Female newcomers' adjustment to life in Toronto, Canada: sources of mental stress and their implications for delivering primary mental health care

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Abstract   Stress disorders and other mental ill health may be brought on by the disruption caused by resettlement. We examine female newcomers' experiences of adjusting to a new place, metropolitan Toronto, Canada and a new health care system. We consider sources of mental stress experienced during adjustment. We frame this adjustment as a process that happens over place and through time. Thematic findings of interviews (n = 35) with female newcomers from five cultural-linguistic groups are reported. Sources of stress in adjusting to life in Toronto include: navigating a new place, personal safety concerns, adapting to a new lifestyle, and finding employment. Sources of stress in adjusting to a new health care system include: learning how to access care, not having access to specialists, and adapting to a new culture of care. We conclude by considering the implications of what newcomers report for the delivery of primary mental health care (i.e. 'first contact' care).

Keywords   Toronto · Immigrant ·
Female newcomer · Stress ·
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Introduction

It is known that stress disorders and other forms of mental ill health can be brought on by the disruption of resettlement after international migration (Pumariega et al. 2005). In Canada, nearly 20% of the population are first generation immigrants (Statistics Canada 2003) and over 200,000 newcomers arrive each year (Ng et al. 2005). Female newcomers[1] are particularly vulnerable to mental ill health during the

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[1] We use the term 'newcomer' to refer to immigrants within their first 6 years of arriving in Canada. Citizenship requires a minimum of 3 years residence over the past 4 years, with at least 2 years of permanent residence. Using a 6 year window allowed us to look at stressors for newcomers in all possible residential circumstances, and thus all possible entitlements, including new citizens.

process of resettlement (Miller et al. 2006; Yakushko and Chronister 2005). Upon arrival to Canada they are more likely than male newcomers to experience isolation due to socio-cultural and linguistic barriers (Mulvihill et al. 2001), which can both compound ill health and also complicate treatment. At the same time, meeting the mental health care needs of female newcomers is urgently required given Canada's reliance on new immigrants to enter the workforce (Beaujot and Kerr 2003). There has, however, been little explicit consideration of neither the specific sources of mental stress these women encounter— something that requires understanding in order to deliver appropriate services—nor how to address the resulting stress via health care and avoid onset of further mental ill health.

In this article we examine female newcomers' experiences of the sources of mental stress encountered in adjusting to life in a new place, the metropolis of Toronto, Canada, and to using a new health care system. We then consider the implications for the delivery of primary mental health care. In doing so, we contribute to a larger community-based participatory action research (CBPAR) study based in Toronto focused on improving primary mental health care for specific groups of female newcomers. The larger study focuses on early signs and symptoms of mental ill health, such as stress, that can potentially be addressed through primary care and health promoting opportunities offered in the community rather than focusing on female newcomers with existing mental health diagnoses. The cultural-linguistic groups of focus are: Spanish-speaking from Latin America, English-speaking from the Caribbean, Urdu-speaking from Pakistan, Dari-speaking from Afghanistan, and Portuguese-speaking from Portugal, Brazil, and Angola. These cultural-linguistic groups were identified as high priority by our three collaborating community centres.

Stress can lead to the onset of mental ill health such as depression and anxiety disorders; it can also exacerbate health conditions (Blehar 2006; Simich et al. 2007). Importantly, intervention at the early signs of mental stress or ill health may stave off longer-term negative health outcomes (e.g. Cuijpers et al. 2006). As we discuss below, such intervention for female newcomers is likely to be given in 'first contact' primary care (e.g. health clinic) and community settings (e.g. home visits from social workers and counsellors) where primary mental health care can be provided. It is for these reasons that mental stress resulting from female newcomers' adjustment to a new place and new health care system is our focus. Importantly, we frame female newcomers' adjustment as a process that happens over place and through time, as opposed to simply a series of static outcomes of immigration. We use this framing because the theme of 'process of adjustment' emerged as central to our analysis of the sources of stress the 35 interviewed women reported. Processes are active and their negotiation involves developing responses through undertaking activities and actions such as learning, adapting, and coping.

Context

Geographers have identified a number of different factors associated with immigrants' access to and utilization of health care services (see, for example, Dyck 2006; Lawrence and Kearns 2005; Wang 2007). Asanin and Wilson (2008) point out that immigrants to Canada often encounter language, location, cost, transportation, cultural competency, and informational barriers to accessing health services (see also Kirmayer et al. 2007; Whitley et al. 2006). Even when language translation is provided, immigrants may continue to not access certain health services (Bhagat et al. 2002). Moreover, immigrants often do not know where to access health care (Wu et al. 2005). Understanding how these barriers are experienced and associated issues, such as how and why ill health has emerged in the first place, requires an exploration of place and spatial factors (Smith and Easterlow 2005). In the present study we make an original contribution through our focus on female immigrants' initial responses to negotiating a new health care system (i.e. during the newcomer period) in a specific place, which is found to be a central process related to resettlement in Toronto.

