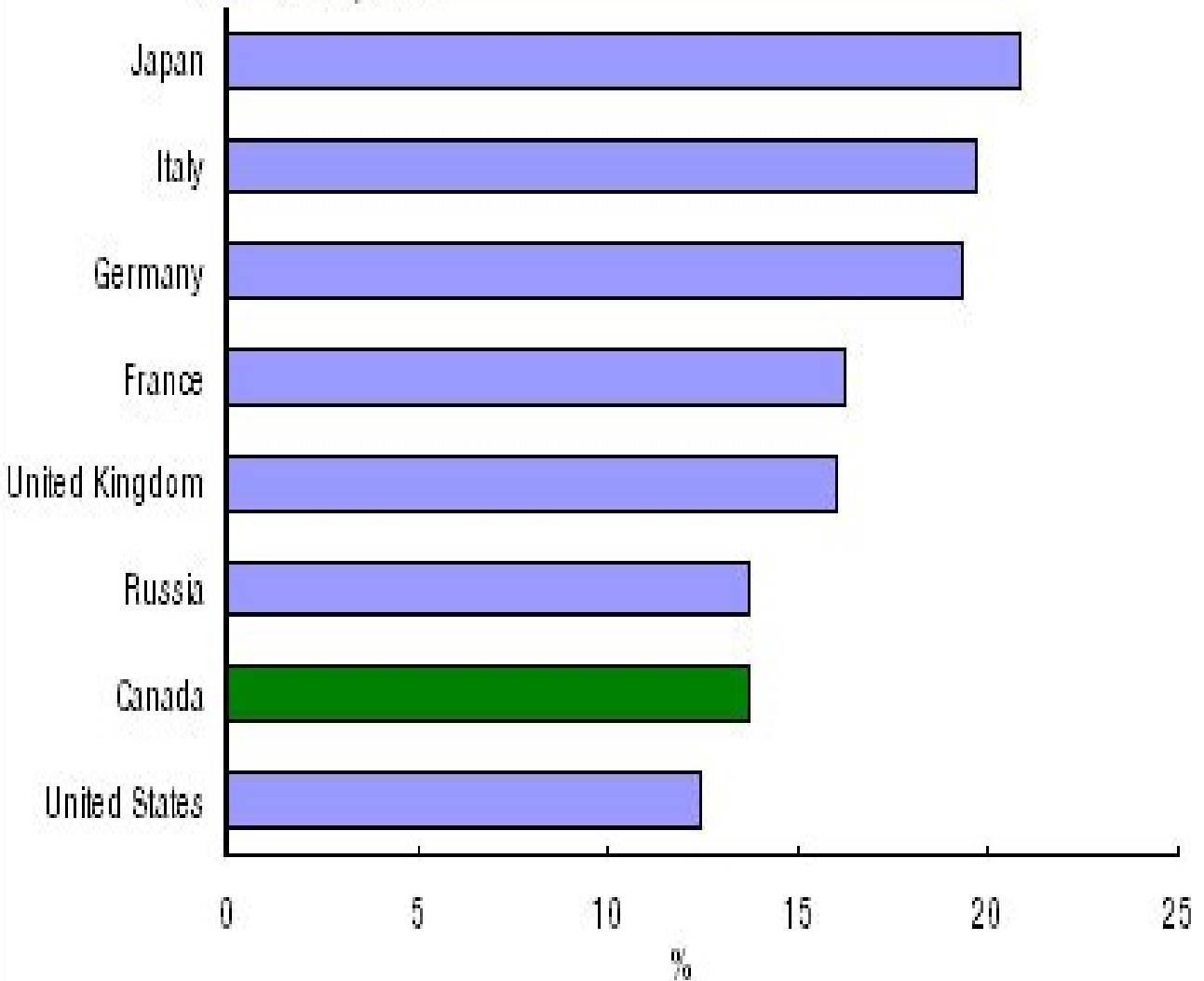
#### **Introduction**

In this chapter, I discuss the background of the study. Firstly, I use statistics to describe the elderly population in Canada, immigrants and the population of immigrant women in Ontario. Secondly, I discuss common mental health illnesses among the elderly people in Canada, linking that to the common mental illnesses that occur among elderly immigrant women. Finally, I give a general account of the current mental health conditions as reported in various studies of immigrants in Canada. The chapter describes the core characteristics of elderly Chinese immigrant women in Canada and states the problem underpinning the study. I wish to mention here that I situate the specific case of the elderly Chinese immigrant women within the broad context of the demographic characteristics of the Canadian population.

#### **1.1 Elderly population in Canada**

Aging is a constant demographic phenomenon. Every country faces some degree of aging in its population. Among G8 countries, Canada is the ‘youngest’ country but with an aging population (see figure 1.1). In comparison, only the United States has a smaller proportion of elderly people. However, ageing is expected to quicken over the next few years, particularly when the baby boomers start turning 65 (Statistics Canada, 2007).

**Chart 28.1 People aged 65 years and older among the G8 countries, 2006**



**Sources:** Statistics Canada, U.S. Census Bureau, Istituto Nazionale di Statistica, Institut National des Statistiques et des Études Économiques, UK Office of National Statistics, Statistics Bureau of Japan, Federal Statistical Office of Germany and Federal State Statistics Service of Russia.

Source: (Statistics Canada, 2007)

Fig 1.1 Population aged 65 years and above among the G8 countries

The Canadian elderly population is steadily growing, a development that began several decades ago. Based on information released by Statistics Canada in 2006, the elderly population 65 years and above “made up a record 13.7% of the total population in 2006” a higher proportion than in the United States which was at 12.4% of the total population (Statistics Canada, 2007). In other words, those aged 65 and older population consisted of 4.4 million, an increase in comparison with 11% in 1987 and 8% in 1972. It is estimated that by 2016, there will be six million elderly people in Canada, composing 16 percent of the population (Statistic Canada 2007). In addition, according to a medium-growth scenario, the proportion of seniors in the Canadian population will reach 27% by 2056 (Statistics Canada 2007). In 2005 women aged 90 years and above accounted for about 75% of senior population, while women aged 65 to 69 accounted for 52% (Statistics Canada, 2006).

Clearly, the growth rate among the elderly population in Canada is currently the fastest. Statistics Canada indicated that, in 2007, 3% of the population was aged 80 and older. They added that this group could account for 10% of the total population by 2056. Several factors have been linked to the increasing aging population; these include low fertility rates and rising life expectancy.

Health-wise, it is argued that seniors are largely in better health currently, they are more comfortable financially, and they lead more active lives than their predecessors (Statistics Canada, 2007). However, Statistics Canada cautions that as this population advance in age, seniors are more likely to be affected by disabilities that will prevent them from going about their day-to-day activities normally. For example, as the elderly population in Canada continues

to increase, so will age related illness, thereby making mental health services and support much more important to government and policy makers.

In Ontario, the elderly population currently is estimated at about 1.5 million; this constitutes 40 percent of Canada's elderly population (Ontario Senior Secretariat 2003). Moreover, the 1.5 million is expected to double to 3 million by 2028 (Ontario Seniors' Secretariat, 2003). The Population Census held on May 16, 2006 revealed that Ontario is the most populous province in Canada. It reveal further that 13.6 percent of the people in Ontario are aged 65 and over (Statistics Canada 2007), an increase from 12.9% for the same category in 2001. Over the same period, the proportion of people under the age of 15 declined from 19.6% to 18.2% (Statistics Canada, 2011). Due to the increasing aging population, the wellbeing of seniors has become very important. The mental health of seniors is an aspect of their wellbeing receiving particular attention.

### **1.1.1 Elderly mental health conditions**

As mentioned earlier, aging is associated with diverse physical and mental health issues. Seniors in Canada consider themselves to be in very good or excellent health, though they are less likely to report being in good health than are younger people (Statistic Canada 2007). In 2005, 44% of people aged 65 to 74 described their health as either very good or excellent, while another 34% considered their health good (Statistics Canada 2007). In comparison, among people aged 20 to 34—one of the most positive age groups when it came to self-evaluating their health—70% reported being in very good or excellent health, and 25% in good health (Statistics Canada 2007).

Elderly populations suffer from diverse mental health illnesses, even though there are few elderly people leaving life with no evidence of mental imbalances. The statistics above indicate that there are many more whose health, especially mental health, is not within the defining criteria of mental wellbeing. Mental health is defined as “a state of wellbeing in which the individual and communities realise his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community” ( WHO 2007 cited by Khanlou 2009: 3). From the definition it is clear that aging plays a great role as individual at certain age cannot realise its own abilities. Therefore, life becomes a burden and much more difficult as we grow old.

### **1.1.2 Forms of Mental illness**

Some of the basic symptoms associated with becoming old among the elderly population in Canada include physical weaknesses, inability to move about freely, lasting and severe pain, mental and sensory impairments (Chundamala et al 2006). Other factors that can worsen the above conditions include the following; retirement from work, changes in income, widowhood, the loss of friendships through death, and new caregiving responsibilities which result in some form of isolation (Chundamala et al 2006). The major mental health condition that elderly people have to deal will consist of the following: depression, schizophrenia, bipolar disorder, anxiety disorder, dementia, alcohol addiction (Health Canada 2002). According to Conn (2002), dementia and delirium are among the mental disorders that occur differently among elderly people, but aside from these two, most other mental health illness occurrences seem to be the same among elderly. Depression is one of the most common mental health problems affecting the elderly population in Canada (Lai 2000: 64).

However, depression is difficult to recognize, and therefore tends to be under diagnosed. According to Bhugra and Ayonrinde (2004), symptoms of depression include guilt, shame and loss of libido. Newman et al (1998) revealed that women experience almost twice the rate of depression compared to men, which is 14.1% for women and 7.3% for men. In general, 10% of elderly population in Canada suffer from depression (Lai, 2000). It is also estimated that 30% to 40% of elderly people residing in institutional home suffer varying degrees of depression (National Advisory Council on Aging, 1999).

Schizophrenia is a brain disease and one of the most serious mental illnesses in Canada, brought on by severe stress (Health Canada, 2002). Symptoms include the following; mixed-up thoughts, delusions (false or irrational beliefs), hallucinations (seeing or hearing things that do not exist) and bizarre behaviour (Health Canada, 2002). People suffering from schizophrenia have difficulty performing tasks that require abstract memory and sustained attention (Health Canada, 2002). According to Health Canada (2002), the possibility of schizophrenia in the general population of Canada is estimated to vary between 0.2% and 2%. However 1% is the generally accepted prevalence estimate rate for seniors (Health Canada 2002).

Anxiety is also another common mental health problem in Canada. Individuals with anxiety disorders go through severe anxiety or fear that causes the anxiety to further develop into a compulsion ritual to lessen the anxiety (Health Canada 2002). Statistically, 12% of the Canadian population suffer from some form of anxiety disorders (Health Canada 2002). In terms of gender, more women have reported suffering from anxiety disorders, have been

diagnosed with anxiety disorders and finally have been more hospitalized with regards to anxiety disorders (Health Canada, 2002). Regarding age, women aged 65 and older have a higher of anxiety rate and are the most hospitalized (Health Canada, 2002). This highlights the fact that anxiety disorders are more pronounced among elderly women as a mental health illness. Severe anxiety disorder develops into depression, dysthymia, alcohol and substance abuse and personality disorders (Health Canada, 2002). Elderly people also go through alcohol or drug addictions, and elder abuse that tend to lead to mental illness. It is estimated that alcohol abuse affects 5% to 11% of elderly people (McEwan et al., 1991).

Elder abuse is another factor closely related to anxiety and depression. Approximately 4% to 10% of Ontario's elderly people experience some type of abuse, such as financial abuse, emotional abuse and physical abuse and neglect (Ministry of Citizenship, 2003). In addition, 75% of those who experience abuse have other forms of mental or physical impairment (Ministry of Citizenship, 2003). Concerning the elderly who have been physically abused, 68% report that the assault was committed by a family member (Ministry of Citizenship, 2003). Family members responsible for such abuse include adult children (42%) and spouses (31%) (Ministry of Citizenship, 2003). Elderly women are more likely to be abused, more specifically, 38%, than male elderly who constitute 18% (Ministry of Citizenship, 2003). In contrast, male elderlies (9%) are more likely to report financial or emotional abuse, compared to female elderlies (5%) (Ministry of Citizenship, 2003).

After considering the statistics concerning the elderly populations and the forms of mental illness that they Canadians experience, the next issue that comes to mind is the case of elderly immigrants and how different or similar are their experiences.

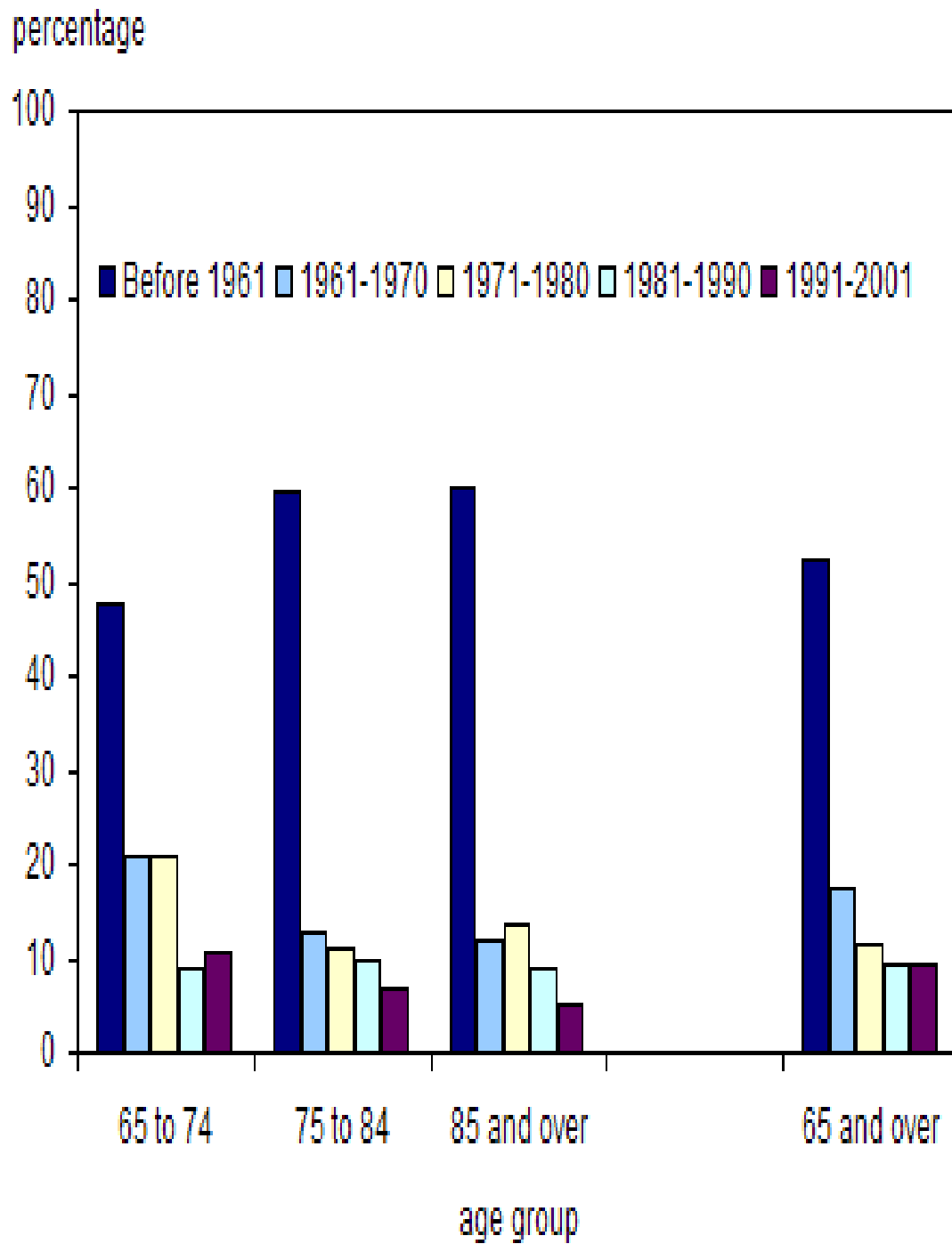
## 1.2 Elderly immigrant population<sup>1</sup>

According to the Public Health Agency of Canada: “an estimated one in four Canadian seniors is born outside of Canada” (2009). Canada is among the countries with active immigration policies which bring in immigrants from all ethnic backgrounds, hence building a multicultural and ethnoracially diverse Canadian society. According to Statistics Canada (2007), among immigrants, just as is the case in the total population, women represent a greater proportion of seniors than men. However, women are less represented among immigrant seniors than Canadian-born seniors. In 2001, some 51% of immigrant seniors aged 65 to 74 were women, compared to 53.7% of non-immigrant seniors (Statistics Canada, 2007). There was also a slight difference among those in the oldest age groups: 58.5% of immigrant seniors aged 75 and over were females, compared to 61.3% of non-immigrants (Statistics Canada, 2007).

