

**POST TRAUMATIC STRESS DISORDER:  
The Lived Experience of Immigrant, Refugee  
and  
Visible Minority Women**

**A Report Conducted Under The Auspices of  
Immigrant, Refugee and Visible Minority Women of  
Saskatchewan**



Project # 24

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**Post Traumatic Stress Disorder:  
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and  
Visible Minority Women**

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# **Post Traumatic Stress Disorder: The Lived Experience of Immigrant, Refugee and Visible Minority Women**

## **EXECUTIVE SUMMARY**

### **Introduction**

Immigrant and refugee women are coming from war-torn countries and from countries where they may have been exposed to disaster, incidents of extreme trauma and continued gender oppression. Statistics Canada (1996) reported that 4,125 women immigrated to Saskatchewan between 1991 and 1996. 185 women arrived from the Middle East, 460 from Africa, 230 from Central and South America and 1,950 from Southern and Eastern Asia (Statistics Canada, 1996). In many cases, the process of migration and the experiences of settlement as an immigrant in Canada have added to the distress and trauma.

### **Purpose of Research**

The aim of this research was to engage in a process of study of personal experiences of immigrant and refugee women who self identified as sufferers of Post Traumatic Stress Disorder (PTSD) and with service providers, including physicians and psychiatrists to gather information regarding their knowledge and awareness of Post Traumatic Stress Disorder particularly in Saskatchewan, their experiences of service provision, service accessibility and about barriers to service and healing. The overall aim was to make recommendations for policy change and to do follow up action that would enhance the healing of immigrant and refugee women suffering from Post Traumatic Stress Disorder.

The study provides a literature review of research on Post Traumatic Stress Disorder. It offers a synthesis of the historical development of research on this topic through an exploration of some writing on the subject of therapy and intervention with sufferers of Post Traumatic Stress Disorder.

The report provides excerpts from the stories recounted by immigrant and refugee women and information about how they addressed their experiences with community based services, what was useful to them in their healing, and what the barriers were. It also describes the knowledge and awareness of Post Traumatic Stress Disorder among physicians, psychiatrists and other service providers and their experiences with immigrant and refugee women suffering from Post Traumatic Stress Disorder. Finally, the study also begins to draw parallels with the experiences of Aboriginal women.

## **Method**

Twenty women from Moose Jaw, Prince Albert, Regina, Saskatoon, Swift Current and Yorkton, were interviewed. Focus groups were held in Swift Current and Saskatoon, with individual interviews with service providers done in Regina and Prince Albert. Four psychiatrists and one general practitioner were interviewed. Semi-structured interviews were completed, using an interview guide.

## **Findings and Analysis**

This report includes the stories of immigrant, refugee and visible minority women who experienced symptoms of PTSD and demonstrates how the trauma experienced by these women was caused by external conditions not created by them. The participants described a wide range of experiences and diversity among immigrant and refugee women's experiences. There were stories of students, academics, professionals and other women whose lives and careers were halted and changed in one split second by the sudden onslaught of war in countries of origin. There were stories of women who had been activists in their countries of origin and who had lived with fear and oppression over a sustained period of time. There were stories of ordinary women who lived in poverty all of their lives because of ongoing war and unrest in their countries of origin. There were accounts of the devastating effects of racism and discrimination on the lives of immigrant and refugee women. There were stories of women who had lived in Canada for several years and who had never accessed help to deal with issues of trauma and who still seemed to have unresolved issues. And there were stories of violence and abuse that permeated so many of these stories.

While the experience of Post Traumatic Stress Disorder can be crippling, many immigrant, refugee and visible minority women interviewed attempted to function to the best of their abilities within their Saskatchewan communities. While they talked about the extent to which their fears caused them to hide indoors or to avoid going out, they also suggested that they had to force themselves to continue with daily activities, often because of family responsibilities or their own will to survive. There were times when these women were unable to engage in any activity and also times when their memories of events and their experiences of Post Traumatic Stress Disorder were overwhelming.