Dunn and Dyck (2000) found that Canadian immigrants from differing cultural groups report different types of unmet health care needs, even when living within the same community. The challenges immigrants face with regard to accessing health care to meet their needs, however, cannot be attributed to cultural differences alone but also to dominant ideologies concerning the meaning of

health (Anderson 1987). Differences in meanings have been found in how specific population groups (e.g. immigrants and non-immigrants) understand health and use health services (Blais and Maiga 1999). Even within these groups, there exists differentiation by gender (Curtis and Lawson 2000) and along marital, socio–economic, and acculturative lines (Chaudhry et al. 2003). We extend this existing geographic work on access through our explicit focus on how issues of language, gender, and immigration status, among others, shape female newcomers' access to primary mental health care.

In Canada, treatment for mental illness, including depression and anxiety disorders caused or amplified by stress, rests heavily within the primary care system (Kates 2002). Reliance on primary care is particularly pronounced for immigrants who do not have access to specialists due to linguistic barriers or a lack of status, as is the case for some female newcomers. Primary care practitioners play an important role in identifying, managing, and treating mental disorders (Pauzé et al. 2005). Their work is often guided by a primary health care philosophy, the crux of which is that first contact care, whether preventative or treatment, should be provided in equitable and accessible ways in the communities in which people live and work (WHO 1978). Primary mental health care thus involves the delivery of care to individuals experiencing or at risk of experiencing mental illness in a first contact setting, typically by a front-line worker. This setting can be a primary care clinic or some other place in the community such as a client's home or an immigration or neighbourhood centre where counsellors and social workers practice. Health and social care providers in these settings are often well positioned to identify mental stress and illness, enact health promoting strategies (e.g. educating clients about stress management), provide ongoing care, and connect clients with other needed services (Haworth et al. 2004). Through engaging in such activities they are, in fact, providing primary mental health care even though they often do not have extensive training in mental health care.

Methods

The study we report on involves three sets of data: one-on-one interviews with female newcomers (n = 35), focus groups with female newcomers

(n = 6 groups, 52 participants), and interviews with primary mental health care providers (n = 14). With these datasets we are laying the foundation for a service provider-client dialogue. In this article, however, we report only about the findings of the one-on-one interviews in order to maintain a specific focus on the sources of stress female newcomers reported.

Study genesis and approach

This study was initiated in late 2005 when the Director of one of our collaborating partners (Centre 1) approached our team to inquire about the possibility of partnering in research. The Director raised concerns that some newcomers, especially women, were unwilling or unable to make use of the Centre's existing primary mental health care. This concern—underutilization of mental health care—is consistent with findings from recent literature on immigrant health and wellbeing (e.g. Scheppers et al. 2006). Centre 1 also held focus groups with immigrant clients regarding service needs, where access to mental health care was ranked as a priority. Centres 2 and 3 were contacted by the research team, who sought to explore additional dimensions of social location by including a wider range of cultural-linguistic groups. These Centres expressed similar concerns to Centre 1 and accepted the invitation to participate. That this study was started by Centre 1 and addresses concerns raised by community members and service providers was taken as an indication that this was a viable problem to address using a CBPAR approach (Israel et al. 1998). The benefit of CBPAR approaches is that they build trust between communities and researchers and increase the relevance of research questions to the community.

Data collection

Female newcomers receiving services from the three collaborating community centres were targeted for recruitment. Posters were placed in the centres advertising the study in the appropriate languages (i.e. English and Spanish in Centre 1, Portuguese in Centre 2, and Urdu and Dari in Centre 3). Workers in the centres also handed out or verbally described study information to eligible clients. Interviewees were asked to share study information with other female newcomers they knew. Eligibility for participation

was limited to female newcomers within their first 6 years in Canada who were over the age of 16.[2] Respondent numbers by group were: Spanish-speaking from Latin America (n = 11), English-speaking from the Caribbean (n = 5), Urdu-speaking from Pakistan (n = 5), Dari-speaking from Afghanistan (n = 5), and Portuguese-speaking from Portugal (n = 3), Brazil (n = 3), and Angola (n = 3).

Data collection took place over 8 months and involved three different interviewers. Interviews were conducted at the offices of the collaborating community centres and lasted on average 1.5 h. This included a discussion before the formal interview regarding the study and informed consent. Because some women had entered Canada illegally and did not hold status, we sought verbal consent.[3] Interviews were organized using a semi-structured guide and were conducted in each interviewee's mother-tongue. The same guide was used for each cultural-linguistic group. To ensure consistency across these groups, the instrument went through the process of translation and back-translation for each language. The semi-structured guide probed women's lives in Canada, including challenges faced and coping strategies adopted, and use of health and social services.