Immigrant seniors tend to reside more in Toronto and Vancouver than non-immigrants (Statistics Canada, 2007). In 2001, 30.4% of them were living in Toronto, compared to only 7.3% of Canadian-born seniors (see Table 1.2) (Statistic Canada, 2007). More recent immigrants were even more likely to live in these two metropolitan areas: among immigrant seniors who came to Canada between 1991 and 2001, 46% lived in Toronto and 22% in Vancouver (Statistic Canada, 2007).

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<sup>1</sup>Statistics base on sex for elderly immigrants were not available



Source: Statistics Canada 2001

Fig 1.2 Immigrant seniors, by period of immigration and age group

**Table 1.1 Place of residence, by immigrant status and period of immigration, 2001.**

	Toronto	Vancouver	Montreal	Other CMA <sup>1</sup>	Non-CMA	Total
	Percent					
<b>Non immigrants</b>	7.3	4.3	11.6	29.6	47.2	<b>100</b>
<b>Immigrant seniors</b>	30.4	11.2	10.7	28.1	19.7	<b>100</b>
<b>Before 1961</b>	24.2	8.1	9.3	32.0	26.3	<b>100</b>
<b>1961 to 1970</b>	32.3	9.2	14.4	27.1	17.0	<b>100</b>
<b>1971 to 1980</b>	35.5	14.7	12.9	23.8	13.0	<b>100</b>
<b>1981 to 1990</b>	40.5	17.0	11.3	22.3	8.9	<b>100</b>
<b>1991 to 2001</b>	45.7	22.1	7.9	18.6	5.8	<b>100</b>

**1. Census metropolitan area (CMA).**

**Source: Statistics Canada, 2001**

### **1.2.1 Elderly immigrants and mental health**

Elderly populations are by their very nature more vulnerable than younger generations since the elderly are compromised by their limited mobility and the hindrances they experience from the common problems of aging. Elderly immigrants are generally more vulnerable than non-immigrants and therefore require more care and support in order to optimally readjust to an environment different from that of their country of origin. Maintenance of general physical health and drawing on resilience in the face of change and resettlement may be more challenging for this population than those who are younger.

According to Statistics Canada (2007), previous research has suggested that the existence of some cultural differences in the interpretation of mental health questions, or in the willingness to report symptoms of depression or alcohol dependence (e.g. Noh et al., 1992). Immigrants responded differently to issues related to mental health. This could be due difference in perception as what constitute mental illness. Recently immigrants have provided different answers to those of the Canadian-born, not only because of their objective situation, but also because of cultural factors (Statistics Canada, 2007). However, it is not possible to estimate the extent to which this is the case. Statistics Canada sums up the situation of immigrants including their mental health:

On various dimensions of the well-being scale, recent immigrant seniors reported slightly less positive answers than non-immigrants. For example when asked if, during the last month, they were curious and interested in all sorts of things (almost always, frequently, half the time, rarely or never), a little less than half of recent immigrant seniors (45%) said that they were almost always curious and interested, lower than the proportion of Canadian-born seniors who said so (54%). However on many other issues regarding well-being, immigrant and non-immigrant seniors showed no signs of lower levels of well-being. For example, almost the same proportion of recent immigrant seniors (60%) and non-immigrants (61%) said that they had almost always smiled easily during the last month. In sum, recent immigrant seniors are slightly less likely than non-immigrants to

suffer from psychological distress, but they are also slightly less likely to report a higher level of well-being (Statistics Canada, 2007).

### **1.2.2 Chinese Immigrant population**

According to Statistics Canada (2007), the population of Canada is 31,241,030 including 1,216,570 Chinese individuals. Statistics Canada further reveals that Canadians of Chinese origin make up the largest non-European ethnic origin group in Canada. Specifically, the Chinese community is the fifth largest of any ethnic origin in Canada other than English or French. According to Statistics Canada, in 2001, the over one million people of Chinese origin living in Canada represented approximately 4% of the total Canadian population (Statistics Canada, 2007). See tables 1.2 and 1.3 which follow

Population groups (28)	Sex (3)		
	Total - Sex	Male	Female
<b>Note(s) :</b>			
<ul style="list-style-type: none"> <li>Excludes census data for one or more incompletely enumerated Indian reserves or Indian settlements.</li> </ul>			
Total - Population groups	31,241,030	15,326,265	15,914,760
Single responses	29,636,765	14,538,100	15,098,660
White	24,920,465	12,248,075	12,672,390
Chinese	1,168,485	559,605	608,880
South Asian	1,233,275	622,220	611,050
Black	696,800	333,535	363,265
Filipino	389,550	165,180	224,375
Latin American	304,245	147,900	156,345
Southeast Asian	231,425	112,415	119,010
Arab	265,550	142,580	122,970
West Asian	156,700	80,700	76,000
Korean	138,425	66,790	71,640
Japanese	60,415	25,270	35,145
Visible minority, n.i.e.	71,420	33,840	37,580
Multiple responses	458,240	227,905	230,335
White and Chinese	48,080	24,655	23,425
White and South Asian	29,595	14,970	14,625
White and Black	86,995	42,155	44,845
White and Filipino	21,145	10,460	10,685
White and Latin American	50,395	24,620	25,780
White and Southeast Asian	8,510	4,010	4,500
White and Arab	46,345	24,375	21,970
White and West Asian	9,705	4,915	4,790
White and Korean	3,460	1,805	1,655
White and Japanese	20,890	10,890	10,000
White and multiple visible minority	28,905	13,915	14,990
Multiple visible minority	104,215	51,135	53,080
Aboriginal self-reporting	1,146,025	560,265	585,76

Source: (Statistics Canada 2007)

Table 1.2 Population of Canada by ethnic origin and sex

<b>Selected ethnic groups in Canada, other than English, French and Canadian, 2001</b>				
	<b>Total population (in thousands)</b>	<b>Multiple responses (in thousands)</b>	<b>Single responses (in thousands)</b>	<b>As a percentage of the total Canadian population</b>
Scottish	4,157.2	3,550.0	607.2	14.0
Irish	3,822.7	3,325.8	496.9	12.9
German	2,742.8	2,037.2	705.6	9.3
Italian	1,270.4	544.1	726.3	4.3
<b>Chinese</b>	<b>1,094.7</b>	<b>158.4</b>	<b>936.2</b>	<b>3.7</b>
Ukrainian	1,071.1	744.9	326.2	3.6
Dutch	923.3	607.1	316.2	3.1
Polish	817.1	556.7	260.4	2.8
East Indian	713.3	131.7	581.7	2.4
<b>Source:</b> Statistics Canada, 2001.				

Table 1.3 Selected ethnic groups in Canada, other than English, French and Canadian.

The Chinese community in Canada is also growing considerably faster than the overall population (Statistics Canada, 2007). Between 1996 and 2001, for example, the number of people who said they had Chinese origin rose by 19%, while the overall population grew by 4% (Statistics Canada, 2007). As a result, the proportion of Canadians of Chinese origin increased from 3% to 4% of the total population in this period (Statistics Canada, 2007). Statistics Canada (2007) writes that a large majority of people in Canada of Chinese origin say they only have Chinese origins. 86% of all those who reported Chinese origin said they had only Chinese roots, while 14% said they also had other ethnic origins (Statistics Canada, 2007).

In terms of distribution, the Chinese in Canada are very concentrated in Ontario and British Columbia (Statistics Canada, 2007). As revealed by Statistics Canada in 2001, 82% of people who reported Chinese origin lived in one of these two provinces; 47% resided in Ontario while another 34% lived in British Columbia (Statistics Canada, 2007). Furthermore, there were over half a million people of Chinese origin living in Ontario, while another 374,000 resided in British Columbia that same year (Statistics Canada, 2007). There were also smaller Chinese communities in other provinces including almost 110,000 in Alberta and 63,000 in Quebec at the same period (Statistics Canada, 2007).

<b>The Chinese population in Canada, by province and territory, 2001</b>			
	<b>Total Chinese population (in thousands)</b>	<b>As a percentage of the provincial/territorial population</b>	<b>As a percentage of the total Chinese population in Canada</b>
Newfoundland and Labrador	1.1	0.2	0.1
Prince Edward Island	0.2	0.2	0.0
Nova Scotia	3.7	0.4	0.3
New Brunswick	2.1	0.3	0.2
Quebec	63.0	0.9	5.8
Ontario	518.6	4.6	47.4
Manitoba	14.2	1.3	1.3
Saskatchewan	9.3	1.0	0.8
Alberta	108.1	3.7	9.9
British Columbia	373.8	9.7	34.1
Yukon	0.3	1.0	0.0
Northwest Territories	0.3	0.8	0.0
Nunavut	0.0	0.2	0.0
<b>Canada</b>	<b>1,094.7</b>	<b>3.7</b>	<b>100</b>

Table 1.4 The Chinese population in Canada, by province and territory, 2001

### **1.2.3 Chinese culture and mental illness**

Culture shapes and informs the behavioral patterns of a group of people. Cultural values have a great influence on social behavior. Chinese culture is complex. The characteristics that define the culture are largely shaped by the work Confucius and his philosophies, religious directives of Taoism and Buddhism (Chong, 2012). The philosophies of Confucius are at the very core of Chinese identity. The thoughts of Confucius that are embedded in the Chinese culture values the importance of family; hierarchical structure of social life, the cultural of morality and self-restraint and the emphasis hard work and achievement. More specifically, the Chinese culture emphasizes collectivism, centrality of family and hierarchical relationships (Chong, 2012). These values affect the perceptions and responses of Chinese people to health issues especially mental health. For example due to the importance of maintaining harmony within relationship, which Confucianism professes, mental illness is thought to arise when relationships are not harmonious. Maintaining harmony in ones relationships is therefore important in Chinese culture. In effect, individual with a mental illness are considered deviant because their character is below standard (Chong, 2012; Fung, Tsang and Chan, 2010).

Values in Chinese culture are also based on the religious constructs of Taoism and Buddhism (Lam et al., 2010) According Lam et al (2010), the practice of Taoism is based on human beings following natural laws and the Way (or Tao) and being humanistic by following human laws (kindness, politeness). Chong (2012) and Lam et al (2010) argued that in Taoism as religious faith, mental illness is considered as a pattern of disharmony within a person's body and illness. For instance depression is seen as a weakness in spiritual strength (Lam et al., 2010).

Similarly, Buddhism follows the belief that performing good deeds will earn positive consequences and doing bad things will result in negative repercussions (Chong, 2010; Lam et al., 2010; Wang, Tse & Michalak, 2009). Therefore in Buddhism mental illness is perceived as a disability resulting from being punished for wrong doings in a past life (Lam et al., 2010). Clearly, Chinese perception of mental illnesses cannot be detached from their cultural values and religious beliefs. Chong writes;

Cultural issues influence detection of illness, utilization of mental health services and adherence (Mok, 2006). Values and beliefs held in Chinese culture could influence how some individuals encounter perceived stress, distress and motivation to access mental health services (Herrick & Brown, 1999). Individuals in Chinese culture may find it difficult to accept the notion of mental health disorders for various reasons. Some Chinese people perceive spirits and ghosts to be responsible for mental illness (Ran et al., 2005). There are some in the Chinese society that perceive people with psychosis to be cruel and prone to violence (Ran et al.) thus individuals are perceived as being dangerous. Having a mental illness often is seen as a punishment for the misbehaviours of ancestors (2012:9).

Elderly Chinese immigrant women arrives Canada with these cultural values and religious beliefs. Their perception and responses to issues of mental illness is therefore defined by their cultural values. Furthermore, the way they are treated by other Chinese people is also based on same cultural values. This cultural attributes set the tone for the state of the problem underpinning this study.

### **1.3 Statement of problem**

Demographically, the composition of immigrants groups are as follows: with regards to country or continent of origin, 60% of recent immigrants migrated from Asia, 16% were from Europe, 11% were from central and southern America and 11% were from Africa (Statistic Canada, 2007; Khanlou, 2009). In terms of age, in 2007, 22% of immigrants were between 0-14 years, 15% were between 15-24 years, 48% were between 25-44 years, 13% were

between 45-64 years and finally 3% were 65 and above (Khanlou, 2009: 7). However it is important to note that the statistics do not cover immigrants with illegal status. In Canada one in five people of ethnic minority are affected by mental health issues (Here to Help.bc.ca, 2006). However, two thirds of people who have been diagnosed of mental disorder in North America do not seek treatment (Drake et al., 2005; Scheffer, 2003). Therefore, the actual number of Canadians affected by mental health issues may be larger than reported and remains undefined.

Further on, there is the problem of health inequalities where women come last with regards to access to health care. According to the Disease Control Priority Project (2008:1) “health research and programs have paid little attention to ways in which women and men suffer differently from the same diseases”. Additionally, they argue that “while little can be done to change biological determinants of health, improving women’s health requires recognizing and addressing gender differences and inequalities affecting girls and women of all ages” (Disease Control Priority Project, 2008:1). In a report submitted to Health Canada in 2007 by Arlene Bierman, she revealed that among low income women 61% report fair or poor health compared to 22% of women in the highest income category. In effect, elderly Chinese immigrant women arrive in Canada to face these health inequalities. These women also arrive with their own cultural and health believes compounding the problem of access to health care.

Furthermore, in North America, it is well documented that Chinese individuals tend to underutilize mainstream mental health services (Chen & Mak, 2008; Hsu & Alden, 2008; Leong & Lau, 2001; Yang, Phelan, & Link, 2008; Yeung and Kung, 2004) relative to the population size. According to Khanlou (2009), migration status affects individual access to health care. Generally, most elderly people experiencing mental health challenges such as depression are cared for mostly by family, home support, home nursing, residential care and

family physicians. Khanlou (2009) highlighted that family and social networks can be important sources of support for migrants as they tend to deal with mental illnesses resulting from their migration in to the new environment. She revealed that research findings confirm that immigrants tend to rely first and foremost on extended family members, especially those who have lived in the country for a longer period of time for various settlement needs and also for their social support network. Khanlou (2009) added that external social supports include the ethnic community, and religious organisations that cater specifically to that ethnic community. Simich et al. (2005:262) mentioned that regarding social support policy makers should include the following; informational, instrumental, and emotional support..

