

# Southern European Immigrant Women:

## Their Experiences in Psychiatric Treatment

by Eleni Skodra

*"So I went to see this doctor. He asked me some strange questions. He wanted to know at what age I started to have a boyfriend and then whether or not I was happy with my husband, and how I met my husband and things like that. My God, I didn't like him at all. Half the things he asked me about...I really couldn't see how they were important at all to what was happening to me. When I left his office, I was numb, I was shocked, I didn't know where I was going, where my steps were taking me, I felt like I was floating in air, I was light headed...it was criminal what this man did with his questions, I didn't go back after that one time. I don't know why he asked such questions...why couldn't he ask me questions which could be helpful to me...I would have stuck with it if he asked something which was helpful, if he had helped me, I would have gone back and talked...I didn't want to go to something which didn't help me with my problems."*

These are the word of a Southern European immigrant woman. Her shocked response to the psychiatric interview is not uncommon. Nothing in her experience has prepared her to be questioned intrusively about her personal life in the fashion that is the norm in psychiatric practices.

For the past several years I have worked, both as a clinician and a researcher, on the general area of Southern European immigrant women and their experiences in psychiatric treatment. In

the present paper I look at the socio-economic-cultural context in which these immigrant women live their everyday lives, present the kinds of experiences which lead them to seek out the help of mental health professionals, and briefly discuss how the immigrant women's experiences are reinterpreted to fit traditional diagnostic systems and how that affects the treatment these women are prescribed. I point to the limitations in one specific type of treatment, psychotherapy, which is considered by many clinicians as the alternative to current psychopharmacological treatments, and outline an alternative approach which may be used when doing psychotherapy which may be of more benefit to the immigrant women and in traditional terms, it may be a "more effective" form of psychotherapy.

Before I proceed with the discussion I want to define an important term. Although we all use the terms 'ethnic' or 'ethnic group,' and 'immigrant' or 'immigrant group,' it is not infrequent that we find that we are not quite sure of what these terms refer to. One of the most useful definitions of 'ethnic group' which I have found, presents an 'ethnic group' as a group of individuals who perceive themselves and are perceived by others as being alike by virtue of the fact that they have common experiences, including language, culture, religion and race (Hagedorn, 1980, p. 235). An immigrant group, on the other hand, possesses the same characteristics as an 'ethnic group' with the added feature of having been uprooted from their country of origin and having settled in a new country or society.

In this paper, I am going to be focusing

on immigrant groups from Southern Europe, and specifically on the women of these groups. An attempt has been made to define the term immigrant women by Ng & Estable (1986):

*Technically, the term 'immigrant' refers to persons having a certain legal status in Canada: that is, persons who are 'landed immigrants' or 'permanent residents,' rather than citizens. In government data, the term 'immigrant' is used frequently interchangeably with 'foreign-born' and includes all persons who are born outside the country, regardless of current citizenship status. In common sense usage, however, not all foreign born persons are actually seen as immigrants; nor do they see themselves as immigrants. The common sense usage of 'immigrant women' generally refers to women of colour, women from the Third World countries, women who do not speak English well, and women who occupy lower positions in the occupational hierarchy. Thus a cleaning lady or sewing machine operator, a black or Asian woman, or a woman who speaks with an accent, are considered to be immigrant women, regardless of the length of time they have resided in Canada. Conversely, a white, English speaking university professor from the United States would be unlikely to be perceived as 'immigrant woman' ...even if she is legally a landed immigrant. In other words, there is a disjunction between the legal, official definition and the common sense understanding of the term 'immigrant woman' (p. 3-4).*

Most of the immigrant women I am talking about have immigrated after the second world war; most did not speak English or French. They had no job skills, at least not which are in demand in the Canadian labour force. When they were able to find jobs outside the home, they found dead end and low paying jobs. Generally speaking, these immigrant women and their families had to share their living accommodations with other families of similar immigration history because they could not afford to live on their own or they had to take care of elderly parents or in-laws. Because they did not speak English or French, they depended on their family members, mainly their children and perhaps their husbands, to help them carry out errands outside their own ethnic community. If the group is not what sociologists call 'institutionally complete,' then that dependency is high. Immigrant women often have full responsibility for taking care of their home, their family and earning a wage and helping the family financially. Moreover, these women find themselves socially isolated in the host society because most of their friends have been left behind in their country of origin. They are restricted in terms of the number of friends they can make in the host society because of their inability to speak the official languages and finally, they actually have very little time to socialize.