Data analysis

All interviews but one were recorded and translated/transcribed in English. In the one instance where the participant did not consent to being audio recorded, the interviewer took detailed notes instead. Transcripts were entered into NVivo™, a qualitative data management program, in preparation for analysis. Thematic analysis of the dataset was employed. This rigourous approach involves categorizing interview data according to themes (units identified from patterns within transcripts), which are then refined when compared to the literature, to the themes present in different interviews, and to the overall study purpose and objectives (Aronson 1994). Links between these

themes were then established in order to interpret the data in a meaningful way.

Our first step in undertaking the analysis was to create a preliminary coding scheme. To do this the principal investigators and two other members of the academic team read in detail two randomly selected transcripts. Each person was instructed to create a list of themes central to both interviews. A principal investigator compiled information shared by everyone into a draft coding scheme. Next the draft scheme was circulated for feedback. Following this, the first stage of coding was undertaken on two other transcripts. The principal investigators and two other members of the academic team not involved in creating the preliminary scheme then reviewed the coded transcripts and provided further feedback. The scheme was refined and the first stage of coding for all interviews was undertaken. Any issues (e.g. redundant notes, theme interpretation) encountered during this process were discussed among the principal investigators. Decisions were recorded and implemented in the second stage of coding which consisted of a review and refinement of coded transcripts.

Participant overview

Participants emigrated from various Caribbean islands (Grenada, St. Vincent, Virgin Islands, St. Lucia, Cuba) (n = 6), Colombia (n = 6), Pakistan (n = 5), Afghanistan (n = 5), Brazil (n = 3), Mexico (n = 3), Angola (n = 3), Portugal (n = 3), and Costa Rica (n = 1). They ranged in age from 22 to 59 with a mean of 39.15, and had lived in Canada for 3 months to 41 years with a median stay of 2 years. Regarding legal status, three women were non-status or illegal, eight were refugee claimants in process, 15 were landed immigrants or approved refugees, five were permanent residents, and two were Canadian citizens (two did not respond). Twenty-nine reported having some form of health coverage while six had no health insurance.[4] Thirteen

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[2] Two participants were not newcomers. Centre 2 requested that we include a limited number of immigrants who were not newcomers in the sample. We asked these women to speak about their years as a newcomer.

[3] Approval for this study was granted by research ethics offices at Simon Fraser University and York University.

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[4] While in Canada health care is publicly funded, immigrants to Ontario in their first 3 months of residency, refugee claimants whose refugee claims have been refused and are awaiting appeal, and those who are in Canada without status are not eligible to receive health insurance. In Ontario, they can only receive free care at community health centres and, in Toronto, municipal public health clinics, which offer a limited number of social and primary care services.

women reported being single, separated or widowed and 19 were married (three did not respond). Twenty-nine lived with family, one with friends, and three on their own (two did not respond). Four had no children, six had one, eight had two, and 15 had three or more (two did not respond). Thirty women reported their employment status, 15 of whom were employed and 15 not employed. Many of the latter discussed not having been employed at all since arriving in Canada. One woman was in college.

Community overview

The Greater Toronto Area is Canada's largest city, with over 5 million residents. Over 40% of all immigrants to Canada between 1996 and 2006 settled in the Toronto metropolitan area (Statistics Canada 2007). Not surprisingly, a significant number of health and social services aimed at immigrants and newcomers are situated in Toronto, including our three collaborating centres. Understanding the neighbourhoods in which these centres are located provides important context for the analytic findings as the majority of participants resided in them. Centre 1 is a non-profit community health centre in Toronto's impoverished Jane-and-Finch Corridor (see FSAT 2004)—an area known throughout the city for gun violence—that provides social and primary care services to clients, many of whom are newcomers. Centre 2 is located in an economically depressed centre-West neighbourhood that was originally home to a large proportion of Toronto's Portuguese community. It offers social services for Portuguese-speaking women and their families. Centre 3 is located in an East-central neighbourhood where 40% of households are low income (City of Toronto 2003). It focuses on providing settlement services and language training to recent newcomers, the majority of whom have come from Pakistan.

Analytic findings

Female newcomers' negotiation of processes of adjustment was a significant theme emergent from the dataset. In this section we focus on how women experienced two processes of adjustment that sometimes caused mental stress, namely adjusting to: (1) the new place of residence, and (2) a new health care system. We look specifically at how these processes were experienced in similar ways across cultural-linguistic groups. Importantly, these two processes of adjustment are intertwined because stressful experiences within one domain (e.g. when adjusting to a new place of residence) may lead to interactions with the other (e.g. the new health care system), and negotiation of the latter has implications for how the former is lived out.