The mental health of Canada's immigrant population is of grave importance, especially to health practitioners, scholars and policymakers. This is because large number of immigrants granted residency in Canada highlights that the general health of the Canadian population is directly tied to the health of immigrants (MacDonald and Kennedy, 2004). Furthermore, the health of immigrants is one important determinant of the costs and benefits of immigration policy, and so relates to questions such as whether immigrants constitute an undue burden on Canada's taxpayer funded healthcare system (Macdonald and Kennedy, 2004: 1613)

Elderly immigrants in Ontario come from a range of countries and cultural backgrounds. Cultural factors can play a major role in blocking or facilitating access to health care, for example, immigrants from a non-Western cultural background may be very apprehensive of accessing mental health services due to a sense of social stigma (O'Mahony & Donnelly, 2007). Elderly immigrant women's mental health therefore requires a thorough understanding. This study is dedicated to exploring further the case of elderly Chinese

immigrant women drawing on the above context of mental health in Canada, forms of mental illness and immigrants' mental health.

The 2006 census revealed that nearly 20% of the Canadian population were immigrants (Statistics Canada, 2007). According to statistics Canada (2007), over a million immigrants entered Canada between 2001 and 2006. As indicated by Khanlou (2009 citing Statistics Canada, 2007), approximately 70% of recent immigrants were in Toronto, Montreal and Vancouver. Clearly we see that a sizeable proportion of Canadian society needs to be taken care of due to their vulnerable nature. Through the chapter we also see that the specific data or statistics with regards to elderly women immigrant are not sufficient. This study creates the opportunity to have special attention for elderly immigrant women. In the next chapter, I discuss the various theories that have been used to explain the difficulties faced by immigrant as they try to settle or readjust to their new environments.

## **Chapter Two**

### **Theoretical framework**

#### **Introduction**

As in indicated in the introduction, elderly immigrant women are the most vulnerable in comparison to younger immigrants and to their male counterparts. They go through a lot of experience trying to adjust and settle in their new environment. Their ways of conducting and organizing their life over time is characterized by several challenges which strongly affect their mental health. In this chapter, I explain the theoretical framework I utilized in pursuing my objective of understanding social factors that affect the mental health of elderly immigrant women. In the initial sections, I discuss various theoretical considerations that have been put forward by different scholars with regards to mental health issues among immigrants. Secondly, I discuss the theoretical perspectives of post-colonial feminist theory and social stressors and how they apply to my study. Through these perspectives, I connect those social factors to feminist postulations about how the lives of elderly immigrant women are shaped as they try to adjust themselves in their new environment.

#### **2.1 Immigrant mental health theories**

##### **2.1.1 Biological arguments**

Some scholarly discussions on mental health of women have centred on biological factors. In this case, other factors affecting the mental health of women are ignored. According to Ballou and Brown (2002) despite the fact that there is a lack of evidence supporting biological claims, human behaviour is still being linked to biology. One of the dominant

biological theories is the stress-vulnerability theory (Smith, 2010). This model postulates that both stress and biological vulnerability contribute to symptoms of mental illness (Smith, 2010).

At the centre of this theory are the biological determinants of the mental health of the individual.

Smith criticise this model saying:

The model places biology in the center ignoring a person's wellness, resilience and strengths. It pathologizes the individual. This model also puts coping on the individual. The idea that a person is individually responsible for illness and recovery (through biology and coping) does not take into account broader social systems at work. There may be some biological reasons for mental illness, but people are also a part of systems – both supportive and oppressive. An understanding of the broader systems at work is important when considering a person's mental health (Smith, 2010: 7)

The argument of Smith indicates that an understanding mental health clearly goes beyond biological factors because human beings are part of social settings. These social settings play huge roles in shaping who they become, their choices and their general wellbeing. Therefore, “there is a continuing need for perspective that give agency to factors contributing to risks and challenges to women's mental health, including avenues to promote their wellness, resilience even in the face of difficulties and adversity, strength, persistence, and empowerment” (Worrell, 2006: 29).

With regards to mental health among immigrants, factors that contribute to mental health should be viewed through the lens of conditions embedded in immigration. Several theoretical perspectives have emerged to also explain why immigrant suffers depression and mental illness. These perspectives have tried to explain and emphasise factors that influence the adjustment of immigrants in their new environment. These include social isolation theory, cultural shock theory, goal-striving theory, cultural change theory, stress process formulation and postcolonial feminist theory.

### **2.1.2 Social isolation theory**

The social isolation theory postulates that ‘immigration involves not only physical separation from homeland but separation from one’s orienting set of mutual rights, obligations and networks of social relations thereby causing the most tumultuous destructive experience associated with immigrant’ (Kuo, 1976: 297). These individuals migrating from their home lands are enacting an act of separation from their home environment, families, friends and many of the other activities they are accustomed to. In this case, isolation becomes a determining and a significant barrier to the integration of immigrants in their new environment which is very different from what they left behind. Several studies have documented the state of isolation experienced by Chinese immigrants who feel separated from their children, home, food and Chinese culture. This theory therefore proposes that any form of social support should take into account the social setting from which the individual has been separated.

A lack of social support compromises the capacity to guard against the negative effects of stress, leading to increased likelihood of physical illness (Gadalla, 2010). The immigrant has to sever personal and social ties and enter a new social network whose small size becomes a barrier to social betterment (Kuo, 1976). In this case the immigrant experience entails strong feelings of loneliness, alienation, desocialisation, low self-esteem and inability to cultivate or sustain social relations (Kuo, 1976).

This theory does not take into consideration the difference in age, race, gender and other cultural factors and how they impact on the immigrants. Specifically social isolation theory does not provide enough explanation for mental health among elderly immigrants. There are several commonalities of immigrant women that pose challenges for their

health and well-being. Immigrants may have had to leave their country of origin due to the pressure of circumstances rather than out of a choice to start building a life in a new country with its own social, cultural and economic realities.

Such elderly women including some elderly Chinese immigrants have to come and depend on systems outside of themselves to help them survive and thrive thus exacerbating their challenges in their new environment. Various factors are associated with the ability of elderly immigrant women to adapt, cope and recreate meaning in their new home or host country. They are faced with unique challenges in terms of acquiring a sense of security before they are able to thrive in their new life. Moreover, older women have more challenges to address before they can ensure optimum mental health and over-all being, and yet the isolation theory does not provide enough insight. Due to their insulation from the broader community (for example, due to entrenchment in a small immigrant community) and issues of a cultural/multicultural nature, elderly immigrant women have a great number of factors working against their integration. These challenges go beyond just being isolated hence the isolation theory is deficient.

### **2.1.3 Cultural shock**

During migration, individuals carry with them their culture and the life styles they are very accustomed to, into new cultures. Their lifestyles and culture in many cases conflict with the culture and life styles of the new environment. This theoretical perspective argues that the most severe adjustment problem of the immigrant is as a result of cultural shock (Kuo 1976). According to Bhugra and Ayonrinde (2004: 15) “cultural shock is sudden unpleasant feeling that violates an individual’s expectation of the new culture and them to value

their own culture negatively”. As discussed in the previous chapter, Chinese immigrants have huge cultural differences from Canadian culture.

Chinese immigrants as well as other migrants always move out their home countries with expectations, the shocks come in when the individual’s expectation culturally are at opposing ends to those of the new country. This creates an adjustment barrier as they have to deal with the shocks. Bhugra and Ayonrinde (2004 citing Oberg, 1964) identified six aspects of cultural shock. This include: 1) sense of loss or feeling of deprivation, 2) rejection by members of the new culture, 3) role expectation and role confusion, 4) surprise, 5) anxiety and indignation; and 6) feeling of impotence. From the point of Oberg, these experiences come to the individual as a shock. In this light culture shock can be seen as a “stress reaction arising from uncertainty of important physical and psychological rewards” (Bhugra and Ayonrinde, 2004: 15). Consequently social support to deal with mental illnesses and depression should take cognizance of cultural shocks.

Giving agency to cultures as the basis for the explanation for the causes of mental illness among immigrants has its own baggage of issues that need to be addressed. With regards to elderly immigrants, the culture shock theory falls short of explaining their mental health conditions, especially in the case of migrants who migrated at tender age and for that matter have endured and overcome the shocks. Immigrants become accustomed with their environment over a period time, reducing their propensity to mental illness (Kuo 1976).

Therefore the “shorter the immigrant period the greater the shock making mental illness more likely” (Kuo, 1976: 298). Elderly women have complex issues that influence their lives. In fact elderly immigrant woman migrating into new environment might not really

face culture shocks. This indicates that culture shock theory does not sufficiently address the very reasons elderly immigrant women go through mental illness. Therefore a social support focussing primarily on dealing with cultural shocks will not suffice.

New immigrants require some time and the expenditure of energy before they are able to access services. They may need to overcome the barriers of language; perhaps ask others for help in learning about the new systems of medical or social services, etc. According to Public Health Agency of Canada, “women are somewhat more likely than men to be unable to speak either English or French. In 1996, 5.2% of senior women, versus 3.5% of their male counterparts, were unable to converse in either official language” (PHAC, 2009).

When elderly immigrants populations are faced with barriers of communication, overcoming the language barrier is further complicated since time and energy are luxuries that are not as available to them as they are to their younger counterparts. With tendencies to depression and limited access to services due to various obstacles such as language barriers, access to services that may exist for such elderly women is restricted. Better understanding these barriers in the unique circumstances of elderly women can help create a bridge between them and helpful resources in order to accelerate settlement and promote improved mental health and adjustment.

#### **2.1.4 Goal striving theory**

Striving to attain a goal is not dependent on cultures but rather dependent on favourable and unfavourable conditions within which one strives to achieve. The argument underpinning goal striving theory is that an individual is stressed when there is a deficit between their expected goal and achieved goal. In other words it is the “discrepancy between an

immigrant's aspiration and his actual achievement" (Kuo, 1976: 298). Achieving a certain level of economic status is a basic challenge for any immigrant who wishes to establish a basic sense of security. So as there is a mismatch between immigrant aspiration and immigrant achievement stress is the resultant product (Bhugra & Ayonrinde, 2004). Such a condition creates "low mood, a sense of alienation and more importantly a sense of failure – all of which can trigger depression" (Bhugra & Ayonrinde, 2004: 16). Several studies have documented specific case of Chinese immigrants who moved from their country believing Canada is a 'paradise of roses'. Their prime aim was to come and turn their economic fortune around only to face huge disappointments. According to Leung (2000: 19) some Chinese immigrants upon arrival have no choice but to accept that their long accumulated work experiences and credentials are not recognised, and start afresh in Canada. They have to do all kind of job to survive. Leung gave an example of a woman who had lengthy experience working in office settings but upon arrival in Canada had to voluntary work to gain Canadian experience:

My experience was like many new immigrants, to accumulate Canadian work experience by becoming volunteers. But this does not really work. For me, I worked as volunteer for only 2 weeks and then I quitted, because I had to leave my son in a day care centre. I paid day care fees, but I don't see any reward. I felt being exploited (Leung, 2000: 19)

A sense of financial security is implicated in the promotion of lower levels of stress and therefore a stronger foundation for mental health. Compared to Canadian born elderly, poverty among elderly immigrants is still high, based on Canadian census data in 2006 (Boyd & Kaida, 2011). A lack of or inadequate state income support has been suggested as the reason for this difference. In effect this theory does raise issues that are of grave importance with regards to elderly immigrant women. However, the aspirations of women may be different from men. Therefore, a generalization of goal striving among all immigrants may not give much detail as to how social

support could be directed towards dealing with immigrant women suffering as result of a mismatch in aspiration and achievement.

### **2.1.5 Cultural exchange theory**

The fundamental argument that proponents of cultural exchange theory try to establish is that immigrants give up their culture and take on the culture of the new country. In other words the individual becomes acculturated. Acculturation is the process by which a member of the minority group assimilates cultural values and beliefs of a majority culture (Bhugra & Ayonrinde, 2004: 15). According to Kuo (1976, 289) cultural exchange theory hypothesizes that the cultural change has a disrupting effect on the psychological orientation of the individual undergoing acculturation. Bhugra and Ayonrinde (2004: 15) stated that the minority group's adaptation of a majority culture's norms, values and language can be voluntary or forced. In situations where individuals are forced to give up their cultural values and norms to take on new cultural values and norms can contribute to a sense of alienation and isolation as there is culture conflict. In the case of Chinese immigrants, it is worse as trading their Chinese cultural values for the Canadian cultural values seem to be a huge task. Chong (2012: 9) affirms this below:

Cultural issues influence detection of illness, utilization of mental health services and adherence (Mok, 2006). Values and beliefs held in Chinese culture could influence how some individuals encounter perceived stress, distress and motivation to access mental health services (Herrick & Brown, 1999). Individuals in Chinese culture may find it difficult to accept the notion of mental health disorders for various reasons. Some Chinese people perceive spirits and ghosts to be responsible for mental illness (Ran et al., 2005). There are some in the Chinese society that perceive people with psychosis to be cruel and prone to violence (Ran et al.) thus individuals are perceived as being dangerous. Having a mental illness often is seen as a punishment for the misbehaviours of ancestors or family's misconduct (Ran et al).

However, unlike in the United States where immigrants are made to assume the American culture because of the practice of the melting pot system, Canada is a multicultural society where immigrants are allowed to keep their cultural values and norms. Therefore this theory does not have enough basis to be applied to the Canadian society. In this light cultural exchange theory does not shed light on the state of mental illness among elderly immigrant's women. Providing social supports in this case should not focus on cultural exchange because elderly immigrants continue keep their cultural values and norms.

### **2.1.6 Stress process formulation**

There is an argument that “social stressors do not occur randomly; rather difficulties in life are systematic and disproportionately distributed across individuals and sociologically definable groups” (Noh and Avison, 2003: 194). This argument underpins the stress process formulation perspective. With regards to this perspective, studies on immigrant mental health have focused on the combined effect of the following factors: factors that tend to stress individuals, factors that mediate the formation process and how individuals cope with stress. In other words, the model showcases the diverse ways in which the harmful consequences of social stressors vary substantially across individuals and social groups, and how such variations are determined by psychological and social coping resources including personality, coping effects and skills and social support (Noh and Avison 2003: 193-194). According to Noh and Avison (2003) there have been competing views within the stress process formulation model that have been synthesized into two sub models, that is, deterring and coping models.

Scholars of the deterring model postulate that pre-existing coping resources act to reduce the impact of stress on the individual in three different ways: reducing stress

independently, suppressing the stress and conditioning the stress (Noh and Avison, 2003). With regard to the coping model, scholars argue that stress may not impact the individual directly, but rather operate through prevailing conditions such as the social and the life strains, to exert itself on the individual (Noh and Avison, 2003). The coping model occurs in three different ways: the stress is counteracted, coping resources mediate the effects of the stress and finally there is the stress-buffering effect of resources as result of interaction between prior stressors and current resources (Noh and Avison, 2003).