It was apparent that the women themselves were capable of identifying the cause of their health problems once they were given information about PTSD. The risk of further oppression and traumatization a) during immigration and settlement and b) by labeling PTSD as an illness rather than a normal response, were also identified. While the research describes much of the pain of these women, it also identifies the strength and resilience of immigrant, refugee and visible minority women who continue to play significant parenting/nurturing and bread-winning roles in spite of their experiences. At the same time, the women

described how PTSD impacts on their lives and sometimes makes it impossible to carry on these roles. Women identified the need for a variety of services and information. These included information about PTSD and support programs such as drop-in groups where they could meet other immigrant and refugee women as well as the need for adequate language training opportunities.

## **Conclusions**

When the research began, the research team wondered whether physicians, psychiatrists and other members of the medical and helping professions were knowledgeable about Post Traumatic Stress Disorder. The research concluded that there appeared to be strong theoretical knowledge of Post Traumatic Stress Disorder, based on the DSM, among medical practitioners who were interviewed. However, this knowledge did not appear to be consistently translated into practice, since physicians and psychiatrists did not appear to be recognizing symptoms of Post Traumatic Stress Disorder among immigrant, refugee and visible minority women clients. Among those psychiatrists who were interviewed, there were those who had worked in other provinces and countries where they had direct experience working with immigrant and refugee women who suffered from this disorder. While these particular psychiatrists appeared to have a strong empathy and openness to working with the immigrant population, they were not usually able to do so since many immigrant and refugee women did not attend mental health services. The medical practitioners and service providers who were interviewed expressed a desire for more opportunities to work with immigrant and refugee women. We believe that the recommendations that follow, respond to the concerns and needs expressed by the women as well as medical practitioners and other service providers who were interviewed.

## **Recommendations**

Based on this research, the research team recommends that this research be used as a basis for helping medical practitioners, mental health workers and other service providers improve services to immigrants and refugees who are victims of Post Traumatic Stress Disorder. The following specific recommendations are made.

### **Policy Change**

1. That policy-makers use this research to build awareness of Post Traumatic Stress Disorder by ensuring that training about the issues of Post Traumatic Stress Disorder be integrated into all programs aimed at serving the needs of immigrant, refugee and visible minority women.

2. That Saskatchewan Health, Health Districts and Mental Health service organizations develop policies of commitment to enhance the recognition and treatment of PTSD by health care workers.
3. That admission forms used by physicians, hospitals and mental health clinics be amended to include a section requesting information about experience with traumatic events.
4. That this research form the basis for developing a mechanism for involvement of immigrant, refugee and visible minority women in the development of policies related to Post Traumatic Stress Disorder.
5. That Saskatchewan Health, Health Districts and Mental Health service organizations develop policies of commitment to enhance access and utilization of mental health services by immigrant, refugee and visible minority women and the recognition and treatment of PTSD by health care workers. Ensuring that there be adequate funding to community based and government agencies, to provide outreach and education awareness programs to immigrant, refugee and visible minority women, could help to achieve this.
6. That Health Canada provide support to research and health promotion to address issues of Post Traumatic Stress Disorder and that they move beyond torture to recognize the diversity of experiences of Post Traumatic Stress Disorder among immigrant and refugee women.
7. That Immigration Canada play a role in ensuring that refugees receive recognition of, referral and treatment for Post Traumatic Stress Disorder.
8. That policy-makers and decision-makers explore the possibility of providing more community-based programming for immigrant, refugee and visible minority women in all locations, particularly smaller communities. This could be delivered through existing organizations that may be providing services to this population.
9. That adequate funding of medical and nursing education be encouraged to enhance information about Post Traumatic Stress and practical experience with immigrant service organizations.
10. That those agencies and organizations serving the needs of immigrant and refugee women continue to explore developing workshops and educational programs that would build and enhance knowledge and awareness of the issue of post-traumatic stress disorder as it affects immigrant and refugee women.

11. That partnerships be developed with psychiatrists, psychologists and physicians, who have particular knowledge and expertise working with immigrant and refugee people so that these individuals can be used as resources to develop and deliver educational and awareness programs.
12. That policy-makers continue to build awareness of post-traumatic stress disorder by ensuring that training about the issues of post-traumatic stress disorder be integrated into all programs aimed at serving the needs of immigrant and refugee women.
13. That helping professionals recognize that children of refugees experience symptoms of Post Traumatic Stress Disorder (e.g. nightmares, fears) and develop specific programs to meet the needs of these children.