Adjusting to the place

Many women expressed stress inducing insecurity and fear over 'going outside' and navigating their new environment without the knowledge of how to get around. This feeling of fear was frequently expressed among the non-English-speaking women who stated that in addition to not being familiar with their new environments, they were often also unable to ask for help from others in their own neighbourhoods. As one woman stated:

> I asked someone [for directions] but was not understood and in turn I didn't understand what the person was saying to me• People didn't understand what I was asking. I felt alone. (Portuguese-speaker from Brazil)

In this instance she felt alone as a result of not being able to communicate with others in this new environment. Repeated feelings of loneliness, solitude, and isolation may not only be stressful but can lead to the onset of depression and other mental ill health (Hawthorne 2008). Further, female newcomers are less likely to speak English or French than their male counterparts, making this issue particularly gendered not only in relation to spatial navigation but in other instances where language is a factor, such as developing friendships and finding employment (CRIAW 2003).

Not knowing one's new environment also led to concerns regarding personal safety. However, feelings of being unsafe extended well beyond not knowing the area or how to ask for directions. In fact, the promise of safety and security is what brought many female newcomers and their families to Canada in the first place. One woman described Canada as a particularly promising place: "We thought that it was a good option; a secure and clean country with more

opportunities for our children" (Spanish-speaker from Mexico). However, upon arrival in Toronto some women found that life was not as safe as they had hoped due to exposure to violence and illicit activities. Other women explained that Canada was much safer than the countries they had left, even when living in areas of Toronto considered relatively dangerous, and particularly noted how it took time to adjust to the idea that one could turn to police for help. Experiences of or exposure to violence in their home countries led still others to find life in Toronto stressful because of existing fears and anxieties relating to their pre-migration experiences, which for some women were heightened by exposure to unfamiliar practices and environments. One woman, for example, commented that learning how to be in public places near men without panicking was a key coping strategy she put in place after arriving in Toronto in order to overcome an existing fear of violence.

Lifestyles known to women in their home countries were typically left behind as they adapted to a 'new' way of life. As a Colombian woman noted, "[y]ou have to work on what I call 'the letting go' of everything." It was made clear by a majority of the interviewees that a sense of community was something that was let go of when adjusting to life in Toronto and that this was stressful. One woman from Grenada expressed that "• back home the older people get in the community, they welcome you in their homes. They [sic] older people will give you the best advice• You have people who are looking out for you." Another woman from the Virgin Islands stated that "[e]ven though I need help, people don't care. It is individual in this country." Canadian culture was viewed by many of the newcomers as not community-based, an outcome of which is that some women found it challenging to develop local social networks, particularly those which extended beyond their specific cultural-linguistic groups. Community networks play important roles in assisting people with maintaining health and wellbeing (Hawthorne 2008; Stockdale et al. 2007); their absence may lead to greater reliance on formal systems and services (Crook et al. 2005). In the context of the present analysis, a lack of community networks and resources such as neighbours, friends, 'aunties', and elders to assist with stress management and the development of coping strategies could place even more

importance on having access to primary mental health care from formal providers.

One of the most commonly cited sources of stress in adjusting to life in Toronto was that past education or job experience was sometimes not recognized by employers which led to un/under employment. Participating in desired occupations such as paid employment in meaningful ways can assist with maintaining health and wellbeing; when this is lacking there are often negative outcomes for mental and physical health (Law et al. 1998). It is thus not surprising that the women found this experience to be mentally stressful. This is likely to be heightened by the systematic discrimination and low social status that racialized groups in Canada face, which contributes to their inadequate employment (Ng et al. 2005) and which can in turn further negatively affect physical and mental health (Pederson and Raphael 2006). This reported source of stress is another highly gendered aspect of the newcomer experience in Canada, as immigrant women are less likely to be employed than are immigrant men and non-immigrant women (CRIAW 2003).

Another outcome of un/under employment was that women and their husbands/partners often worked in low wage 'survival jobs' in order to meet financial demands. Learning how to live on these wages while meeting financial demands was a central part of the process of adjusting to life in Toronto. This not only required, often reluctantly, accepting certain setbacks in the standards of living many were used to prior to migration, but also, for some, a re-questioning of identity and feelings of self-worth. A woman from Colombia said: "it [low-skill/paying work] makes you forget who you are; a moment arrives where you lose your identity." Feeling a sense of degradation and loss from having to take low-skill/paying jobs was common among the un/under employed interviewed women. The implications of feelings of degradation for mental health and wellbeing are clear. In fact, an Urdu-speaking woman from Pakistan talked about crying while at work, describing menial employment as "torture." The financial demands of living in Toronto—most notably high rent and high tax—further forced newcomers to place priority on finding income, resulting in many women working multiple jobs with long hours. This compounded employment-related mental stress and eroded family life.