The case of Chinese immigrants blends perfectly well with the stress formulation theory. This is because several of the scholarly sources highlight combinations of challenges faced by the Chinese immigrants. These include unemployment, communication barriers, stigmatisation, discrimination, access to health care, food, transportation and many other social determinants that tend to shape their lives in Canada.

In contrast to the biological factor, isolation, cultural shock, cultural exchange and goal-striving theories, the stress process formulation perspective goes further as it centres its arguments on stress factors, resources and coping abilities of the immigrant. This approach therefore offers a more sociological approach as the immigrant mental health is analysed through the social lens. However the theory does not account for differences in gender and age which are important demographic factors that inform and shape the health of the individuals. A merger with a feminist perspective offers a more holistic approach to deal with mental health conditions among elderly Chinese immigrant women.

### 2.1.7 Postcolonial Feminist theory

Feminist theorizing gives particular attention to the ways the disenfranchised and marginalized are impacted by broader factors (Smith, 2010). Smith writes that:

“Many feminists have taken a different perspective on (di)stress, and have developed new definitions, arguing that (dis)stress is not centered in biology. Laura Brown (1994) reframes distress, not as a disease, but as communication about unjust systems. She looks at disease as a possible indicator of health and a capacity to resist patriarchy, even at a cost. She claims that this reframing is a "revolutionary development" coming from feminist theorizing and applied to psychological practice. Similarly, Ballou and Brown (2002) state that the ways in which the —normal and —abnormal are portrayed in mainstream mental health professions are intricately connected to the experiences of oppression and the sources of resilience arising from structures of gender, culture, class, race and sexuality. This is also important when realizing that, in the mental health culture of the 21st century, making distress and difficulty equivalent to disease or psychopathology can become profitable” (Smith, 2010: 8).

Clearly feminist scholars continue to argue that attributing mental illness among women to biology is incorrect. They tend to attached huge importance to external factors or causes as the explanation of mental health conditions among women as well as their inability to access social supports. “These external causes can include power inequities and discrimination in the sociocultural environment” (Worrell, 2001 cited by Smith, 2010, 9). Also, distress may be an attempt or manifestation of attempts at resilient responses in extraordinary circumstances, rather than a failure of resilience (Smith, 2010, 9 citing Ballou and Brown, 2002).

One of such feminist perspective is the postcolonial feminist theory. The proponents of the postcolonial feminist theory focus primarily on factors influencing mental illness among women as well as factors impeding their access to health care. In her article entitled ‘The Impact of Race, Gender, and Class in Postcolonial Feminist Fieldwork: A Retrospective Critique of Methodological Dilemmas’ (2011) Racine explains the concept of post colonialism as follows:

Postcolonialism cannot be conceptualized as a single and universal theory, but as an umbrella of ontological and epistemological assumptions used to allow the disenfranchised knowledge of colonized populations to be heard and acknowledged. As such, in using postcolonial approaches, researchers make visible the exclusionary effects of race and class on health disparities that arise from social inequities (2011:18).

She also explains postcolonial feminism as follows:

Drawing from Schutte (2000) I refer to postcolonial ‘feminisms’ in its plural form to indicate the multiple voices and locations from which postcolonial feminist scholars speak. Inspired by Anderson (2000-2003) Reimer, Kirkham, and Anderson (2002), Meleis and Im (1999) and Smith (1987) postcolonial feminism may be defined as a critical perspective aimed at addressing health issues stemming from social inequalities that have an impact on the health of non-Western populations...A postcolonial feminist epistemology not only focuses on patriarchy as a source of oppression, but that also examines how social inequalities are inscribed within a historical, political, social, cultural, and economic context that influences health and health care delivery. This underlines why issues of race, gender, and class are important to explore in health and nursing research. Discrimination within the health care system is acknowledged to exist and to be socially constructed along the lines of race, gender, and class. Postcolonial ‘feminisms’ disrupt the relations of ruling that silence the culturally different voices by allowing for the integration of subjugated knowledge into health and nursing theories. Finally, postcolonial feminist researchers try to equalize the power asymmetry with participants to foster the development of transformative knowledge and avoid the pitfalls of cultural essentialism (Racine 2003) (Racine 2011:18).

From Racine’s explanation, the post-colonial feminist theory is concerned with how the race of a person, her gender as well as her class relations tend to impact the social, cultural, political, and economic factors that she encounters, which in turn shape her life as an immigrant women living with mental illness. In comparison to the other theories already discussed above, the post-colonial feminist theory adds to its defining attribute the social determinants of mental illness among women, as well as factors that have become barriers to them access social support. For example, “as women often migrate as dependents of their male relatives, their unique migration trajectories and specific health needs are often not incorporated into policy formulation, the focus being on male migrants thereby undermining their access to healthcare services” (Khanlou, 2009: 11)

This study with its focus on elderly immigrant women in Canada, applies the postcolonial feminist theory to argue out the case of elderly immigrant Chinese women. Furthermore, the conditions of elderly immigrants Chinese women can better be appraised and comprehended through this theoretical framework.

## **2.2 Applying the post-colonial feminist and stress process formulation perspectives**

A variety of social factors have been identified in terms of immigrant health and over-all well-being including general factors as well as those related more specifically to elderly Chinese immigrant women. For example, a sense of personal control appears to be a significant factor related to life satisfaction with no significant difference between men and women based on 81 elderly Chinese participants aged 65 years to 96 years in Western Canada, (Lai, 1995). A study that uses the lens of post-colonial feminism examines how inequality and unequal power relations shape the distribution of health care resources and accessibility of health care services for women and other marginalised social groups (Anderson et al 2002). Some aspects of women's live that are shaped by the inequality and unequal distribution are discussed below.

Immigrant Chinese women's understanding and definition of themselves is intimately tied to socio-political climates and also to local material realities. This includes how better to comprehend how they define themselves as mother, wife and immigrant (Dyck, 2004). In this sense, the process of elderly Chinese immigrant women redefining themselves in the context of their new homes, away from the home and lifestyle they left behind, is embedded in the social and political conditions prevailing in the new environment. This may be particularly complicated in situations where the country of origin's definition of womanhood and that of an

elderly woman is very different from female identity in Canada. For example, in China, an elderly immigrant woman defined her identity as a woman in terms of depending on a man. Thus in accessing resources or health services she would face a greater obstacle to getting the help that she needs because she is dependent on someone else.

Shifting identities and self-definitions in a new social context is incorporated in the health of immigrant women. One such shift, Feminist Identity Development (FID), has been observed as part of psychological well-being in a sample of 151 Iranian immigrant women from the United States, Canada, Europe and Australia. The study used a model of FID to examine the relationship between stages of FID and mental health through an online survey. The results, as expected, confirmed a positive correlation between more advanced levels of FID with improved psychological well-being (Kaighobadi, 2008). This would mean that immigrant Chinese women who are elderly and come from a place where their FID is not well developed would be more likely to display the negative mental health status of depressive symptoms. This is particularly crucial with the elderly who tend to be insulated from broader community due to the various factors that keep them from potentially developing their feminist identity. Although acculturation and ethnic identity developments are positively correlated with well-being, (Kaighobadi, 2008) they can also be a source of tremendous psychological stress. The point here would be what the impact is experiencing a culturally and socially new milieu in which the newly immigrated elderly Chinese women find themselves, and how this may lead to the integration or the isolation of these women upon their settlement in their new home, in this case, in Ontario.

Immigrating to a new country involves tremendous stress. Therefore, another important factor worthy of attention here is the concept of post-immigration stress and how immigrants cope with this kind of stress. A qualitative study of 24 South Asian women

concluded that “loss of social support, economic uncertainties, downward social mobility, mechanistic lifestyle are stresses that act as barriers in accessing health services” (Ahmad et. al, 2004:113). Coping strategies reported by the participants were: “increased efforts to socialize, use of preventative health practices and self-awareness” (Ahmad et. al., 2004:113).

Personal resilience is a significant and crucial aspect of healthy readjustment for migrating women (Spitzer, 2007). Chilean, Chinese and Somali immigrant women, according to a recent study, have been able to create new meanings in a new place while remaining in connection with the culture from which they originated, by negotiating personal resources and communal resources and how they are used all testifying to the women’s resilience (Spitzer, 2007). This study highlights that there can be active participation on the part of the immigrants to create new meaning rather than a passive un-engaged role played in creating new meaning.

Canada is a multicultural society and thus care-giving needs to take into account that care-giving can vary in terms of its delivery and effectiveness. In order to better provide care-giving to the elderly, an important factor to consider is ethnically appropriate care-giving, for example the use of less formal means and more family-oriented forms of care-giving for populations in which family-oriented approaches may be more productive and effective (Yoshino, 2011) For example, whereas in one socio-cultural context family members may view care of elderly relatives as a burden, other cultures like the Chinese culture may see care of relatives as a highly socially valued part of the life of younger family members (Yoshino, 2011).

This becomes a crucial aspect of mental health care since typically Western forms of mental health care intervention may not be suitable for or accessible to new immigrant elderly women in Ontario. The socio-cultural reality of such immigrants must be taken into

account when developing programs or policies, when they come into contact with health care professionals and providers and with family members whose approach to their elderly relatives may have the most impact on the women's mental health and readjustment in their new social and cultural environment.

Psychological distress may be reduced when members of a minority find themselves in higher proportions in a given region. A study attempting to investigate the possible roots for the apparently reduced incidence of depression among immigrants concluded that immigrants and members of visible minorities living in regions in which their density was numbered or higher numbers in a given region were less likely to be depressed (Stafford et al., 2011), thus further emphasizing the healthy effects of community on otherwise disadvantaged groups. However, if there are positive effects associated with being in one's own community, then the chances of reaching beyond the community for integration in the larger community may be diminished. This is an important point to take into consideration in the case of the isolation of elderly immigrants from broader social communities in situations where their access to for supportive programs or services is restricted.

When policies and government funding for social and health services are not coordinated with a view to promoting the healthy and effective resettlement of immigrants, the resulting outcome is detrimental for new immigrants (Stewart et. al, 2006). Language barriers and separation from the country of origin and the process of immigrating have been identified as factors that further complicate challenges to adjustment for immigrant Chinese women (Stewart et. al, 2006:329). The following is a brief overview based on the study conducted in by Stewart et al (2006):

“The identified barriers to support reinforce the importance of modifying and expanding policies and programmes affecting immigrant women’s ability to care for family members with illnesses or disabilities within the context of Canadian society. Participants recommended changes to policies and programmes to deal with information, transportation, language, attitudinal and network barriers. The various barriers to services and programmes which were experienced by immigrant women caregivers underscore the importance of caregiving policies affecting immigration, caregiving, and access to health and social services. Intersectoral collaboration among agencies is essential to reduce the barriers identified in the present study, and to establish services which are linguistically and culturally appropriate” (p. 329).

Overcrowding has been indicated as a resulting consequence of older immigrants having to live with their sponsors due to non-eligibility criteria of government transfer payments or welfare benefits for up to 10 years in Canada (Basavarajappa, 1998), potentially creating additional challenges in terms of the living conditions for both the newly arrived and the hosting family. The likelihood of immigrants who come from developing parts of the world living in these conditions is “up to 18 times greater than that for the Canadian-born or immigrants from developed regions” (Basavarajappa, 1998:409).

There are cultural differences and particular preferences have an impact on the choices that are made by the immigrants in terms of affecting their lifestyle after immigrating and these choices are influenced by the structures that they come from (Basavarajappa, 1998), making the challenge of integration larger in that the newly immigrated must recreate new meaning in their new reality in their host country. The region from which immigration originates is another significant determinant of the health of immigrants (McDonald et al, 2004). Basavarajappa, K. (1998) found that: “variables such as average income, [proportion] receiving Old Age Security payments, [proportion] widowed, & duration of residence in Canada are significantly associated with proportions of immigrants living in such arrangements, and explain about 84% of birthplace variation for males & 81% for females” (p. 409).

There are patriarchal barriers to adjustment and empowerment of elderly women after moving to Canada from a country where the opportunities for women were non-existent or limited. There is a failure of outreach to women who are new immigrants and are sheltered by their kin who have sponsored them or by barriers such as language or mobility. Cultural gender relations encourage men to have more exposure to the public domain versus women from other cultures who tend to stay at home.

Women from other countries where men are expected to deal with matters outside the home may be further secluded from the community or resources that may be beneficial to them. They are harder for health care or social work professionals to reach since there may not be any grounds to visit them or assess them (etc). Therefore the work that needs to be done in order to reach them in a manner conducive to optimum mental health is to reach their family/sponsors regarding the resources available to them and how this would be beneficial, not only to their elderly family member(s) but also to them as the host care providers.

There is research that indicates a troubling and counter intuitive effect experienced by some women who migrate to North America on grounds of freedom from the restrictive structures of their country of origin towards women. In a study by Shankar et. al. (2009), contrary to the expectation that women would benefit from legal, economic or political resources to empower themselves rather than on patriarchal structures, there seems to be an increased attempt at gaining control through the sons or grandsons of older Indo-Fijian immigrant women in Canada (Shankar et. al, 2009).

In another study, life satisfaction, social support, health and functional status, number of years in the country to which the participants immigrated (the United States in this

case), level of acculturation and command of the English language were found to have an inverse correlation with depressive symptomatology (Lam, 1997). The overall well-being of elderly immigrant women therefore is particularly at risk if they are new to the country, do not speak the language of majority in their region in Ontario and have limited exposure to the dominant culture of Ontario due to isolation.

The postcolonial feminist perspective therefore links the arguments of all the other theories to inequality and unequal power relations by unmasking the “interlocking oppressive effects of race, gender, and social class” (Racine, 2011: 17). In effect the “postcolonial feminist approaches unpack the cultural, historical, social, and economic factors that intersect to shape different oppressive contexts that affect health and well-being” (Racine 2011: 17) of elderly Chinese immigrant women. Together with the stress process formulation theory, this study accounts for the case of elderly Chinese immigrant women’s mental health and how they access support social support in Ontario.

In this chapter we have seen how different theories have been used to explain the mental health conditions of immigrant. These include social isolation theory, cultural theories, goal striving theory, social processing theories and the postcolonial feminist theory. Through these theoretical concepts we comprehend the various social factors that impact the mental health of immigrant. This thesis uses the social processing theory and the post-colonial feminist theories to explain its finding in chapter four. The next chapter discusses the methodological approach adopted in the present study.

## **Chapter Three**

### **Methodology**

#### **Introduction**

This chapter is centered on my methodological approach. I approach this study qualitatively, using the qualitative content analysis. Understanding people's experiences, especially those concerning issues of settlement or living conditions, it is important to share in their experience or share in their narrations regarding their experiences. Due to time and financial constraints, I gathered data on the lived experiences of elderly immigrant women through reports on elderly Chinese immigrant women and studies conducted on elderly immigrants' women in which some form interview or survey was conducted. I developed codes from these reports and studies out of which I came out with categories which I used to analyse my data.