### **Language**

14. 14. That adequate funding be allocated for English as a Second Language (ESL) programs since language was identified as a key to integration.
15. That adequate funding be made available for programs to be able to provide levels of language training and length of programming that would reflect the diversity of needs.

### **Other Barriers**

16. That those agencies and organizations serving the needs of immigrant, refugee and visible minority women begin/continue to integrate anti-racist strategies into all programming and that particular attention be paid to how the intersectionality of race, class and gender manifests itself among this very diverse population.

### **Further Research**

17. That organizations and agencies serving the needs of immigrant and refugee women build partnerships with First Nations and other Aboriginal women's organizations to explore further research about the parallel issues of post-traumatic disorder within their communities.
18. That Immigrant, Refugee and Visible Minority Women of Saskatchewan pursue a program of related research, including the examination of Post Traumatic Stress Disorder among immigrant children, elderly and lesbians.

## **Community Action**

**19.** That organizations serving the needs of immigrant, refugee and visible minority women develop partnerships and take the lead in stimulating policy change by meeting with :

- Policy makers to ensure development of prototype policies to meet the needs of this population;
- Health agencies to identify changes needed in intake forms;
- Saskatchewan Health, Health Districts and Mental Health service organizations to develop policies of commitment to enhance a) access and utilization of mental health services by immigrant, refugee and visible minority women and b) the recognition and treatment of PTSD by health workers.;
- Policy-makers and decision-makers to communicate the need for more community-based programming in all locations, particularly smaller communities.
- Primary Canadian publishers of medical and nursing textbooks to lobby them to request inclusion of expanded content related to immigrants and PTSD by authors who write regularly for them;
- Deans of the Colleges of Medicine, Nursing, and Education, University of Saskatchewan and the Deans of Education and Social Work, University of Regina to facilitate curriculum enhancements;
- Psychiatrists, psychologists and physicians who have particular knowledge and expertise with immigrants and refugees to develop partnerships;
- The Association of ESL Instructors to develop an action plan for expanding the scope and availability of ESL instruction.

## 1. INTRODUCTION

One day in the spring of 1998 one of the staff at Immigrant, Refugee and Visible Minority Women of Saskatchewan, the provincial organization representing immigrant women's groups across the province, swept into the office in tears. She had just come from her doctor who had told her that she had been in Canada 25 years and by now should have forgotten what happened to her prior to coming here as a refugee. "Don't they know you never forget? It is always there!" She has Post Traumatic Stress Disorder. She went on to talk about all the frustrations she had experienced. Not being listened to. Being told it was all in her mind, as if she ought to be able to control it! If she was having these problems, she wondered how many others were having similar problems? Were their problems the same or different from hers? What help were they getting? Thus began the three-year odyssey that culminates in this report.

Globally, there has been an increase in the number of calamitous events and resultant tragedies over the past several decades (Taylor, 1989). Such events and tragedies include: the Bhopal explosion in 1984 (leading to over 2,000 deaths and 200,000 casualties), wars that caused the deaths of over 110 million, the increase in the number of refugees and displaced persons, the occurrence of natural disasters such as floods, fires, typhoons, landslides, volcanic eruptions and earthquakes, nuclear radiation and AIDS (Taylor, 1989). Other events such as the violence, terrorism and conflict in many countries of the world, the persistence of famine, drought and extreme poverty have also been significant occurrences during the past several decades (Taylor, 1989). In addition to these incidents of extreme trauma, women all over the world have been experiencing incidents of violence, including domestic, sexual violence and abuse.

The study of trauma, and in particular Post Traumatic Stress Disorder (PTSD) is of relevance to professionals and other community workers in Saskatchewan because of the ongoing arrival and settlement of immigrant and refugee women from many parts of the world. An increasing number of immigrant and refugee women are coming from war-torn countries and from countries where there has been a high risk of exposure to disaster, incidents of extreme trauma and continued gender oppression. Statistics Canada (1996) reported that 4,125 women immigrated to Saskatchewan between 1991 and 1996. 185 women arrived from the Middle East, 460 from Africa, 230 from Central and South America and 1,950 from Southern and Eastern Asia (Statistics Canada, 1996). In many cases, the process of migration and the experiences of settlement as an immigrant in Canada have added to the distress and trauma.