Adjusting to the health care system

For most of the interviewees, adjusting to how health care in Canada is delivered was a difficult process. It was stressful trying to negotiate the system with little familiarity or support. The first step in their process of adjustment was learning how to gain access to care. In Toronto, a health card is required in order to access most public health care services. Women learned how to get a card through friends, family, social networks, and health and social service organizations. For women who did not hold status, and were therefore not entitled to most publicly funded health care services, a significant stressor was figuring out how to find affordable care. As one woman put it:

> Without the work permit and the health coverage, health for me and the little child is very expensive• whatever the fee is you have to pay because you don't have any health coverage• when I come to [Centre 1] these are the people that help me. (English-speaker from Grenada)

As per this quote, health and social services were available at Centres 1, 2, and 3 at no-cost to those who do not hold status. This did not, however, ensure that doctors in particular and sometimes even community health workers at these and other clinics were available to women when they needed them. Toronto faces a significant physician shortage that has left many, including newcomers, spending months or years trying to locate a clinic that will accept new patients (Asanin and Wilson 2008). In fact, using the Longitudinal Survey of Immigrants to Canada, Schellenberg and Maheux (2007) found that long waiting lists and not being able to find a doctor accepting patients were the most commonly cited difficulties new immigrants faced when accessing health care.[5]

That secondary and tertiary care was not covered for the newcomer women who did not hold status was repeatedly cited as a source of both mental and financial stress. Seeing specialists and hospital visits required out-of-pocket payments for those who did not have full entitlements. In many cases women avoided using such care, which in turn placed a greater reliance on the no-cost primary care clinics they did have access

to, due to the financial strain. As one woman explained: "All I needed here at the time I came was a psychologist but I could not afford it" (Portuguese-speaker from Brazil). In this case, the woman recognized her need for specialized mental health care but could not gain access to it because of the high cost. In such an instance, primary mental health care offered in primary care clinics and by some other health and social care workers was the fall-back.

Some of the stress associated with adapting to being a patient in a new health care system came from expectations that were based on care delivered in women's home countries. One of the most frequently discussed issues was the nature of provider-patient interactions. Comments such as "they don't give you no time," "he didn't even spend two minutes with me," and "they give you a prescription and you go out the door" were frequently cited. The amount of time allocated to interactions with family doctors was consistently noted across participants. An issue underlying, but not fully explaining, participants' desire for more face-to-face time with doctors during appointments is likely the gendered nature of health care communication and specifically female patients' desires to build relationships with doctors and enhance information sharing (van den Brink-Muinen 2002). The female newcomers expected to have appointments with family doctors lasting longer than the 5–10 min that are common to the Canadian system. Direct parallels to health care systems in their home countries were made:

> • back home you go to a professional and they are very friendly. There was conversation about how you are doing, and seeing what you are feeling. He [current doctor], it's just "What do you feel?" it's like that here, at the doctor I went to. (Spanish-speaker from Colombia)

> The doctors in Portugal are more available to [talk to] the patients• My doctor in Portugal is the best in town. I showed him my tests from here. The doctor [in Portugal] thought I had a big depression. (Portuguese-speaker from Portugal)

Interestingly, in the second example the woman still sought care, specifically second opinions, from her family doctor in Portugal. She cited this as a way to compensate for the lack of time available to receive information from and discuss treatment options with

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[5] It is important to note that these same issues are faced by many Canadians and not newcomers or immigrants alone. Schellenberg and Maheux (2007) point this out in their report.

her doctor in Toronto. In contrast to doctors, only five instances were cited concerning a lack of time with nurses. Social workers and counsellors were never spoken about in this regard.

Language barriers and cultural differences were frequently cited sources of stress for many of the women during the ongoing process of adjusting to the Canadian health care system. These system barriers/challenges were confirmed in Asanin and Wilson's (2008) recent focus group research with immigrants in the Toronto area regarding access to health care. Newcomers' expectations regarding culturally competent care in particular were shaped at least in part by cultural practices and standards related to conversational etiquette. One Portuguese-speaking woman from Brazil noted:

> I know they [health care workers] get stressed as well, but we need them. We want them to look at us when they see us. The most important is to be respectful and caring. There are doctors that don't even look at you in the face when they talk to you.

Lack of respect was inferred from perceptions such as feeling rushed and lack of eye contact, and this caused mental stress. This was particularly concerning given that for some women even speaking about mental health issues with health and social care providers meant overcoming cultural taboos (Whitley et al. 2006). Having health care providers interact in a style indicative of respectfulness was thus a strong desire of the women. For those women not fluent in English or able to find a doctor conversant in their mother-tongue, challenges experienced in creating successful provider-patient interactions were further compounded by language barriers; having to negotiate, simultaneously, language barriers and uncertain cultural norms when seeing doctors was cited as stress inducing.

Discussion: female newcomers' geographies of mentally stressful processes

Evidenced in the previous section, the female newcomers interviewed faced numerous sources of stress. Two processes they had to negotiate upon arrival to Canada, namely adjusting to life in their new place of residence and to a new health care system, were cited as challenging and stress inducing. Because our data collection was with newcomers, such negotiation was actively underway at the time of the interviews. Thus, women talked about still learning about, adapting to, and coping with the changes brought on by these processes and the ways in which they took place through time and across place. Sources of stress in adjusting to life in Toronto included: navigating around a new place, concerns regarding personal safety, adapting to a new lifestyle, and finding and maintaining employment. Sources of stress in adjusting to the new health care system included: learning how to access needed care, coping with not having access to specialists, language barriers, and adapting to a new culture of care.