#### **3.1 Methodological approach- Qualitative Content Analysis**

Content analysis involves “making inferences by systematically and objectively identifying special characteristics of messages” (Berg, 2009: 341). According to Berg, with this approach “photographs, videotapes, or any item that can be made into text is amenable to content analysis” (Berg 2009: 341). Content analysis can either be qualitative or quantitative. This study was conducted using the qualitative content analysis. According to Zhang and Wildermuth (2009) qualitative content analysis can be defined as follows;

- A research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns ( Hseih and Shannon, 2002: 1278 cited by Zhang and Wildermuth, 2009))
- An approach of empirical, methodological controlled analysis of texts within their context of communication, following content analytic rules and step by step models, without rash quantification ( Mayring, 2000: 2 cited by Zhang and Wildermuth, 2009))
- Any qualitative data reduction and sense-making efforts that takes a volume of qualitative material and attempts to identify core consistencies and meaning (Patton, 2002 cited by Zhang and Wildermuth, 2009)

According to Zhang and Wildermuth (2009), these three definitions illustrate that qualitative content analysis emphasizes an integrated view of speech or text and their specific content. Based on these definitions I developed my data selection criteria.

### **3.1.1 Unit of analysis**

The unit of analysis is the basic unit of text to be classified during any content analysis. My unit of analysis is the overall text of reports from organisations and articles centred on elderly Chinese immigrant women and their mental health. I drew on the above sources because the publications and reports from them raised important issues on elderly Chinese immigrants. The importance of the data from these sources is that it assists to bridge the gaps in the specific data on Chinese immigrants. I read through the written reports and articles with particular attention on the elderly Chinese immigrant women's life activities at various stages of contact, specifically pre-migration, settlement and post migration. I also directly assessed the degree to which the process of immigration is addressed (by interventions or programs,

education, enhancement of accessibility, etc) in terms of insuring the optimum mental health of the elderly Chinese women who immigrate to Canada and more specifically Ontario.

### **3.1.2 Data collection and analysis**

As I have indicated already, the methodological approach is qualitative content analysis. I searched for the reports and articles using various databases and the Morrisset library at the University of Ottawa. I searched for reports on Chinese immigrants, and from the library I searched for articles and published reports on elderly Chinese immigrant women. I used the following key words during my search: elderly Chinese immigrant women, mental illnesses, and feminist health promotion. My search yielded lots of articles and reports. I then selected the relevant articles for my analysis based on my research questions and theoretical considerations. Further on, I narrowed the number of articles and reports using the following data selection criteria:

- Since the research was concerned with elderly immigrant women, I first collected data with regards to immigrant women aged 65 years and above upon arrival into Canada. In cases where the data does not indicate age range but rather indicated generally with the use of the word elderly, I still included such data in my corpus for analysis since conventionally in Canada, elderly population in most cases refers to people aged 65 or older.
- The country of origin of elderly immigrant women was my second. Specifically, this study focuses on elderly Chinese women from either Mainland China and/or Hong Kong.

- Period of time residing in Canada is another important factor found related to health (Wong & Wong, 2003). Therefore, I singled out texts or documents that indicated the period of an immigrant has lived in the Canada. In some cases where the reports or articles do not make it explicit, I searched for pattern of use and the tone of the interviews embedded in the text. Furthermore, in some few cases, I drew on works about recently arrived Chinese immigrants since they shed more light on the pre-migration conditions and the prevalence for depression.
- Circumstances of immigration (e.g. refugee status, sponsorship). In effect, I selected articles and reports that focus on data that make it clearly as to why particular immigrants or immigrants in general migrated to Canada.
- Mental health data about elderly Chinese immigrant (as can be found through various means, such as: number of visits to hospital, mental illnesses reported, frequency of visits to the psychiatrist/psychotherapist, and the nature of complaints related to mental health and adjustment). In effect, I selected records of discourse related to the experiences of the elderly Chinese immigrant women living in Canada as an elderly immigrant woman (once again, as can be found).
- Nature (e.g. Federal, Provincial, or non-profit organizations) and the scope (e.g. settlement or culturally targeted organizations) of services provided for these women in their respective regions of Ontario

- Other data, that unforeseen or added data as is found relevant (e.g. if “violence in the home” or “level of community participation” or any other unforeseen but relevant data that may emerge in the course of the research).

The six data selection criteria were not mutually exclusive. Some reports and articles were selected on the basis of more than one of the criteria.

Based on these criteria, I selected eleven articles and reports. I read through each article at least twice. In each article, I underlined or highlighted paragraphs and sentences that gave detail information or explanations regarding the elderly Chinese immigrant women’s life experiences. Zhang and Wildermuth (2009) write with regards to themes, concepts, sentences and paragraphs that:

Qualitative content analysis usually uses individual themes as the unit for analysis, rather than the physical linguistic units (e.g., word, sentence, or paragraph) most often used in quantitative content analysis. An instance of a theme might be expressed in a single word, a phrase, a sentence, a paragraph, or an entire document. When using theme as the coding unit, you are primarily looking for the expressions of an idea (Minichiello et al., 1990). Thus, you might assign a code to a text chunk of any size, as long as that chunk represents a single theme or issue of relevance to your research question(s).

I gave each article underlined or highlighted theme, sentence and paragraphs a code which represented a category. According to Chong (2012 citing Morse, 1994)) coding is a process that helps to sort data and cover underlying meaning in text and metaphorical references. Similar to the work of Chong (2012), I coded line by line looking out for the linkages between concepts or with context. Codes developed are units of information that stand by themselves (Chong, 2012 citing Lincoln and Guba 1985). From the coded data I developed three categories.

The three categories are pre-migration conditions, settlement conditions and health promotion. Under each category, I used a word or a phrase to represent any issues that I

found to be related to mental health of the elderly Chinese immigrant woman. Below is a table showing categories and words or phrases representing relevant issues.

Table 3.1 Table showing categories and words or phrases

<b><u>Pre-migration conditions<sup>2</sup></u></b>	<b><u>Settlement conditions</u></b>	<b><u>Health promotion</u></b>
<p>Issues coded under this category represented by a single word or phrase include the following:</p> <ul style="list-style-type: none"> <li>• Separation,</li> <li>• Caregiving ,</li> <li>• economic goal,</li> <li>• family reunification</li> </ul>	<p>Issues coded under this category represented by a single word or phrase includes the following:</p> <ul style="list-style-type: none"> <li>• Isolation</li> <li>• loneliness,</li> <li>• communication barrier,</li> <li>• discrimination,</li> <li>• marginalisation,</li> <li>• racism,</li> <li>• physical mobility, economic barrier or dependence ,</li> <li>• stigmatisation</li> <li>• Psychological, physical health and illness</li> <li>• Food challenges</li> <li>• Family conflict</li> <li>• Life satisfaction</li> <li>• Elder abuse</li> <li>• Access to health care</li> </ul>	<p>Issues coded under this category represented by a single word or phrase includes the following:</p> <ul style="list-style-type: none"> <li>• Empowerment,</li> <li>• Cultural relevance and spiritual affiliation,</li> <li>• Family and community support,</li> <li>• Economic independence,</li> <li>• Access to health and social support,</li> <li>• Communication</li> </ul>

<sup>2</sup>The issues under this category are better understood when explained together with the issues under the settlement challenges category. For that matter in chapter four the issues under this category will merge with issues under the settlement challenges category.

### **3.2.2 Pre-migration challenges**

The first category is pre-migration conditions. Under this category, that is the first column, are words and phrases that highlight pre-migration conditions. These are separation, caregiving, family reunification and economic goals. These words and phrases represent reasons elderly Chinese immigrants women indicate were behind their immigrating into Canada. This category is very important because it creates the opportunity to understand the conditions that cause the elderly Chinese immigrant woman to leave her home country and the impact of the departure on her life.

### **3.2.3 Settlement conditions**

Settlement experiences in the second column looks at post migration experiences of elderly immigrants. These are settlement difficulties, family difficulties, mobility, and access to health care, marginalisation, discrimination, racism, stigmatisation, economic dependence and other challenges. In addition are social factors that make it difficult for elderly immigrant women to access the available social and health supports available in Canada. Under this category texts that made reference to quality of life and life satisfaction of immigrants were noted.

### **3.2.4 Health promotion**

The final column in table 3.1 is headed health promotion. I created this category because it explains the connection between the mental health conditions of the elderly immigrant woman and the postcolonial feminist theory. Secondly, the research is concerned with how the issues affecting elderly Chinese immigrant women's health can be addressed. Thirdly, this is to highlight that promotion of mental health of elderly Chinese immigrant must emanate

from identified problems. I draw on those policies and programs that immigrants mention they are involved in and the degree to which it is being helpful.

Data analysis is a process requiring astute questioning by the researcher, a relentless search for answers, active observation and accurate (Morse, 1994 cited by Chong, 2012). Through data analysis, we try to organise and provide structure to elicit meaning from the data collected (Chong, 2012). It requires making accurate records and spending time to immerse oneself in records as well as to develop a sense of whole beyond an immediate impression of what it is they contain (Chong, 2012). Following the collection of the data, the content of these sources was analysed and compared in the context of risks and/or opportunities facing this population in terms of mental health. Further on a comparison between the duration since immigration and the mental health status of women provided a platform for sub-factors that can accelerate the effectiveness of social integration for improved mental health for future prevention of the development of depression in the elderly women's population.

The words or phrases under each category are not mutually exclusive. Some the words are better understood when merged together. In chapter four, some of the words or phrases were explained together to bring out the most appropriate understanding on the issues confronting elderly Chinese immigrant women.

### **3.3 Limits of the data**

Data that is deemed beyond the scope of this work (for example, medical root causes of mental health issues) were excluded. Only material pertaining to the social/societal factors that relate to the improvement, maintenance or the detriment of mental health of elderly women was considered. For each social factor category, the nature and effects of contact with

programs and/or professionals was listed in order to get a clearer picture of the points at which this population comes into contact with interventions/programs. It is crucial that immigration to a new country and readjustment is seen through a process lens rather than a static set of predetermined steps. The nature of the process is undeniably different for every individual.

The study uses qualitative content analysis as its methodological approach. The unit of analysis was the complete text of reports from organisations committed to the welfare of elderly immigrant women, studies conducted on elderly immigrant women and other government documents that give details on immigrant women and their health in Canada. Three main categories were created under which coding of the data was done. In the next chapter I talk of my findings in relation to the theoretical framework.

## **Chapter Four**

### **Findings and discussions: Settlement stressors**

#### **Introduction**

All immigrants face diverse challenges as they try to settle in their new environment. Nevertheless “older immigrant women generally face greater mental health problems compared to their male counterparts or to native-born women” (Chundamala et al., 2006: 4). Similarly, elderly immigrant women are the most disadvantaged with regards to accessing social and medical support. In most cases, the conditions of older immigrant women are worsened (Chundamala et al., 2006: 4). In this chapter, I discuss the findings of the study. Specifically, I highlight the challenges or conditions that elderly Chinese immigrant women face, the social supports available and factors hindering their access to these social supports.

#### **4.1 Settlement challenges**

Focusing on the health of elderly Chinese immigrant women as reported by the organisational reports and articles I analysed, the following conditions or challenges are recurring themes that are linked with poor health in older immigrant women. These include isolation, loneliness, family conflict, and economic dependence, communication barriers that create problems of discrimination, marginalisation, racism and stigmatisation. Others are life satisfaction, food, transportation and physical mobility. These conditions together influence individual immigrants physically and mentally. Furthermore, these conditions hinder the treatment of mental health conditions by impeding the available supports that have been proven to be effective.

#### **4.1.1 Separation, isolation and loneliness**

Separation, isolation and loneliness were common problems across the reports and articles on elderly Chinese immigrant women with regards to their settlement experiences in Canada. Elderly Chinese immigrant women who have migrated are faced with the challenge of creating a new social self-identity and adjustment into a new socio-cultural reality. Loneliness and isolation move hand in hand because when people are isolated they feel lonely. These immigrant women therefore are faced with the problem of loneliness as conditions worsen in the new environment over a period of time. According to Li and Browne (2000) loneliness according to participants they interviewed is due to their family members being far away. Li and Browne narrated the responds of a participant feeling of loneliness in Canada:

When I am restless, and this happens every day, my husband tells me to watch soap operas on tape; of course the tapes are in my native language. The more I watch that kind of movie, the more I want to go back to my home country (Li and Browne, 2000: 148).

From the reports and articles some of these women lamented the isolation and loneliness they experienced due to their separation from the country of origin. They considered these conditions stressful because they require the use of all the women's resources, both internal/psychological/spiritual ones and those that are external and beyond their direct control.

According to Da and Garcia (2010) elderly Chinese immigrant women face many settlement challenges due to their being separated from their children back home in China. They added that this affects the perception of the immigrants with regard to their satisfaction of life in Canada. Da and Garcia write:

For most participants reunification with one or two of their children meant separation from other children left behind in China, and this influenced how they felt about their lives in the

new country. Sarah, in her early 60s, was sponsored by her husband. She has two children who chose to remain in China. She felt her life in Canada is not better than it had been in China, because of the separation (Da and Garcia, 2010:11).

When individuals migrate from their home country they are not only physically separated from their homeland but also they are separated from their familiar set of mutual rights, obligations and network of social relations thereby causing the most tumultuous destructive experience associated with migration (Kuo, 1976: 297). The individuals migrating from their home lands are distanced from their home environment, families, friends and many other activities they are accustomed to.

Da and Garcia (2010) indicated that some elderly Chinese immigrant women had to leave their country of origin due to the pressure of circumstances rather than out of a choice to start building a life in a new country with its own social, cultural and economic realities. According to Da and Garcia, what exacerbates the complexity and renders the task more challenging for these women is their dependence on systems outside of themselves to help them survive and thrive. Various factors are associated with the ability of the elderly Chinese immigrant women to adapt, cope and create meaning in their new home or host country. They are faced with other unique challenges in terms of acquiring a sense of security before they are able to thrive in their new life. Moreover, unlike older men young women, older women have more challenges to address before they can ensure optimum mental health and over-all being.

Chundamala, Matsuo and Peng (2006) also emphasise that isolation and loneliness are part of the pervasive resettlement experiences that older immigrant Chinese women go through when they arrive in Canada. In their analysis, they tied the state of isolation and loneliness of elderly immigrant Chinese women to factors such as decreased social supports

from children due to their busy lives and the lack of the ability to speak either English or French or both on the part of the immigrant women. This clearly indicates that family conditions turned out to be a negative influence when members of the family have less time to solidify the reunification, show care and attention to elderly Chinese immigrant women who have arrived in Canada.

#### **4.1.2 Family conflict and economic barrier**

Some of the reports and articles also indicated the huge role family conflict and economic barriers play on the mental health of elderly Chinese immigrant women. Elderly Chinese immigrant women face problems in their family which are fundamentally a result of change in values. Authors like Leung (2000), Chundamala et al, (2006), Da and Garcia (2010), and Chong (2012) indicated that grandparents clash with their grandchildren over differences in values. They explain further that most of these elderly Chinese immigrant women migrated to Canada as care givers to take care of their grandchildren. These women are at times stressed when these children demonstrate values different from their traditional values. The women perceive their grandchildren as disrespectful and disobedient when they enact these newly acquired values. This leads to conflict which consequently impacts on the mental health of the elderly women. In severe cases, grandchildren end up physically abusing their grandparents. Elder abuse, as noted in the introductory chapter, contributes immensely to depression and mental health conditions of elderly immigrant women.