We often believe that with time, these everyday life situations of the immigrant women improve. In fact, even several years after immigration, the immigrant women continue to experience some of the situations I have mentioned above. What the literature and my own work suggest is that several years post immigration these immigrant women still have limited knowledge of English or French, still have the same or similar dead end jobs and so on. The one thing which does change for the immigrant women and their families is that by 10 to 15 years after immigration, they often own their own house. The only thing different is that in previous years the immigrant women have worked to help pay the rent, and now they are working to help pay the mortgage. The immigrant women still struggle to find a balance between being a 'good wife and mother' and being a 'good worker.' Within this very general social context, then, I would like to situate the

kinds of life experiences and difficulties which immigrant women bring to the mainstream mental health/psychiatric system.

The life experiences and difficulties which immigrant women bring to psychiatric treatment are experiences which have been developing for many years after immigration as a result of the stress of difficult socio-economic conditions in the new society. The women seek out help for these experiences at the point when they feel they either cannot deal with them anymore or when they interpret them as medical problems which require the intervention of medical professionals.

The kinds of everyday life experiences for which the immigrant women seek help are primarily 'somatic difficulties.' These are often accompanied by what I call 'affective difficulties' and 'cognitive difficulties.' The immigrant women experience a variety of somatic difficulties; the experience here is one of body pain, concentrated for the most part in two areas of the body, the head and the chest. Pain is also experienced in other parts of the body but not to the same extent. Included in what I call 'affective difficulties' are a series of complex feelings which women describe as "feeling numb," as "having no feeling" or as "not feeling alive." These feelings have often been compared with "having your whole body fall asleep." In the group I refer to as 'cognitive difficulties' are included the experiences of being "uneasy," "fearful" that "something bad is going to happen." In addition, this group of experiences includes things like, "worrying a lot," "being concerned" and "thinking too much." In most cases, the 'somatic difficulties' appear simultaneously with the affective or the cognitive difficulties. It is not unusual, therefore, to find women who experience severe chest pain and also worry and are very concerned about their families.

When the immigrant women first have these 'somatic difficulties,' they interpret them as "strange," that is, as unfamiliar. Most of the women I spoke to told me that their 'somatic difficulties' had come on suddenly, with no apparent warning. None of the women had had any of their body pain before. Second, and I suspect in part as a result of the first, these experiences are interpreted by the women as medical problems. The fact that the difficulties the women experience are related

to their bodies would also lead them to interpret them as medical problems. The immigrant women, just like all women, have been socialized into seeking help from medical professionals whenever they have had bodily pain; for example, during menstruation or childbirth (Bassuk, 1985). Such experiences have been constructed as forms of illness regardless of the fact that they are common experiences that most women go through. This kind of interpretation of women's experiences has been present for centuries. For example, Bassuk (1985), discussing the Victorian era, states that most of women's normal physiological experiences, such as menstruation and childbirth and menopause, were considered diseases.