This research has been a voyage of discovery with many sailors. For many, it has also been a healing journey. Certainly it has enriched all who were on board. This report will describe that journey including the literature reviewed, research methods used, findings obtained, our analysis of what those findings mean and conclude with a series of recommendations for improving the health of these women.

## 1.1 Purpose of Research

The purpose of this study was to gather information that could be used to improve the health care of immigrant, refugee and visible minority women who suffer from PTSD. The expected outcomes were: a) an enhanced understanding of PTSD sufferers, their health challenges, and the care received and b) a set of recommendations for policy change and action that would enhance the healing of immigrant and refugee women.

There were therefore five main goals:

1. To describe how post traumatic stress influences the health of immigrant, refugee and visible minority women
2. To describe the extent to which physicians, mental health workers and other service providers recognize Post Traumatic Stress Disorder in immigrant, refugee and visible minority women and provide needed care.
3. To determine the women's experiences with accessing health care.
4. To explore the parallels between the experiences of immigrant, refugee and visible minority women and those of Aboriginal women.
5. To provide recommendations for improving care at the different levels of the health system as well as outside the health sector.

This report will be of particular interest to physicians, policy makers and caregivers within health, education, social and immigrant service agencies.

## 2. METHODS

This research proceeded in two stages. At the outset, it was determined that the women most intimately connected to the problem must control and direct the research. The direction was important to keep the research true to its vision. The control was important to ensure a process that was healing for those involved. Fortunately, others, particularly those at the Prairie Women's Health Centre of Excellence (PWHCE), shared these values and were prepared to support them. In November 1998 a proposal was submitted for Stage I. Money was requested for travel to meet and form a Participatory Action Research Team (PAR team). The initial team of eight (8) women met first in April 1999. Thirteen (13) women were involved at some point over the life of the project. Although five (5) women made their contribution then left, a core of eight (8) remained throughout. These women conceptualized the research, helped locate participants, organized meetings, shared experiences and provided feedback on the final report. In all, the PAR team met six times. One member acted as Coordinator and each made a written commitment to the research process. The PAR team essentially provided the backbone

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for the research process. See Appendix A for team membership, pictures of the Team and a sample of meeting minutes.

The proposal for Stage II, the actual conduct of the research, was submitted to PWHCE in September 1999. After some revision the proposal was approved in April 2000 and a cheque arrived in September officially beginning the research phase. During the period from September to December 2000, the PAR team recruited the research team.

The research resulted from a collaborative effort involving staff from both the University of Regina and the Saskatchewan Indian Federated College, an affiliate of the University of Regina. The research team consisted of four people - a Lead Researcher, two Research Assistants and an Operations Consultant. The Researcher conducted all the interviews, facilitated the focus groups, analyzed the data and drafted the Final Report. One Research Assistant assisted in setting up and recording interviews and focus groups in the south (Swift Current, Moose Jaw and Regina) and the other worked primarily in the north (Saskatoon, Yorkton, and Prince Albert), The Research Assistant, South and the PAR Team Leader trained interpreters. Most women interviewed were able to communicate in English, however four interpreters were used. The Team received clerical support from an Administrative Support Officer who also transcribed recorded interviews and maintained financial records.

The Operations Consultant managed the administrative aspects of the research and kept the lines of communication open between the Research Team, PWHCE, and the PAR Team. She played a significant role in coordinating communication among all those involved. This was a key task because there were so many people directly involved (16). She also spoke through interpreters about PTSD with 20 new immigrants in Moose Jaw, 9 of whom identified themselves as PTSD sufferers and offered to participate. All members of the research team assisted in the literature search and participated in decision-making.

This research project received ethics approval from PWHCE. The research teams began working on the literature review in the fall of 2000 and proceeded to plan interviews in January 2001. The advisory team had already developed a profile listing signs and symptoms of post-traumatic stress disorder. They included this information on posters that were displayed at various locations. These included the following:

1. The offices of Immigrant Women of Saskatchewan, Regina and Saskatoon offices;
2. The offices of Regina Open Door Society and Saskatoon Open Door Society;
3. The offices Prince Albert Multicultural Council, Moose Jaw Multicultural Council and Saskatchewan Intercultural Association.
4. The offices of various mental health clinics.
5. The University of Regina
6. The Saskatoon Family Support Centre and the Global Gathering Place
7. The bulletin Board of the College of Medicine.