Furthermore, several of the articles and reports I analysed revealed that elderly Chinese immigrant women face intense difficulties in their family as they suffer further abuses, isolation and loneliness simply because they have become economically dependent

members of the family. The articles reveal that the sources of livelihood and survival of elderly immigrant women are their children and grandchildren, through whom all their needs must be met (Chundamala et al., 2006). In situations where their children and grandchildren are not able to provide for all their needs, the elderly Chinese immigrant women live lives of regret, and stress because of not having their own source of income. The poverty condition of elderly Chinese immigrants is therefore a basic challenge for the immigrant woman who wishes to establish a basic sense of security. A sense of financial security promotes lower levels of stress and therefore a stronger foundation for mental wellbeing. According to Boyd and Kaida (2011), based on Canadian Census data of 2006, poverty among elderly Chinese immigrants is higher than among Canadian born elderly. The absence of income support has been suggested as the reason for this difference.

In a reports prepared by Ho Hon Leung (2000) for the Chinese Canadian National Council, Toronto Chapter, the author highlighted the constant complaint of participants concerning the fact that their credentials are not judged equivalent to Canadian credentials when trying to acquire jobs within their fields of study. Such a situation has contributed immensely to the economic crisis that most of these immigrant families experience, because they are denied opportunities to make sufficient money to cater for themselves and their parents who have moved to stay with them. This was a remark by a participant who spoke to Leung;

I studied business administration in Hong Kong. I headed a department and handled a lot of business with Mainland China. I once hope I could get back into international sales and marketing in Canada. I find I had no chance at all, not even an interview. Later I discovered that the employers did not want to give me a chance. If I were placed on a position equivalent to my education and experience, the co-workers will be furious. If I were placed on lower position I might not work for long. This is a fact I realise only after I came to Canada. Finally I decided to forget everything and apply for a position of sales trainee. I got my job in this way (2000:19).

According to Leung, such conditions create serious settlement challenges for immigrants and their families. It worsens the plight of elderly immigrant women who tend to worry because their children are not able to find a sufficiently well-paying job in the field to care for them as their children will love to do. In some situations the elderly immigrants tend to make too many demands, therefore they are abused verbally and physically by their children. This further contributes to the deteriorating state of their mental wellbeing.

My analysis again revealed that the above conditions of conflicts within families further worsen the mental state of elderly Chinese immigrant women. As Chundamale et al. (2006: 7) write; “when family conflict arise, these women become vulnerable as they may have little access to resources or options for independent living”. Succinctly, economic conditions can serve as barriers to determine to a great extent the mental health of the women who have migrated to Canada to stay with their children or grandchildren. These economic impediments act as significant forces that influence the stresses on the lives of immigrant women thereby affecting their families, the unit which has to serve as a primary source of social support or cushioning for the elderly immigrants as they try to settle in their new environment.

#### **4.1.3 Communication barrier, psychological, physical health and illness:**

Language constraint, psychological and physical illnesses were also extensively highlighted in the reports and articles. These conditions were linked to marginalisation, discrimination, racism and stigmatisation. According to Leung (2000:22) the consequence of a language barrier could be critical, since an immigrant needs to be able to communicate in order to access community supports needed in order to carry on their daily life in Canada, especially when they need services.

There is a great concern as to the extent to which immigrants are marginalised, suffer discrimination, are racialized and more importantly stigmatised because they cannot speak English or they are suffering from some form of mental illness (Chong, 2012; Crooks et al., 2009; Chundamala et al., 2006; Li and Browne, 2000). With elderly Chinese immigrant women, these communication problems are more pronounced, and impact heavily on their mental wellbeing. All the articles and reports revealed that elderly Chinese immigrant women are discriminated against firstly due to their age, then their gender and finally their immigrant status (Chong, 2012; Crooks et al., 2009; Chundamala et al., 2006). This is what I describe as ‘triple discriminatory conditions’.

The Immigration Act of Canada introduced in 1976 clearly affirmed the fundamental objectives of Canada’s immigration law including family unification, non-discrimination, concerns for refugees, and the promotion of Canada’s demographic, economic and cultural goals (Atkey, 1990: 2). Studies confirm that many immigrants experience discrimination, especially when they try to access social, economic and medical support to counter their conditions of depression and mental health (Chong, 2012; Crooks et al., 2009).

Elderly Chinese immigrant women, due to their acute vulnerability, tend to experience severe discrimination, which in turn reminds them of their marginalised status or minority position (Chundamala et al., 2006; Li and Browne, 2000). The reports and articles highlighted how elderly Chinese immigrant women are discriminated against due to their inability to speak English. A language barrier is one of the consistent settlement experiences that elderly Chinese women reveal as being challenging and impeding their quality of life in the Canada. These are the lamentations of some women narrated by Leung in his report:

I have difficulty in helping my daughter. When she takes her report card, or circulars back that require me to sign up. I need help. It was lucky that I was accepted into the ESL class soon after I applied for it. I studied for 2 years in classes offered by CICS. It is better now. At the beginning I felt uneasy because I relied on my friends to tell me what the school circulars were all about. I still have difficulties communicating with teachers (2000:23).

And

You don't know most of the medical terms. You can't tell the doctor your exact problem. You rely more on Chinese doctors. The hospital I stayed does not have translation service. This in turn limits your access to better medical care. I believe non-Chinese speaking doctors can't understand exactly what medical experience we had before we came to Canada because we can't use proper medical terms to explain the problems to them (2000:23).

Leung explains that the medical situation can become more acute and more impeding for the elderly immigrant women who have limited English proficiency (2000:23). Most of these elderly women tend to be discriminated against because they are old and cannot speak the English language.

Closely linked to the discrimination is stigmatisation. In general, all immigrants have to deal with the problem of stigmatisation. According to Li and Browne (2000) among the Chinese (all the Asian countries) there is high level of stigmatization of the mental illness, therefore cases of mental illnesses are kept in the family as a secret. With stigmatisation one is severely disapproved of on the grounds of characteristics that distinguish him or her from other members of the group or society. Stigmatization is the practice whereby people react to others which in turn disfigures their normal identity (Goffman, 1963). The three forms of stigma recognized by Goffman include the following: mental illness such as depression and schizophrenia; a physical form of deformity or undesired differentness; and an association with a

particular race, religion, belief, etc. (Goffman, 1963). In the case of elderly Chinese immigrant women, they are stigmatized due their Chinese culture, age, physical challenges, immigrant status, language barriers, gender and race (Chong, 2012; Chundermala et al., 2006; Leung, 2000; Li and Browne, 2000).

Susan Chong (2012) extensively discussed the concept of stigmatisation among elderly immigrant Chinese women suffering from diverse forms of depression or mental illness. According to Chong, elderly Chinese immigrant women experience two forms stigmatization, Self and public stigmatisation. Chong explains that the Chinese women experience negative feelings resulting from their negative social reactions within their ethnocultural group. That is:

For the women in this study, having mental illness meant they would be treated differently within their respective social community. Several women noted it was common within their ethnocultural group to hear negative comments related to individuals with mental illness... (Chong, 2012: 43).

These are the statements of some participants interviewed by Chong with regards to stigmatization:

Once they know that oh you are going into those hospitals or seeing psychiatrist, they kind of like feeling that you are a mental patient and they will be sacred of you or staying away from you, so I guess it's hard for people, Chinese , like if they have problems they don't want to tell people. They just want to hide them and they were scared of being labeled crazy or abnormal and also Chinese culture is like people spread like ...spread the information fast like because they like taking about people... (Chong, 2012: 43).

and

There is a stigma between mental illness, I think there probably ..... there would be more people that need help, but they don't understand and they don't like the stigma behind it

being able to go find help from team or whatever, but umm I think because of the being Chinese background, it's ....I find people don't accept you as a person with mental illness (Chong, 2012:43).

Obviously, we see the lamentations of elderly Chinese immigrants regarding how other people's perceptions make them feel about themselves. This result from the public stigma, and according to Chong, public stigma is comprised of the reaction of the general public towards a group based stigma about that group, such as individuals with mental illness" (2012:44). She explains further that this fuels the issue of self-stigma because the vital connection between an elderly immigrant Chinese woman and her social network of supports, such as family is threatened hence 'loss of face' (Chong, 2012; Yang et al., 2007). Chong write;

Loss of face was a contributing factor to self-stigma for Chinese women; this associated with the individual perceived lost moral status in local community. In this study, the women's experience of loss of face was associated with public stigma emanated from within their particular ethnocultural group - an experience that was internalized (self-stigma). For many Chinese, stigma occurs when family members of an individual with a mental illness experiences 'loss of face' as they are humiliated and unable to face others (Spencer et al., 2010; Yang et al., 2007). This is due to etiological beliefs about mental illness that assign mental illness as a moral effect to sufferers and family members (Yang et al.). Many of the families of the women in this study experienced shame due to living with a mental illness (2012: 44).

Chong gives an example in which a participant discusses her perspective on loss of face and stigma:

because as a whole it's something that my family is very ashamed. You don't talk about it and I still see that when I hear some of my friends and family talk depending.... so as a whole I'd say that stigma is more within the Chinese community (2012: 44-45).

From the work of Chong, we can understand the grave impact of stigmatisation on the life of elderly Chinese immigrant women as result of the mental illness they may suffer as part of their

settlement challenge. This further hinders them from accessing medical or social support. In similar vein, elderly immigrant women suffer from racism, a concept that I personally describe as a social cancer. According to McKenzie (2002), racism has been found to have an effect on the mental health of immigrants. Racialised elderly Chinese immigrant women encounter barriers of discrimination, prejudice, stigmatization and racism based on their skin colour, accent and sometimes cultural differences. Li and Browne (2000) indicated that 5% percent of the Chinese participants they interviewed during a study of Asian immigrant in Canada reported racial discrimination. Further on, these women are marginalized in their new environment; settling therefore becomes a huge challenge that eats up their mental fabric. Additionally, they are not able to access support that may be available due to the above conditions, worsening their mental health and impacting on their social and family ties.

#### **4.1.4 Food, transport and life satisfaction**

Continuing from the settlement challenges already discussed, the lack of Chinese foods and transportation have been reported as issues affecting the lives of elderly Chinese immigrant women in Canada. The difference in food among two different countries further strengthens the argument about cultural shocks and how it affects the mental health of immigrants while the issues of transportation affirms the biological arguments.

From the various reports, elderly Chinese women consistently complain about the lack of diversity in the Chinese food they have eaten since their arrival in Canada. One elderly Chinese woman lamented to Da and Garcia (2010:11) during a research in London Ontario:

“Food is very important for me to adjust my life here. I think among all things I need, the availability of Chinese food is a must”.

Clearly, elderly Chinese women are depressed because they are not able to have access the varieties of Chinese food they had back home. This may not be the case in all cities and/or towns in Ontario, but my experience as immigrant reveals that there is always a difference in the taste and quality of the food. According Da and Garcia (2010), such feelings affect the quality of life of the elderly women, making them to feel isolated and neglected as well. They tend to regret leaving their home country.

Another challenge that was consistent in some of the reports and articles concerns transportation (Chong, 2012; Da and Garcia, 2010; Leung, 2000). As I mentioned in my third chapter, one of the biological arguments is that elderly people are not able to move about because they are physically disabled. The various articles confirm the following: firstly, elderly Chinese immigrant women feel that public transportation is not convenient for them. Secondly, they consider the cost of bus passes or ticket to be too expensive. This condition further affirms the point about the lack of economic resources available to elderly immigrant women. “This was the concern of an elderly Chinese immigrant woman during an interview with Da and Garcia (2010:11);

“Transportation is also a barrier for me to go out. Public transport is not convenient; I feel that the ticket fare is expensive for us, even if we have discounted fares”.

The content of the articles and reports revealed that elderly Chinese immigrant women feel they have no access to recreation centres, because of transportation or lack recreational centres hence social life in Canada is a challenge. Elderly Chinese immigrant women therefore feel there is lack of avenues for them to make friends and socialise in their new environment. It has been argued that social networks are immensely important to the improvement of mental health of elderly immigrant; the lack of social life reported by elderly

Chinese immigrant women only affirms the argument. According to Da and Garcia (2010) a majority of the elderly Chinese women they interviewed indicated that they are affiliated with churches so as to make friends and have a social life. Many more other also attend English classes through which they make friends not only with Chinese immigrants but also with immigrants from other cultural backgrounds. However, there are some elderly Chinese immigrant women who revealed that their role as care giver and home care taker affect their desire to attend church or English classes to make friends. Furthermore, the cost of transportation also causes some others to also give up on the English classes:

“I used to attend English classes, but could not go now. The school I went used to provide free transportation. However, the policy has changed and they put some conditions. They now require us to provide information about the income of our children (Da and Garcia, 2010:10)”.

This statement by an elderly Chinese immigrant woman clearly indicates that these settlement challenges of elderly immigrant women are interconnected.

#### **4.1.5 Caregiving, living arrangements and other conditions**

Caregiving is another activity that is stressing elderly Chinese immigrant women. The reports and articles that I drew on clearly assert that elderly Chinese immigrant women leave their home country to Canada not only to reunite with their children but also to take care of their grandchildren while their children go to work. As argued by Chundamala et al. (2006) elderly women try to preserve their cultural values and traditions and as a result they fail to renegotiate their caregiving responsibility. Studies have shown that caregiving strengthens immigrant women sense of cultural identity but also creates enormous conflict for the women as they attempt to reconcile caregiving responsibilities and other responsibilities. Furthermore

caregiving creates enormous conflict for elderly women as they attempt to reconcile their care giving and other responsibilities (Spitzer et al., 2003).

The case of Chinese elderly immigrant women is not different. According to Da and Garcia (2010), the need for care for grandchildren is the main reason why elderly Chinese immigrant women migrated in to Canada. Da and Garcia (2010: 7) share the experience of a 70 years old Chinese woman:

The reason I came to Canada was to take care of my grandsons (twins) because I felt I have the obligation to....after my daughter finished her degree in France she and her husband applied to immigrate to Canada. After they arrive there, my daughter soon got pregnant.....she was then told by the doctor she has twins and she might have a chance to miscarry.....my son in-law at that time was very busy, having no time to take good care of my daughter. I decided to come over and to help temporarily....after the two babies were born, I could not leave them because my daughter needed me desperately to help her care for the babies. Then, my daughter found a full time job, which matches her qualification. I extended my visa again and again.....eventually became a permanent resident.

The responsibilities of some the elderly Chinese immigrant women include taking care of all the household chores such as making meals, cleaning and gardening. The role as caregiver further isolates these women as they are not able to participate in social activities and, as I mentioned previously, attend English classes. Furthermore, the stressful conditions of being a caregiver make them feel like living on their own. But once again, they are economically limited because they do not work for pay or earn any income.

My analyses revealed further that elderly Chinese immigrant women face challenges that do not really fall under the above broad categories. For example; there is a consistent lamentation about long waiting lists for medical services (Lai, 2000). In effect elderly Chinese immigrant women consider it very stressful if they have to wait for a long time before receiving medical service. This condition might apply to all other immigrants and even Canadian

born. However, it is a challenge to these women because such a situation might not prevail in their home country, especially since they are old. Also, there are concerns about receiving limited social services: most elderly Chinese immigrant women mentioned that social services are available to elderly people are limited (Chundamala et al., 2006; Leung, 2000). Finally, the cost of dental care to elderly Chinese immigrant women was just too expensive. They face regular problems with their teeth and mouth, but due to the cost involved they are not able to access treatment. Furthermore, their eating is greatly affected by the teeth and mouth problems. Together, they precipitate other illnesses.