The idea that the bodily pain experienced by women is some type of medical problem is consistent with the general construction of women's natural experiences as disease. To illustrate how this situation is lived by immigrant women I present the case of Anna. Anna was 19 when she married her husband and immigrated to Canada. This was her first trip away from her family. For several months after they immigrated she said she had been missing her family and had been having headaches, and she went to see her family physician. She recalls the experience:

*"I missed my family...we were very close and when something was wrong, they were there for me...When I came here I would think about them a lot and sometimes I would get headaches. I went to see my family doctor...He said that, there was nothing wrong with me, that it was my 'nerves' that gave me the pain. What I had to do was learn to relax, stop thinking about my family and start thinking about the important things like my house, my husband and my kids. To help me relax, he gave me some pills—tranquilizers they're called."*

As is suggested in the above example, once the immigrant women have interpreted their experiences as 'medical problems,' they seek out the help of medical experts. These medical experts may be the women's general practitioners or in some cases it may be the medical staff of a hospital emergency room. The latter often make the referral to a mental health pro-

essional. In some cases, an informal referral to a mental health professional comes from a friend who has had similar experiences and has sought the help of a mental health professional herself. The role of the woman's family is also very important in that they encourage her to see a medical doctor or a mental health professional (usually a psychiatrist).

Elsewhere (Skodra, 1987), I have discussed at length how immigrant women's everyday life experiences are reinterpreted by mental health professionals in order to fit traditional categories in diagnostic classification systems such as the DSM-III. When the immigrant women see a mental health professional often what happens is that their life experiences or difficulties become reinterpreted as psychopathology. Whatever difficulties or concerns or stress that these women have are invalidated, made invisible by the professional's reinterpretation of these as psychopathology. The reinterpretation of women's life experiences or difficulties may occur during clinical interviews or a psychometric assessment or sometimes both.

Regardless of which procedure the reinterpretation is based on, the label psychopathology has clear implications for the immigrant women. The most obvious of these is that the immigrant women become eligible for 'psychiatric treatment.' I place the word 'treatment' in quotes because the word treatment implies that there is an 'illness' which needs to be treated. An 'illness,' almost by its nature, is thought to be rooted in the individual. Consequently, in order to 'treat' the 'illness,' the mental health professional has to 'treat' the individual.

There are a number of treatment modalities, and they range from ECT to psychotherapy to drug therapy. For the most part, the immigrant women I spoke to are treated with drug therapy. There are a number of practical and philosophical reasons as to why drug therapy is used by medical and mental health professionals to 'treat' immigrant women. One reason often put forth to explain the use of drug therapy with these women is that they have deficient official language skills, they are less articulate and they are less educated and less psychologically sophisticated than other patients. Whether or not these reasons are valid, the fact is that the immigrant women are prescribed an

enormous amount of medicine.

The kind of mood modifying drugs which the women are prescribed vary depending on the type of psychopathology they have been diagnosed to have. The most often prescribed drugs for the immigrant women are major tranquilizers, followed by anti-depressants and anti-psychotics (Brown & Harris, 1978).

In most cases, drug treatment is the extent of the treatment the immigrant women receive. For a number of immigrant women, however, psychotherapy is recommended as an adjunct to drug treatment. This is certainly true of those women who are referred to psychologists. Because psychologists spend time engaging in psychotherapy and counselling with immigrant women, I would like to turn my attention to this topic. If a psychologist feels that the woman will benefit from psychotropic medication a referral may be made for the woman to a general practitioner or a psychiatrist who can prescribe the medication.

One of the most important difficulties has to do with the fact that the immigrant women are not familiar with the institution of psychotherapy or counselling. It has never been a part of their experience in their country of origin and it is not something which they would normally hear about or be exposed to in their everyday lives in Canadian society. Generally, they see a mental health professional with the expectation that they are going to be helped. Rather, women get a mental health expert who tries to tell them that their everyday life experiences are symptoms of psychopathology, or that they need to change their way of life and remain in their 'right place,' that is in the private sphere of the home.

The psychiatric perspective is a male perspective which, generally speaking, adheres to a medical model of human functioning and sees the individual women as deviants, that is, as ill, requiring treatment. Within this tradition, the assumption is made that psychotherapists, in most cases males, know the ultimate science-based truth about women's development, behavior and personality. This assumption is made regardless of the fact that, with a few exceptions (Gilligan, 1982), theories of development, behavior and personality have been based on a male norm and thus do not reflect women's experiences at all. In the case of immi-

grant women, the situation is even more problematic in that, not only do the male psychotherapists not know their experiences as women, they do not know their experiences as immigrants and they do not know about their experiences as members of the working class.