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The research team also allowed women to self-identify. A snowball sampling approach allowed the researchers to reach a diverse group of women. Letters of introduction were sent out to organizations, agencies and to individuals who self-identified. The team made contact with service providers, physicians, psychiatrists and other agency and organization staff and volunteers through similar methods.

Twenty (20) women from Moose Jaw, Prince Albert, Regina, Saskatoon, Swift Current and Yorkton, were interviewed. Table 1 identifies numbers of interviews completed by location. Seven (7) could be visibly identified as belonging to a visible minority however none of these women verbally identified themselves as visible minority women. Two (2) of the seven were Aboriginal women.

One focus group comprising five (5) service providers was held in Swift Current and another comprising four (4) professionals was held in Saskatoon. Four (4) of the women who self-identified as sufferers of Post Traumatic Stress Disorder were also service providers.

**Table 1: Number of Interviews with Women, by Location**

<b>MOOSE JAW</b>	<b>REGINA</b>	<b>SASKATOON</b>	<b>SWIFT CURRENT</b>	<b>PRINCE ALBERT</b>	<b>YORKTON</b>
5	3	6	3	1	2

Two individual interviews with service providers were conducted in Prince Albert and one individual interview with a service provider was completed in Regina. Four psychiatrists and one general practitioner were interviewed. There were no formal interviews with medical practitioners or service providers in Yorkton. Semi-structured interviews were completed, using an interview guide (see Appendix D). Interviews were audio-taped and transcribed at the office by the Administrative Assistant hired for this role. The team finished the last interviews in June 2001.

The findings were organized using the following headings:

1. Defining and identifying post-traumatic stress disorder.
2. Experiences with service providers
3. Experiences of service providers.
4. Experiences of physicians and psychiatrists
5. Sources of support and assistance
6. Blocks to women's healing:
7. Issues of Aboriginal and First Nations Women

Women were assigned fictitious names for the purpose of reporting in order to maintain confidentiality.

## Post-Traumatic Stress Disorder: The Lived Experience

This data was then analyzed under the following headings.

1. Language.
2. Education and awareness of post-traumatic stress disorder.
3. The connection between trauma and the immigrant and refugee experiences.
4. The problem of identifying and understanding the immigrant and refugee woman.
5. Knowledge, understanding of and intervention with immigrant, refugee and visible minority women who suffer from post-traumatic stress disorder.

### **3.0 LIMITATIONS OF THE STUDY**

The issue of Post Traumatic Stress Disorder is one that evokes much emotion. The research team and the PAR Team were extremely conscious of this as we proceeded with the task of identifying participants for the study.

We understood that the small size of ethnic communities (e.g. Bosnian, Iranian) in each geographic location would present challenges, including concerns about confidentiality and how to allay the fears of participants. There are tensions and power issues within and among cultural and ethnic communities. These contribute to concerns around confidentiality and trust.

The issue of trust presented a significant challenge to the research team. This was partially related to the closeness of ethnic communities just discussed, but also the sensitive nature of the study topic. Many of the events that are traumatic (e.g. rape) carry a heavy stigma in ethnic communities. For many who wanted to reach out, this stigma was a huge barrier.

Mental health workers reported that immigrant and refugee women were not seeking professional assistance. The lack of comfort with reaching out for professional help also limited women's willingness to participate in the study.

Lack of knowledge about Post Traumatic Stress Disorder among immigrant and refugee women presented a barrier to self-identification. They knew what they were feeling but lacked language to name the problem.

Comfort with the English language was also an issue facing the research team. Posters were displayed in English. Many newcomers might not have been able to read and understand these posters. In cases where interpreters were used, the team also had to ensure that the participant was comfortable talking with the person who was interpreting.

The fact that mental health workers were not seeing immigrant and refugee women influenced the project in two ways. Firstly, they were unable to refer clients for participation. One health district had ethical requirements different from those approved

by Prairie Women's Health Center of Excellence (PWHCE). Because their approval process was slow and the research team was already beginning to realize that few professional service providers ever saw immigrant women with PTSD, the process of seeking this district's participation was suspended. Secondly, mental health workers were unwilling to participate in the research themselves because they did not have immigrant clients. Even a mass mail-out to psychiatric nurses resulted in few responses.