Numerous spatio-temporal issues were brought to the fore regarding the women's negotiations of the processes of adjusting to their new place of residence and health care system; these issues highlight both the social and physical properties of their sites of adjustment. Regarding place as a social entity, learning about, coping with, and adapting to factors such as a new local culture, lack of familiarity with place-based norms, fears over personal safety in public and private space, an eroded sense of community, and learning how to gain cultural, linguistic, geographic, and financial access to health and social care featured prominently in the women's discussions of mental stressors. Ways in which they lived out these factors were also significant. Financial demands and employment availability, for example, were dictated by their new place of residence which, in turn, for some, eroded their new sense of identity in place, something that was stress inducing. Regarding place as a physical entity, learning how to move around in one's new immediate surroundings, searching for safe spaces, and also having restricted access to certain clinical spaces (e.g. non-status female newcomers not being able to access specialist care) were cited as sources of stress. Time certainly underpinned all of the women's reported experiences. At the more micro-scale, for example, there was a desire to spend more time interacting with family doctors and nurses and a belief that this could lessen some of the stress associated with adjusting to a new health care system.

The women had to contend with multiple sources of stress simultaneously. Their responses to this stress varied, as did the coping strategies they employed. In

the broadest sense, the two main coping strategies are problem-focused and emotion-focused (DeCoster and Cummings 2004). Problem-focused coping takes place when one identifies and adopts a strategy that will assist with engaging in activities of daily living as a way of minimizing the stress associated with change or adjustment. An example of this was the woman who spoke of seeking a second opinion from her doctor in Portugal. Some problem-focused coping strategies are inherently spatial. For example, there was the woman who learned to not panic when in the company of strange men in public space, this despite previous experiences of violence in her home country that made her fearful of such situations. Emotion-focused coping centres on managing one's inner states, and thus developing ways to come to terms with one's altered life, sense of self, and place in the world. An example of this was women who managed their feelings of distress by telling themselves to "let go" of their past lives. While women talked about engaging in both types of coping with potential stressors as a result of negotiating these processes of adjustment, it was indeed evident that many were emotionally distressed and focusing on dealing with these negative emotions. Certainly emotional states can exacerbate experiences of mental stress and its impact upon mental health (Cavazos-Rehg et al. 2007). Bondi et al. (2005) contend that we are emotionally involved with places and thus, not surprisingly, managing relocation adds another layer of emotion (e.g. loss) to the stress of adjustment, both of which have implications for newcomers' mental health.

Conclusion: revisiting primary mental health care

We have, in this article, identified sources of stress experienced in relation to the processes of adjusting to life in a new place, namely Toronto, and a new health care system reported by 35 female newcomers from specific cultural-linguistic groups. Without doubt there are further stressful experiences resulting from immigration not discussed here that contribute to these processes, or others, such as securing housing, encountering racism, and accessing education/training (see Schellenberg and Maheux 2007). We conclude by revisiting our discussion of primary mental health care and consider the implications of

the analytic findings for the provision of such care to female newcomers.[6]

Mental stress can take away from one's sense of wellbeing in and of itself and can also contribute to the onset or exacerbation of mental disorders such as depression and anxiety (Simich et al. 2007). It is thus important that individuals who feel particularly stressed are able to access the care needed to assist with minimizing both symptoms and stressors. This can include seeing primary care providers (e.g. nurses, doctors) and other social care workers (e.g. social workers, immigration counsellors) who can together or individually provide primary mental health care by directing female newcomers to available community-based supports or even directly providing symptom/stress management. Importantly, both provider groups can assist with orienting newcomers to the new health care system, which can assist in overcoming this reported source of mental stress.

Health and social care workers outside the formal primary care system, such as social workers and counsellors, are well positioned to assist female newcomers in coping with stressors, sometimes in collaboration with primary care providers. This is especially the case given the barriers the interviewees reported experiencing in relation to accessing medical care from a doctor, namely waiting lists and difficulties getting on patient rosters, and that many newcomers are not entitled to access specialist care without paying out-of-pocket. Importantly, these primary care providers typically work in the communities in which these women live and work (e.g. in homes, in neighbourhood centres), which would make them attractive sources of support. It was clear from the women's interviews that they were looking to establish a sense of community, to develop networks within their immediate neighbourhoods, and to use local services. These front-line workers are in a position to be involved in newcomers' community-based networks of care. They may also be able to

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[6] It should be acknowledged that given the applied nature of this CBPAR study our next steps as a research team are to work with the community partners on putting into practice what we recommend here and to consider further the implications of the analytic findings for their day-to-day operations.

monitor for ongoing signs of stress or exacerbations in symptoms, including emotional breakdown, because of the nature of their ongoing front-line practice. It is thus essential that they are trained in identifying mental stress and actively engage in speaking with newcomer clients about how it can be minimized. In doing so, they must, however, carefully negotiate the cultural norms and language issues that the interviewees identified as barriers to care by asking the right questions in the right ways, and being sensitive to cultural specific non-verbal signals of respect and listening.