But what about female therapists engaging in psychotherapy with immigrant women? We often assume that because the psychotherapist is a woman the immigrant women will be heard, understood and helped within the context of psychotherapy or counselling. I want to point out that this is not always the case, for a number of reasons. First, with few exceptions, the professional training that women therapists receive is exactly the same as that of men and second, most women therapists come from middle and upper-middle class backgrounds. Both these things often make female therapists see the world and their clients from the traditional viewpoint of male therapists. Finally, even if female therapists share some of the experiences of the immigrant women (by virtue of being women), often many of the women therapists do not share the experience of being an immigrant, a situation which also, I think, influences how one sees the world.

One of the approaches to psychotherapy or counselling which can be beneficial for immigrant women is an approach generally known to us as feminist therapy. Although I agree with a great deal of what feminist therapy has to offer, as I will discuss below, I would like to preface my discussion with a concern I have. In a number of the leading textbooks of feminist therapy and in the practice of a number of feminist therapists, working class and immigrant women are a) either neglected altogether or b) dismissed as "not being an appropriate group" for this kind of therapy. This type of response on the part of feminist therapists raises questions on a philosophical but also on a practical level, such as what happens to the 80% of the working class women—15-20% of whom are immigrants—when they seek the help of mental health professionals?

Having raised my concern, I want to focus now on the 'goals' of feminist therapy which are useful when working with immigrant women. 1) We first have to define the therapy or counselling situation as one where women are helped, given the space, if you like, to explore who they are,

define themselves, find out what they want, what goals they want to set up for themselves and how to, realistically for them, go about realizing them. The role of the therapist, on the other hand, is to help, that is, to facilitate this process the immigrant women have decided to undertake. The therapist should not define the client or set up goals for the client, independent of the client. 2) To do this, it is important to remember that, as therapists, we should stop seeing ourselves as 'experts,' who by virtue of our scientific based training possess the ultimate truth. We have to begin to see ourselves as people who are involved in a continuous learning process. We have to keep in mind that we can learn from our own experience as well as that of our clients. 3) Therefore, we should be able to move from creating a power difference between ourselves and our clients to having a more egalitarian relationship. 4) One step toward this egalitarian relationship is the establishment of trust which, in my experience with immigrant women, is difficult. It is important for these women to know that the therapist is trying to understand their everyday life experience, the way in which it differs from the experience of the mainstream Canadians, the difficulties they are having and above all, the way in which they interpret their everyday life experience and their difficulties, an interpretation clearly influenced by their own culture. It is sensitive to their specific needs and to the fact that the way in which they live their culture is very different from the way in which mainstream Canadian culture is lived. 5) One of the best ways to understand their culture is by encouraging them to share those everyday life experiences as well as their history in

their home country and in Canada. The immigrant women, like all women, have a voice, and they should be given the opportunity to use it.

Some immigrant women may feel comfortable sharing their experiences in a one to one therapy situation, while others may feel comfortable sharing these experiences in a group setting with others of a similar background. Although I agree that the "personal is political" and that women should be encouraged to share their experiences, by working with immigrant women I have learned that they each, as we all do, have a different pace at which they reach the point of wanting or needing to share their experiences with others. It is important, therefore, to take it one step at a time and facilitate what they are able to do at a given moment in time. If the therapist pushes too hard, she creates a situation for these women which is as oppressive as others the women find themselves in and the immigrant women may never come back to see the therapist again, even though they may benefit from the help of a mental health professional.

In conclusion I would like to emphasize that immigrant women are the experts of their own lives. They have voices of their own and they appreciate sharing the experiences of their lives, if they are given the appropriate opportunity to use those voices. I hope that we who are working with immigrant women can give them that appropriate space in which to use their voices.

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