Another challenge for the research team was the timeframe for the project. This influenced the effectiveness of the snowball method of sampling. The team required more time to get the word out and to get potential participants thinking about the topic. Some participants volunteered after the data collection had already ceased. Tight schedules among mental health workers, other service providers and medical student also made it difficult to organize focus groups. Attempts were made to organize focus groups in Prince Albert and Yorkton but these did not occur due to scheduling difficulties. No interviews were held with medical students because of lack of response to invitations which might be attributed to their tight schedules.

These issues posed tremendous barriers to identifying immigrant and refugee women who would participate in the study. The team was concerned about the need to be respectful, especially when women were reluctant to self-identify or participate. Despite these constraints, the target sample size, although small, was achieved.

Finally, an objective of the research had been to gather information about the experiences of Aboriginal women with PTSD in order to recognize parallels and build partnerships. The research team interviewed two Aboriginal women as a first step in that direction. Although the research team did not meet with many Aboriginal women, they did meet with mental health professionals and service providers who talked about seeing large numbers of Aboriginal women with symptoms similar to those of PTSD.

## **4. LITERATURE REVIEW**

### **4.1 Introduction**

This literature review will offer a synthesis of the historical development of theories and research on Post Traumatic Stress Disorder. The review will include an overview of cultural and political issues influencing the diagnosis and treatment of women who suffer from post-traumatic stress disorder, and some description of treatment models or approaches and issues that relate to the experiences of women in therapy.

## 4.2 Historical Development of Theories and Research

Trauma has been a subject of research for several decades and the theories and research on this topic have evolved over time. Dr. Jacob Mendes DaCosta worked with Civil War veterans and observed symptoms such as palpitation, pain in the cardiac region, headache and giddiness. He called this condition "Irritable Heart" (Scrignar, 1988). Later Sir Thomas Lewis also worked with World War I soldiers and noted similar symptoms of chest pain and palpitation. He called the condition "Soldier's Heart and the Effort Syndrome" (Scrignar, 1988). Oppenheimer used the term "neurocirculatory asthenia" to describe the same symptoms (Scrignar, 1988). Many of the physicians in the early 20<sup>th</sup> century focused on the cardiac symptoms of soldiers exposed to war. In the late 20<sup>th</sup> century, psychiatry and other behavioural professions expanded their study of trauma to situations not related to war. Research evolved into three main divisions: anxiety neurosis, stress and behavioural psychology (Scrignar, 1988).

### 4.2.1 Anxiety Neurosis

Sigmund Freud engaged in research which led him to distinguish "anxiety" from a range of other symptoms among patients suffering from neurasthenia (a disorder characterized by lack of motivation and feelings of inadequacy). The concept of anxiety neurosis gained recognition and was applied in work with war veterans. While this led to the rise of terms such as "Traumatic War Neurosis", other professionals preferred to use terms such as *Combat or Battle Stress*, *Battle Fatigue*, *Combat Exhaustion* and *Acute Combat Reaction* (Scrignar, 1988). Scrignar explains that the term "neurosis" was problematic because Neurosis was considered to be a developmental disorder and was used with respect to individuals who had unresolved, unconscious childhood difficulties. On the other hand, "traumatic neurosis" involved environmental events that occurred during adulthood. "Neurosis" also referred to numerous psychiatric disorders. The term "neurosis" was later rejected and replaced by the term "anxiety disorders".

### 4.2.2 Stress

In the late 1920s, Walter Cannon and Hans Selye studied psychophysiological aspects of trauma. Cannon wrote about the response of individuals when they confront a threat. He argued that the individual responds to a traumatic stimulus by activating the sympathetic nervous system and stimulating the neuroendocrine system. The individual's physiological or body response such as increased heart rate and respiration resulted from a flight or fight response which was the body's mechanism for adaptation and survival. Selye introduced the term "stress" as a physiologic concept and used the expression "general adaptation syndrome" to refer to the immediate response to trauma (Selye, 1976).