Primary care providers also play an important role in delivering primary mental health care to female newcomers. A central role for these providers is to be ever aware of ways in which processes that newcomers engage in upon arrival can be stressful and/or exacerbate symptoms of mental disorder. Such awareness includes recognizing that if health services are themselves experienced as mentally stressful this may deter female newcomers from pursuing them, such as persisting in accessing care when system navigation barriers are encountered. Our framing of the women's experiences as being part of larger processes also serves as a reminder that mental health status pre-immigration or immediately upon arrival is not necessarily indicative of what it will be within a few years after arrival. Many stressors are still encountered years after resettlement in Toronto, as shown in the analytic discussion above. Thus, primary care providers must continually inquire about mental health status. They must also do this in a way that is respectful, culturally appropriate, and reflective of a high quality of care, as per the women's desired provider-patient interaction style. Finally, all primary mental health care providers should integrate their consideration of female newcomers' health into thinking about the other spheres of these women's lives given that, as we have shown above, singular events are linked together by larger processes of temporal-spatial adjustment experienced upon arrival in a new place.

References

Anderson, J. M. (1987). Migration and health—perspectives on immigrant women. Sociology of Health & Illness, 9(4), 410–438.

Aronson, J. A. (1994). Pragmatic view of thematic analysis. The Qualitative Report, 2(1). http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html. Accessed 26 June 2006.

Asanin, J., & Wilson, K. (2008). "I spent nine years looking for a doctor": Exploring access to health care among immigrants in Mississauga, Ontario, Canada. Social Science and Medicine, 66(6), 1271–1283.

Beaujot, R., & Kerr, D. (2003). Population change in Canada. Toronto: Oxford University Press.

Bhagat, R., Johnson, J., Grewal, S., Pandher, P., Quong, E., & Triolet, K. (2002). Mobilizing the community to address the prenatal health needs of immigrant Punjabi women. Public Health Nursing, 19(3), 209–214.

Blais, R., & Maiga, A. (1999). Do ethnic groups use health services like the majority of the population? A study from Quebec, Canada. Social Science and Medicine, 48(9), 1237–1245.

Blehar, M. C. (2006). Women's mental health research: The emergence of a biomedical field. Annual Review of Clinical Psychology, 2, 135–160.

Bondi, L., Davidson, J., & Smith, M. (2005). Introduction: Geography's 'emotional turn'. In J. Davidson, L. Bondi, & M. Smith (Eds.), Emotional geographies (pp. 1–16). Ashgate: Burlington VT & Aldershot.

Cavazos-Rehg, P. A., Zayas, L. H., & Spitznagel, E. L. (2007). Legal status, emotional well-being and subjective health status of Latino immigrants. Journal of the National Medical Association, 99(10), 1126–1131.

Chaudhry, S., Fink, A., Gelberg, L., & Brook, R. (2003). Utilization of papanicolaou smears by South Asian women living in the United States. Journal of General Internal Medicine, 18(5), 377–384.

City of Toronto. (2003). Toronto neighbourhood profiles. http://www.toronto.ca/demographics/neighbourhoods.htm. Accessed 30 Nov 2007.

CRIAW (Canadian Research Institute for the Advancement of Women). (2003). Immigrant and refugee women. Ottawa: CRIAW.

Crook, J., Browne, G., Roberts, J., & Gafni, A. (2005). Impact of support services provided by a community-based AIDS service organization on persons living with HIV/AIDS. Journal of the Association of Nurses in AIDS Care, 16(4), 39–49.

Cuijpers, P., van Straten, A., Smits, N., & Smit, F. (2006). Screening and early psychological intervention for depression in schools: Systematic review and meta-analysis. European Child Adolescent Psychiatry, 15(5), 300–307.

Curtis, S., & Lawson, K. (2000). Gender, ethnicity and self-reported health: The case of African-Caribbean populations in London. Social Science and Medicine, 50(3), 365–385.

DeCoster, V. A., & Cummings, S. (2004). Coping with type 2 diabetes: Do race and gender matter? Social Work in Health Care, 40(2), 37–53.

Dunn, J. R., & Dyck, I. (2000). Social determinants of health in Canada's immigrant population: Results from the national population health survey. Social Science and Medicine, 51(11), 1573–1593.

Dyck, I. (2006). Traveling tales and migratory meanings: South Asian migrant women talk of place, health and healing. Social & Cultural Geography, 7(1), 1–18.

FSAT (Family Services Association of Toronto). (2004). What's new: Neighbourhoods in need. http://www.fsatoronto.com/whatsnew/neighbourhoods.html. Accessed 15 Aug 2006.