I concluded from my analysis that living arrangements also greatly influence the mental health of elderly Chinese immigrant women whose arrival in Canada is quite recent. Da and Garcia (2010) revealed that most elderly immigrant women would prefer independent living. They describe the case of a participant, Suzan, a Chinese woman who owned her home in China before moving into Canada: she has been living with her daughter and son in-law for nine years. This was her lamentation regarding her living arrangement:

I wish I could live by myself, but this is not realistic at present because I do not have financial resources. I am now worried....I want to lead the rest of my life my way. I do not want a life of luxury, and neither do I want to spend a lot of money on food and clothes..... I cannot travel because of my leg problem. What I want is to have some time on my own, and do whatever I want to do.... They (her daughter and son-in-law) treat me well but they do not really understand what I need (Da and Garcia, 2010:8)

Condensing all the settlement challenges discussed above, we see the connections between them, with the family and economic resources being central. Clearly, elderly Chinese immigrant women tend to experience complexly interwoven social determinants in their lives which affect them mentally and hinder their obtaining available support. The settlement experiences of elderly Chinese immigrant women are felt particularly acutely when

these women try to access health and social support. The statement below by Leung sums up the arguments:

No doubt, family reunion is supposedly to have a positive impact on the family life. However, in the process of settling in a new receiving country where the culture and official languages are completely different the sending country, many elderly immigrants face another set of challenges that may affect their wellbeing.....elderly parents face language barriers, particularly when they seek medical help, access to transportation is also a concern.....As a result, some elderly immigrants may experience isolation. However, many services that the senior immigrant need are either not counted as settlement services or are underfunded (Leung, 2000: 21).

Below, I discuss some of the sources of support available and how the above conditions faced by elderly Chinese immigrant women are making it difficult for them to access these services.

#### **4.2 Social and medical supports and hindering factors**

The settlement stressors that I have discussed have precipitated studies and policies on mental health of older populations in Canada. These policies have been geared toward developing support mechanisms to stem mental illness. Generally, the support systems available are based on the conditions of the Canadian-born and not immigrants. In effect, the conditions of the immigrant are not adequately incorporated into schemes, programs and policies centered on the mental health of seniors in Canada. Examples of conditions peculiar to immigrants include the following: cultural practices, cultural background, maintaining a link with their new roles and self-identities like moving from being a care provider to being cared for. The elderly immigrants, especially women, would not be able to access resources conducive to optimum mental health because these support programs, which I am about to discuss, do not cover their specific conditions, some of which I mentioned above. Critical examination some of the

available support programs, schemes and policies is called for. This allows for the discovery of inadequacies.

#### **4.2.1 Community support services**

My analysis revealed that one of the common sources of social support currently in operation to meet the needs of seniors with mental health conditions are community support services. The Canadian Mental Health Association of Ontario in their paper: Mental health and addiction issues for older adults: opening the doors to a strategic framework (March 2010), highlighted that in 2008 the Toronto central Local Health Integration Network produced a list of community support services available to seniors. These included intervention and assistance services or non-intensive care management, support and counselling, adult day programs, recreational programs, meals on wheels and friendly visiting, transportation, volunteer services, care giver support services, respite services, peer support services and home support services.

The list of community support services reveals the importance of community involvement in talking about issues of elder mental health. However, the specific conditions of elderly Chinese immigrant women are not adequately dealt with in the community support services. Furthermore, the lack of social support for these elderly immigrant women compromises their capacity to guard against the negative effects of stress, leading to increased likelihood of physical illness (Gadalla, 2010). Given their insulation from the broader community and issues of a cultural/multicultural nature, elderly immigrant women have a great barrage of factors working against their integration.

The transition period of immigrants into their new home requires the assistance of family members and health care providers/resources in the social and mental health domains to ensure that changes are possible in the resettling of elderly immigrant women. The people who are most implicated in the transition are family members with whom the contact is greatest, but there are also resources beyond the home that could promote mental health and consequently overall well-being. Therefore, we arrive at a situation where community service cannot make any impact as most of these community services do not incorporate other family members.

#### **4.2.2 Specialised case management**

From the various articles and reports another form of social support, special case management, has been developed to deal with issues of the mental health conditions of seniors in Canada. As the name suggests it is targeted at seniors with special or severe cases. It constitutes intensive and comprehensive community support service in which case managers support the client and care givers in the management of the health condition, as well as providing mental health information, helping with goal setting and day-to-day task management.

Newly arrived elderly Chinese immigrant women require some time and the expenditure of energy before they are able to access services as such specialised case management and even other community and health supports. They need to overcome the barriers of language, perhaps asking others for help in learning about the new systems of medical or social services, etc. According to Public Health Agency of Canada, “women are somewhat more likely than men to be unable to speak either English or French. In 1996, 5.2% of senior women,

versus 3.5% of their male counterparts, were unable to converse in either official language” (PHAC, 2009).

When elderly immigrant populations are faced with barriers of communication, overcoming the language barrier is further complicated since time and energy are luxuries that are not as available to them as they are to their younger counterparts. With tendencies to depression and limited access to services, due to various obstacles such as language barriers, access to services that may exist for such elderly women is restricted.

A better understanding of these barriers that constitute unique circumstances of elderly Chinese immigrant women is necessary to help create a bridge between them and helpful resources in order to accelerate settlement and promote improved mental health and adjustment. The elderly are generally less able to take care of themselves as a result of the detrimental effects of mental health problems. The more extreme the mental health problems, the more difficult it can become for elderly to reach out and get the help they need. An increase in the severity of health problems can exacerbate an already existing difficult situation by creating secondary mental health issues.

#### **4.2.3 Outpatient programs**

The outpatient program is another support mentioned in the various articles and reports. In such a program elderly people facing mental health problems also have access to outpatient programs which enable them to access support and health services at home while remaining in their homes. In other words, patients are taken care of in their various homes. In fact the support or care providers come to their homes to provide care.

There is no doubt that such a program could be of immense benefit to elderly Chinese immigrant women especially those who cannot move about due their age. However, this support system is a difficult one for elderly Chinese immigrant women to access due the language barrier and the cost involved. On the other hand, elderly immigrant women are not able to communicate their problems to care providers so the exact issues needing solution are missed, and proper medical care and attention is therefore compromised. Additionally, these elderly women depend on their children, grandchildren or husbands for financial support. In situations where their sponsors are not able to provide the necessary support, the women are not able to access the outpatient programs.

#### **4.2.4 Health care systems**

Immigrants with mental illness have the opportunity of accessing health care services to improve their mental wellbeing. Canada has an extensive health care system in which elderly population is very well represented. Nevertheless, the health care system is structured on the basic requirements of Canadian-born, so that, immigrants and factors that shape their mental health are not factored into the health care system. Consequently, not all conditions faced by elderly Chinese immigrant women are dealt with by the health system which is also new to them. Furthermore, elderly individuals who have reduced mobility face additional barriers in accessing mental health care. The women are not able to get to the health centres due their immobility.

Most importantly, immigrant women face diverse forms of health inequalities which go a long way to worsening their mental state. The condition of elderly immigrant women is worsened due to their physical disabilities, age and gender. Additionally,

language can be an impeding factor to accessing mental health care. Further on the problem of stigmatization, racism and all other form of elderly immigrant discrimination is entrenched. All the settlement stressors that I have discussed regarding elderly Chinese immigrants women restrict their access to health care. As I indicated earlier on, some of the women complain of long waiting lists, transportation and cost of health care especially dental health care.

Clearly, elderly Chinese immigrant women are not insulated from the conditions of mental illness. Their inability to have access to community support, specialised case treatment, and outpatient programs of health care further worsen their condition. Consequently the quality of life of these women in their new environment is affected. They therefore become dissatisfied with their life. They begin to have regrets about leaving their home country leading to other series of mental illness. According to Racine (2011:18) postcolonial feminist also “examines how social inequalities are inscribed within a historical political, social, cultural, and economic context that influences health and health care delivery”. In effect the challenges that the elderly Chinese immigrant women experience are a result of the inequalities that prevail in the Canadian society. These inequalities are results of historical, political, social, cultural, and economic decisions or indecision on the part of the government and other stakeholders. In the next chapter, I specifically look at health promotion of elderly Chinese immigrant women. Once again, I present my recommendation within the general context to situate the case of the elderly Chinese immigrant women within a broader spectrum.

The present chapter reviewed the unique challenges that elderly immigrants face as a visible minority subgroup. Specifically, elderly Chinese immigrant women are faced with isolation and loneliness, family conflict and economic dependence, abuses, language barriers and mobility challenges. They are also discriminated against, marginalised, racialized

and stigmatised. Even though support services such as community service, specialised case management and out patients programs of health care are available, elderly immigrants are not able to benefit from these support services due to the challenges they face as elderly immigrant women and are not incorporated into the programs. The next chapter discusses the way forward for elderly Chinese immigrant women who are trying to settle into their new environment despite the resulting stress, depression and other forms of mental illness that they experience. The chapter deals with mental health promotion through a feminist health promotion lens.

## **Chapter Five**

### **Recommendation: feminist health promotion**

#### **Introduction**

Building from the previous chapter, I focus on how the mental health of elderly Chinese immigrant women can be promoted through empowerment so the women are able to overcome the settlement challenges that they face. There are numerous resources that may benefit these women, but there may be simple or easy way that program/policy developers and social workers can create systems in which integration can be possible for elderly Chinese immigrant women so they can access the available resources. For example, if immigrants come from more collectivistic cultures, then networking with other members of the same ethnic and/or cultural group may be all it takes to provide the conditions necessary for optimum mental health and adjustment. Integration would then follow naturally, rather than having to be instilled by other means. Using the example above, integration can become possible by addressing the social milieu of elderly Chinese immigrant women rather than focusing only on the immigrant women themselves. This example illustrates only one area in which work can be done to address the needs of the elderly immigrant woman. There are others and these will be the focus of investigation in this chapter. I approach this chapter through the lens of the feminist health promotion approach. As I mention previously, even though I write with the case of elderly Chinese immigrant women as the prime focus, I present the results in this chapter, just as I did in the previous chapter, through a general lens. I situate the case of elderly Chinese immigrant women within the general works of the elderly immigrant.

## 5.1 Feminist health promotion

Health promotion, according to the World Health Organisation, is the process of enabling people to take control over, and to improve, health (WHO, 1984). According to Labonte (1993b), the concept of health promotion is basically an act of empowerment. Feminist health promotion therefore emphasizes that “empowering redresses inequitable interpersonal relationships and social structures and creates opportunities for change” (Ward-Griffin and Ploeg, 1997:281). Feminist theories have identified gender, race, class and age as intersecting variables that create added layers of complexities for women of which the elderly Chinese immigrant woman is a part. Ward-Griffin and Ploeg (1997) argue that feminist theories suggest that sexism limits women’s health opportunities and subjects them to an array of situations including marginalization, powerlessness and exploitation.

Pape and Gallepeault (2002) writes that Mental Health Promotion as a subset of Health Promotion has been defined in an international workshop sponsored by Health Canada (1996) as the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for equity, social justice, interconnections and personal dignity (Centre for Health Promotion, 1997). According to MacDonnell et al. (2012:1) over the past decades the Centre for Health Promotion at the University of Toronto, Ontario Canada has called for a positive view of mental health promotion aligned with the Ottawa Charter for Health Promotion’s priorities of community development, empowerment, and community capacity to promote equity and social justice. Elderly Chinese immigrant women fall within the parameters of the charter because they are one of such population experiencing health inequalities (MacDonnell et al., 2012). Feminist health promotion

frameworks therefore advocate for the creating of opportunities for immigrant women as a population and subpopulation to create meaningful knowledge and responsive strategies to foster their wellbeing (MacDonnell et al., 2012:1).

Programs and policies that currently exist are relevant; however, in the context of feminist health promotion, and in connection with the challenges already discussed, there is the need for the development of new frameworks. Frameworks grounded on the promotion of factors that lead to elderly Chinese immigrant women's optimum adjustment and resettlement in Canada. The framework should be targeted at addressing socio-environmental factors which produce changes in life situations such as poverty and isolation as they limit choices the elderly women can make to optimize their health (Ward-Griffin and Ploeg, 1997). Therefore, the mental health of elderly Chinese immigrant women should be promoted through empowerment, a concept that is fundamental to health promotion. Through empowerment, there is a positive commitment to enhancing the voices and visibility of these women (MacDonnell et al., 2012).

## **5.2 Empowerment**

According to Kar, Pascual and Chickering (1999:1433) "empowerment is as a process through which individuals, communities and organizations gain control over issues and problems that concern them most". According to MacDonnell et al. (2012) the idea of empowering has long been a topical issue in the promotion of mental health in Canada. The concept of empowerment has been defined by some scholars as follows: according to Gibson (1991: 359) "empowerment is a social process of recognizing, promoting, and enhancing people's abilities to meet their own needs, solve their problems, and mobilize the necessary

resources in order to feel control of their lives”. Bookman and Morgen (1988:4) contrastingly described empowerment as an inherently political process which aims to change the nature and distribution of power in a particular cultural context. As I already mentioned above, feminist scholars’ definitions of empowerment focuses on the inequalities faced by women and how they are redressed such that they further the health of women.

For all immigrants and their mental wellbeing, empowerment makes them resilient (MacDonnell et al., 2012). However, the empowerment of elderly Chinese immigrant women should be treated as a special case and dealt with in manner that will take into account their age and vulnerability. With the feminist health promotion approach, empowering elderly Chinese immigrant women is like a form of social justice in which the experiences of the women are placed at the centre of analysis as means to improve the conditions in which they live (Anderson, 2002; Ward-Griffin and Ploeg, 1997). Through empowerment, immigrant women, especially the elderly, are enabled to overcome the conditions that oppress them, such as the conditions that make them feel isolated and lonely, marginalised, discriminated against and conditions that make it difficult for them to access health care. Da and Garcia recommended that:

Settlement services should include the organisation of social events for older immigrants to help them create new social networks. Such events should be organised at the local level in community centres or schools, which are easily accessible to older immigrants living the area (2010: 16).

I suggest that the empowering of the elderly immigrant Chinese woman should be facilitated through her family and community, making health care accessible, providing social support, and incorporating her culture, values and religious needs.

### **5.2.1 Sense of family connectedness and social support**

Several studies on the relative influence of family, friends, and coworkers on issues regarding the mental health of elderly immigrant women reveal that family members, sponsors or supporters have the strongest influence, with friends being the second most influential group, followed by coworkers (Zimmerman and Connor, 1989). According to Hurdle (2001:75) several “studies indicate that a woman’s social network, particularly her family and women friends have a strong effect on her use of preventive health behaviour”. In the case of elderly Chinese immigrant women, the process of adjusting to a new social reality is not linear and may lead to detrimental scenarios despite all the work and energy spent towards their optimum mental health. There is no guarantee that these women will not suffer from overwhelming stress and anxiety leading to depressive symptoms. As mentioned in the previous chapter, elder abuse is a source of mental health depletion even if all other factors of support and mental health promotion have been effective. Elderly immigrant women therefore need systems or support and resources that they can depend upon in such times. This is where the family becomes an important in promoting the mental health of elderly Chinese immigrant women. The first point of contact for immigrants coming into Canada is their family members or sponsors. Therefore, the family members or sponsors need to know which services or resources are available for their newly arrived immigrant relatives and encourage them to use these service or resources in the long run.