Selye's research focused on the impact of environmental factors on the body as a whole. Scrignar (1988) suggests that this was different from the approach previously taken by psychiatrists and psychologists who tended to see stress as "anxiety" and focused on "neurosis".

### 4.2.3 Behavioural Psychology

Behavioural psychologists concentrated on psychophysiological responses to environmental stimuli and tended to be oriented toward helping the individual (Scrignar, 1988). Behaviorists wanted to develop a method of treating the symptoms and behaviour that troubled the individual. One early experiment demonstrated how traumatic events could elicit fear and anxiety. Following on this work, researchers described PTSD symptoms as a learned (conditioned) response to a traumatic event (Scrignar, 1988). Scrignar suggests that there is a growing body of research that supports the conditioning model in PTSD. He notes that the development of behavior therapy added another dimension to the research on PTSD because it describes the relationship between the mental processes (such as intrusive thoughts, flashbacks and nightmares) and other post-traumatic symptoms. Scrignar (1988) suggests that this body of research led to behavior therapy which focuses on changing the individual's response (thoughts and behavior) that result from trauma. Scrignar (1988) suggests that behavioural approaches to treatment may prove to be particularly important for PTSD sufferers.

### 4.3 The Traumatic Principle

Scrignar (1988) describes the "Traumatic Principle" as

*any environmental stimulus which poses a realistic threat to life or limb, impacting on one, or more likely a combination of the five sensory pathways to the brain, if perceived as a serious threat to one's life or physical integrity, whether it produces physical injury or not, can be regarded as a trauma and precipitate a PTSD in a vulnerable individual (p.13).*

Scrignar further notes that the central factor is whether the trauma "poses a realistic threat to life or limb and a person is consciously aware and has a full appreciation of the potential for serious injury or death to self or others" (p.14). What is also important is the intense activation of the autonomic nervous system before, during or after the traumatic event (Scrignar, 1988). The individual must realize the life threatening nature of the incident. It may take only seconds for this realization to occur.

### 4.4 The Three E's and PTSD

The combination of the Environment, Encephalic events and Endogenous processes create and maintain the symptoms of PTSD. Appendix C lists a number of stressors that

can cause PTSD. Encephalic events refer to functions relating to thoughts, visual images, flashbacks, beliefs, assumptions, perceptions of external events and dreams. Endogenous processes refer to symptoms such as pain, discomfort and other internal bodily responses to PTSD.

### **4.5 More on Symptoms**

Many sufferers of PTSD develop phobic avoidance related to their trauma. They avoid thoughts, feelings or activities and situations associated with the trauma. Symptoms related to numbing include a number of responses that are associated with depression. These include obvious diminished interest in important activities, and feelings of detachment and estrangement from others. There is also hyperactivity and anxiety. Sufferers experience difficulty falling or staying asleep, irritability, anger, difficulty concentrating, hypervigilance, and exaggerated startle response. Sufferers may experience return of symptoms when they are exposed to incidents that resemble the trauma. They may make great efforts to avoid situations that resemble the event that created the trauma and may develop exaggerated fears as a result. Many of these symptoms are similar to those experienced by patients with other kinds of anxiety disorders.

More complex PTSD was identified by later research. Levin, Blanch and Jennings report that when abuse occurs within a particularly close relationship, a "more complex form of PTSD may result" (Levin, Blanch & Jennings, 1998, p.188). These authors suggest that there may be a connection between long term exposure to trauma and the presenting conditions of sufferers, such as dissociative or psychotic symptoms, suicidal behaviour and self mutilation.

Symptoms of complex Post Traumatic Stress Disorder may include changes in emotional regulations, consciousness, self-perception, perception of perpetrator, relations with other people, and changes in system of meanings (Whealan, 2000; Levin, Blanch & Jennings, 1998). That is, sufferers may appear to have persistent sadness, suicidal thoughts, explosive anger or inhibited anger. They may also feel helplessness, shame, a sense of guilt and sense of being different from others. They may become isolated, distrustful and hopeless. The victims may feel betrayed and fear the world is no longer a safe place for them. Researchers for the Sidran Traumatic Stress Foundation note that survivors of childhood abuse may not see the world as a safe place. They may have difficulty trusting others, organizing their thoughts and making decisions. They may be vulnerable to exploitation. They may also demonstrate symptoms such as agitation, paranoia, psychosis and self-sabotage (The Sidran Stress Disorder Foundation, 1995-2000).