Haworth, H., Powell, S., Burley, J., & Bell, P. (2004). Collaboration between community health workers or counsellors and psychiatrists in a shared care setting. CPA Bulletin, 36(2), 15–18.

Hawthorne, G. (2008). Perceived social isolation in a community sample: Its prevalence and correlates with aspects of peoples' lives. Social Psychiatry and Psychiatric Epidemiology, 43(2), 140–150.

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. Annual Review of Public Health, 19, 173–202.

Kates, N. (2002). Shared mental health care—the way ahead. Canadian Family Physician, 48, 853–855.

Kirmayer, L. J., Weinfeld, M., Burgos, G., du Fort, G. G., Lasry, J. C., & Young, A. (2007). Use of health care services for psychological distress by immigrants in an urban multicultural milieu. Canadian Journal of Psychiatry, 52(5), 295–304.

Law, M., Steinwender, S., & Leclair, L. (1998). Occupation, health and well-being. Canadian Journal of Occupational Therapy, 65(2), 81–91.

Lawrence, J., & Kearns, R. (2005). Exploring the 'fit' between people and providers: Refugee health needs and health care services in Mt Roskill, Auckland, New Zealand. Health and Social Care in the Community, 13(5), 451–461.

Miller, A. M., Sorokin, O., Wang, E., Feetham, S., Choi, M., & Wilbur, J. (2006). Acculturation, social alienation and depressed mood in midlife women from the former Soviet Union. Research in Nursing and Health, 29(2), 134–146.

Mulvihill, M. A., Mailloux, L., & Atkin, W. (2001). Advancing policy and research responses to immigrant and refugee women's health in Canada. Winnipeg, MB: Centres of Excellence in Women's Health.

Ng, E., Wilkins, R., Gendron, J., & Berthelot, J.-M. (2005). Dynamics of immigrants' health in Canada: Evidence from the national population health survey. Ottawa: Statistics Canada.

Pauzé, E., Gagné, M.-A., & Pautler, K. (2005). Collaborative mental health care in primary health care: A review of Canadian initiatives—volume 1 analysis of initiatives. Canada: Canadian Collaborative Mental Health Initiative Secretariat.

Pederson, A., & Raphael, D. (2006). Gender, race and health inequalities. In D. Raphael, T. Bryant, & M. Rioux (Eds.), Staying alive: Critical perspectives on health, illness and health care. Toronto: Canadian Scholars' Press.

Pumariega, A. J., Rothe, E., & Pumareiga, J. B. (2005). Mental health of immigrants and refugees. Community Mental Health Journal, 41(5), 581–597.

Schellenberg, G., & Maheux, H. (2007). Canadian social trends. Special edition—Immigrants' perspectives on their first four years in Canada. Ottawa, Ontario: Statistics Canada.

Scheppers, E., van Dongen, E., Dekker, J., Geertzen, & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: A review. Family Practice, 23(3), 325–348.

Simich, L., Wu, F., & Nerad, S. (2007). Status and health security: An exploratory study of irregular immigrants in Toronto. Canadian Journal of Public Health, 98(5), 369–373.

Smith, S. J., & Easterlow, D. (2005). The strange geography of health inequalities. Transactions of the Institute of British Geographers, 30(2), 173–190.

Statistics Canada. (2003). 2001 Census analysis series. Canada's ethnocultural portrait: The changing mosaic. http://www12.statcan.ca/english/census01/products/analytic/companion/etoimm/subprovs.cfm#toronto. Accessed 28 Oct 2005.

Statistics Canada. (2007). 2006 Immigration and citizenship highlight tables. http://www12.statcan.ca/english/census06/data/highlights/Immigration/Table403.cfm?Lang=E&T=403&GH=8&SC=1&S=0&O=A. Accessed 4 Dec 2007.

Stockdale, S. E., Wells, K. B., Tang, L., Belin, T. R., Zhang, L., & Sherbourne, C. D. (2007). The importance of social context: Neighborhood stressors, stress-buffering mechanisms, and alcohol, drug and mental health disorders. Social Science and Medicine, 65(9), 1867–1881.

van den Brink-Muinen, A. (Ed.) (2002). The role of gender in healthcare communication (special collection). Patient Education and Counseling, 48(3), 199–264.

Wang, L. (2007). Immigration, ethnicity, and accessibility to culturally diverse family physicians. Health & Place, 13(3), 656–671.

Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: A qualitative study from Montréal. Canadian Journal of Psychiatry, 51(4), 205–209.

WHO (World Health Organisation). (1978). The Alma-Ata declaration. Geneva: World Health Organization.

Wu, Z., Penning, M. J., & Schimmele, C. M. (2005). Immigrant status and unmet health care needs. Canadian Journal of Public Health, 96(5), 369–373.

Yakushko, O., & Chronister, K. M. (2005). Immigrant women and counseling: The invisible others. Journal of Counseling & Development, 83(3), 292–298.