The sponsors or supporters of the elderly women who immigrate to Ontario and are involved in their lives would be the first to know of any mental problem. These sponsors or support networks may or may not know what the symptoms of depression are. Thus it becomes extremely important to educate them or at the very least, make available relevant

information concerning the elderly mental health of elderly women, and the available resources. Sponsors or care-taking family members would benefit by having their minds at peace because they know their elderly relative/family member have resources available to deal with their mental health problems and their overall well-being.

According to Hurdle (2001) social supports greatly influence the health of women. She argued that recent theories on the importance of relationship to women of all ages go a long way to explain the reason behind social supports' strong and positive effects on the health of women. Hurdle writes that;

These theories (self-in-relation in psychological development, ethic-of-care in moral development) indicate that for girls and women, at every developmental stage, the need for connection and relationships with others is a primary motivation that determines cognition, affect, and behavior. Therefore, the influence of social relationships may assume a more primary role for girls and women and influence the decisions they make and their feelings about health issues. Studies show that women prefer to receive health information from friends and family, a finding consistent with this orientation to relationships. For example, a study of channels of information for mammography screening shows that the most influential sources of health-related information for women are family and friends and other women who have had breast cancer (Marshall, Smith, & McKeon, 1995). The women also preferred sources of information to be one-to-one communication rather than letters or more impersonal means (2001:74).

Hurdle's argument further buttresses the recommendation that the health promotion of elderly Chinese immigrant women should be channelled through their family with whom they share common demographic features, are more likely to feel comfortable around and listened to.

I therefore suggest that programs and policies with the goal of having a positive impact on elderly immigrant women cannot be static one if they are to take into account the ongoing and fluid nature of change, adjustment and the huge difference family relations can make. If family members are aware of the fluidity of the transition process and the associated

struggles of readjustment, resources may be accessed more easily than if there is an expectation that needs should be ‘fixed’ once and for all. If family members are educated to know about the nature of elderly mental health as dynamic and vulnerable, it would alleviate the stress on them and put them in a frame of mind that the elderly are expected to regress and need help repeatedly over time. Having this perspective is also beneficial to health care professionals who come in contact with these women since they will be able to identify potential areas of risk in terms of mental health issues and provide conditions for their recovery before a mental health issue even develop. As argued by Ward-Griffin and Ploeg (1997) the impetus of feminist scholars is to initiate a social action to change the existing social structure which oppresses the women.

### **5.2.3 Cultural relevance and spiritual affiliation**

Culture is a core component that is inextricably tied to the analysis of immigrant women and their mental health. In this sense, health promotion strategies or efforts should be culturally sensitive to the health beliefs, health practices, values and normative behaviours of elderly Chinese immigrant woman. According to Hurdle (2001) in the promotion of health among women of colour, it is important to ensure that health education efforts are relevant, respect cultural traditions of family relationships, use appropriate words and incorporate cultural values. In the previous chapter, we noticed how changes in values and the environment tend to create conflict in families, thereby stressing elderly Chinese immigrant women. In this light, addressing some of these challenges hinges on developing support systems that are culturally relevant.

Culture has been identified as the contributing factor to the mental health conditions of immigrants. Specifically, culture shock and culture exchange has been identified as

the means through which settlement conditions of immigrants worsen. It is in this light I suggest policies and social programs that mitigate the cultural difficulties as immigrants try to make Canada their new home. As Hurdle (2001) suggested as well, other conditions for culturally relevant health promotion for women such as translating all materials and presentations into language of targeted groups and using tribal stories and themes in the health promotion efforts should be enforced.

Over the years services provided to immigrant women have been into the western clinical system which does not capture the culture and spiritual or religious factors that may influence the life of the immigrants. This is not to deny the relevance of the western clinical system but rather to use merger, with cultural-specific programs that completes the process of addressing mental health issues of elderly immigrant women.

For some immigrants, religious affiliation may be a vital source of resilience and social support. It is important to note that although religious affiliation may be a source of support, it may also be a liability, as for example in the case where a member of the elderly immigrant community feels that she falls short of her expected role as a woman, defined by the new socio-religious context. Religiosity and spirituality are strongly related to improved states of mental health through multifactorial effects such as social involvement, conducting a healthier lifestyle and having a positive framework in terms of addressing suffering and stress (Moreira-Almeida, et al., 2006). Therefore what becomes important is for elderly immigrant women to make use of the aspects of religiosity that are an asset for them and provide a sense of support and resilience. Khanlou writes:

Religiosity in particular plays an important role in the lives of different groups and their religious affiliation may even be strengthened post migration, whether for reason of

renewed religious beliefs in context marginalised of religious identities or because religious institutions become locations of community support (2009: 11)

Khanlou argues further that;

Religious organisations together with ethnic communities cater for the specific needs of immigrants. Some mosque for instance, while not formally connected to settlement programs, provide informal assistance to newcomers from legal advice, to employment skills to explanation of cultural difference (2009:12)

#### **5.2.4 Improved conditions and easy access to health care**

As Hurdle argues, health promotion is emerging as a strong focus in the current health care system, both as a way to reduce the costs of medical treatment and as a way to increase community health (2001:72). Promotion of the mental health in the elderly immigrant women in Ontario entails the provision of systems and supports that create a sense that help is there if it is needed. Creating that sense of available assistance empowers them. I must indicate here that this is a challenge for those for whom discussing feelings of sadness or depression is a private and perhaps stigmatized issue. What becomes important here is to address the systems and supports that already exist in the lives of these women who have immigrated. To give an example in this area, we can take the case of the elderly woman who is visiting her family doctor, is depressed and is grieving her separation from her country of origin. If she is initially paired with a family doctor who speaks her native language and is in contact with local counsellors or social workers who deal with depression and grief, she is more likely to get the service that she needs than if she were to visit a doctor who was not aware of the issue of elderly grief related to geographical separation or of the mental health support available in the area. According to Chong (2012:71);

Collaboration with community agencies that service the Chinese population would be helpful in order for mental health promotion and education. This would help raise

awareness of mental health illness and the possibilities for engagement with the process of recovery, i.e., mental health literacy would be supported.

In a similar vein, those who work solely with the elderly, such as health care and social workers in geriatrics, will be better able to assist their clients and also promote mental health in the elderly in ways that promote the overall health and recovery of these women who may be suffering from a sense of isolation and lack of community. An added benefit from this model of prevention in the context of immigration is that hospitals can assist in developing peer relationships with other elderly from a similar place of origin or with a similar sense of isolation, by helping to create a new sense of community which is conducive to improved mental health. In this light, Chong recommended that:

it is fundamentally important that nurses have foundational knowledge in mental health such as assessment, treatment of mental illness, prevention, and promotion of mental health and well-being regardless of where they will be working. As future nurses, they would be able to help [Chinese] women who may be having issues with their mental health by being able to recognize their need for help and to assist them with access to appropriate resources. In addition, nursing students need to learn appropriate communication skills to build rapport, which is integral in a therapeutic working relationship (2012:71).

The mental health of elderly Chinese immigrant women cannot be assessed directly as this would be a very challenging endeavour. These women have unique needs, circumstances and vulnerabilities of which we are aware. It is at this level that we can help support them rather than directly attempting to assess or treat them. Khanlou (2009:13) suggests that service must take into account that immigrants are not a monolithic or homogenous group and their heterogeneities are significant enough to warrant new delivery models, based on the age, gender, cultural difference and immigration status. This does not mean we cannot help elderly immigrant women whom we know are vulnerable to developing mental health problems and potentially long term depression. For example, elderly women who immigrate from

collectivist cultures may benefit in the long run from the simple facilitation of the community of their choice (for example, contact with members of their own ethnic or age groups) as a means to create the most favourable context for their mental health and further towards their overall well-being. The question here is a matter of how to reach them and then how to help them in ways to ensure that their mental health is addressed.

This is possible by developing policies by the voices and visibility of elderly Chinese immigrant women can be enhanced. By means of building process that foregrounds their agency and empowerment. Furthermore, such an approach takes into account the intersection between age, sex, race and other social location in relations to power and privileges that shape the livelihood of these elderly immigrant women. With the basic aim of feminism being to improve the women's position in society (Fee, 1992), empowering as a model of health promotion leads to a change in political strategies such as community participation and coalition building which are used to address the social inequalities of mental health (Ward-Griffin and Ploeg, 1997)

Most importantly elderly Chinese immigrant women need to be able to access health care. Thus making health care accessible is an integral part of health promotion. My findings in the previous chapter confirm Khanlou's assertion that migration status influence access to health care. I suggest therefore that social policies should also be directed towards addressing those conditions that make it difficult for immigrants to access medical solutions when they are stressed, depressed or suffering from other mental illness.

Addressing the issue of language is one means of making health care accessible to the elderly immigrants, especially those of Chinese origin. The extent to which language is a

problem to accessing health care as well as other social supports is evidenced by its importance in research on migration and settlement problems. Firstly, there is a communication gap created between patients and the service providers (Chundamala et al., 2006). According to Chundamala, Matsuo and Peng (2006) sometimes service providers have to rely on family members and other ethnic community members for interpretation of conditions faced by immigrant elderly women. This need for interpretation services is due to lack of resources to bridge the communications gap (Chundamala et al., 2006). There are inconsistencies in deciding which services require interpretation and additionally not understanding the role that culture plays in interpretations as problem arises in access to health care. Leung suggested;

Service agencies in the community should prepare themselves to offer services to mandarin-speaking Chinese immigrants. They should employ staffs that are able to speak the dialect or offer mandarin courses to service providers who need them. The service providers should prepare themselves to meet their Chinese clients from diverse cultural and social background (2000:53).

Da and Garcia also suggested that;

English as second language program should be accessible to all older immigrants regardless of how long they have been living in Canada and whether they have become Canadians or not. They added further that, free public transport during off peaks hours and in cities should be available to immigrants aged 65 and over in Canada (2010:16).

Individual communication and communication barriers are the primary problems of health care accessibility for elderly Chinese immigrant women (Chundamala et al., 2006). They inherently promote discrimination and stigmatisation because the problem is made into individual not a systemic one (Chundamala et al., 2006). In effect addressing the problem of discrimination and stigmatisation places elderly immigrants at a level where accessing health

care would not be difficult. According to Chundamala, Matsuo and Peng (2006), racism is often viewed as an individual problem rather than an institutional problem for client and worker. It is therefore the duty of health authorities to understand that ethnic minority clients and workers experience racism and to find remedies.

Addressing the needs of elderly immigrants, as we noticed throughout the chapter, starts with empowerment. The elderly Chinese immigrant women need to be empowered to deal with those factors that oppress them, and make it difficult for them to access health and social support. Secondly, government programs and policies should be tailored to elderly immigrant women, taking into account their special needs and weakness so as to enable them settle with ease in their new homes. Specifically, programs that deal with language barrier, financial barriers and all forms of discrimination, marginalisation and stigmatisation should be of high priority for the health policy maker and other stakeholders concerned with the mental health of elderly immigrant women. Chong advocated that:

there is the need for policy decision-makers to consider ways of addressing long wait lists. It precluded timely access to mental health care and for services to be in places that provide essential information in the preferred language of clients/patients, including for example, professional interpreters. Nurses as important providers of care can use their expertise to influence policy. As stakeholders in health care and important advocates for clients/patients, nurses are in a good position to engage with policy decision-makers and other health care professionals with the development of strategies to improve access to mental health services. In addition, nurses can use their voice to help change mental health standards, protocols and policies to the betterment of mental health care or services and supports for clients or patients. Nurses can engage with decision making processes, for example, by sitting on community and workplace committees and boards such as the Canadian Mental Health Association and the Mood Disorders Society and others, local, provincial and national (2012: 74-75).

## Conclusion

The 2006 census revealed that nearly 20% of the Canadian population were immigrants (Statistics Canada 2007). According to Statistics Canada (2007) over a million immigrants entered Canada between 2001 and 2006. As indicated by Khanlou (2009 citing Statistics Canada 2007) approximately 70% of recent immigrants were in Toronto, Montreal and Vancouver. With this sizeable proportion of Canadian society being vulnerable with needs to be taken care of, this study qualitatively delved into the case of elderly Chinese immigrant women. Specifically, the study examines factors contributing to depression and mental illness among elderly Chinese immigrant women.

This study tries to find answers to the following questions: what are the unique settlement challenges faced by elderly Chinese immigrant women? How are these challenges impeding their access to social support and health care? What systems can address these unique challenges to help overcome obstacles working against them? How can we aid them in terms of their resettlement and in what ways can we open avenues to health care for these women who are otherwise left out? Finally, how can our understanding of the case of elderly Chinese immigrant women in Ontario contribute to the development of policies aimed at addressing the social challenges causing mental health issues among elderly immigrant women in Canada? With this question, various theoretical concepts regarding immigrant mental health were discussed extensively

These theories include social isolation theory, cultural theories, goal striving theory, cultural exchange theory, cultural shock theory, social processing theories and the postcolonial feminist theory. Through these theoretical concepts we fathom the various

challenges that shape the mental health of immigrant in general. However in the case of elderly Chinese immigrant women, the study adopted the social stress formulation theory or social processing theory and the post-colonial feminist theories to explain the findings.

The themes concerning challenges faced by elderly Chinese immigrant women as they try to settle in the new environment include the following; isolation and loneliness, family conflict and economic dependence, abuses, language barriers, physical mobility, discrimination, marginalisation, racism and stigmatisation. Elderly Chinese immigrant women are also not able to access the available sources of supports in these settlement challenges they face. The study recommended the feminist health promotion approach as a means of dealing with challenges faced by these elderly Chinese immigrant women. Feminist health promotion entail that elderly immigrant women need to be empowered to deal with those factors that oppress them, that make it difficult for them to access health and social supports. Secondly, feminist health promotion recommends that programs and policies should be tailored to elderly Chinese immigrant women, taking into account their special needs and weaknesses so as to enable them to settle with ease in their new homes. Specifically, programs that deal with language barriers, financial barriers and all forms of discrimination, marginalisation and stigmatisation should be of high priority for the health policy makers and other stakeholders concerned with the mental health of elderly immigrant women.

Empowerment of elderly women according to Ward-Griffin and Ploeg (1997:291) is severely limited by the lack of gender, class, race, and age analysis in health promotion. In this light Ward-griffin and Ploeg (1997:291) suggest an implementation of a feminist socio-environmental paradigm as it will help to create a society in which older women like Chinese elderly women who are also immigrants will have their voices heard and they also

gain control over their own health. All stakeholders need to come together with elderly immigrant women to address the current economic, social and health inequalities and bring about a transformation of the immigrant society, life and their aging. Health promotion activists need to join forces with feminist activists in analysing and reconstructing the power relationships in health care system that oppress women especially elderly immigrant women.

The most important and valuable contribution of this work is that it addresses the overall quality of life of elderly Chinese immigrant women. The consequences will not only improve the mental health of elderly immigrant women, but also that of family members who host them. Therefore the positive impacts of the study are numerous. It is hoped that having a mentally healthier elderly immigrant female population can lead to improved mental wellbeing and spending costs for government agencies on the long run. Mental health of the elderly can be both difficult to address and very challenging to understand and work with. This work paves the way by furthering our understanding in this area. Further to the conclusions and model provided by this work, research can be done in the area of looking at specific groups and their particular needs.

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## Appendix:

### List of reports and articles analysed

1. Canadian Mental Health Association. (2010). Mental health and addiction issues for older adult: Opening the door to a strategic framework.
2. Chong Susan. (2012). Chinese women's experience of accessing mental health service. Master of Science in nursing thesis. University of British Columbia.
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