## 4.6 Current Definition and Diagnosis

In 1974, the Council on Research and Development appointed an advisory committee on Anxiety and Dissociative Disorders. This committee worked for several years and decided to eliminate the term “neurosis” from diagnosis and use instead “anxiety disorders”. Post Traumatic Stress Disorder became officially recognized in 1980 when it was included in the third edition of the Diagnostic and Statistical Manual (DSM-III) published by the American Psychiatric Association. This diagnosis was further revised in 1987 in DSMIII-R and most recently in DSM IV. Since then, there have been many volumes of research material written on the topic. (Picquet, 1986; Scrignar, 1988; Foa & Rothbaum, 1998; Miller, 1994; Dana, 1998; Levin, Blanch & Jennings, 1999; Field, 1999; Yehuda et al, 1995; Debellis et al, 1994; Fullerton & Ursana, 1997, Peterson, Prout & Schwarz, 1991). DSM III-R defined Post Traumatic Stress Disorder as:

*an anxiety disorder precipitated by an event that falls outside usual human experience and characterized by symptoms of re-experiencing (e.g., nightmares, flashbacks), avoidance and numbing (e.g., avoidance of reminders, psychogenic amnesia), and arousal (e.g., difficulty sleeping, exaggerated startle) that persist longer than 1 month after the trauma (Foa & Rothbaum, 1998, p.8).*

The DSM-IV retained the symptoms described above but made some changes to the trauma criterion and now includes "characteristics of the traumatic event and the individual's perception of threat rather than the rarity of the event" (Foa and Rothbaum, p.8). The terms "chronic" and "acute" are included to describe the course of the reaction. The most current version of the DSM (DSM-IV-TR; 2000) was published in June 2000. Baldwin (2000) notes that the World Health Organization uses an alternative classification system in its International Classification of Diseases (ICD-10).

This diagnosis recognizes that "the problem does not originate within the individual's personality, but rather that an external event has created lasting, but not incurable, symptoms or reactions" (Miller, 1994, p. 172). In other words, Post Traumatic Stress Disorder identifies the origin of the damage to the individual person. (Miller, 1994).

Researchers now acknowledge that a traumatic event would be distressing to anyone. They note that physical injury need not occur and that witnessing an incidence of violence or destruction could precipitate a traumatic response. Events and incidents such as threat or harm to a child, close relative, friends or spouse could elicit a traumatic response. Likewise, trauma can be precipitated by sudden destruction of one's home, community, or seeing another person seriously injured or killed as a result of an accident or physical violence. The precipitating incident could have been a recent past or presently occurring event. PTSD could occur up to a year after the incident or traumatic event (Giller & Vermilyea, 2000). Persistent re-experiencing of a traumatic event is a significant characteristic of PTSD. Sufferers must display at least one of the following before the diagnosis PTSD is given:

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- Recurrent and intrusive distressing recollections of the event;
- Recurrent distressing dreams;
- Dissociative episodes (flashbacks);
- Intense psychological distress at exposure to events that symbolize or resemble the traumatic event.

### 4.7 Victimization

Survivors, sufferers, researchers, practitioners and community workers have been concerned with victimization and re-victimization of survivors through lack of or inappropriate treatment.

*"..being a victim of crime, a victim of war, a survivor of human cruelty is not the equivalent of being mentally ill. Specialists in victim services understand this. But generalists who care about serving victims may not. Victims often avoid mental health practitioners in order to avoid what they correctly perceive as a high risk of re-victimization in a field that inadvertently patronizes and stigmatizes its clientele. A victim, by definition, has been violated and belittled; he or she can ill afford a second injury. Of course, mentally ill people are subject to victimization and, owing to economic and social deprivation, are victimized at relatively high rates. But the impact of human cruelty is experienced with a recognizable pattern of personal and interpersonal disruption and does not confer "patienthood" per se (Ochberg, 1988).*

While PTSD may have a devastating impact on the lives of sufferers, many avoid treatment. Those who seek treatment are often misdiagnosed. Physiological and mental problems may mask PTSD or make it difficult to diagnose (the Sidran Traumatic Stress Foundation, 1995-2000). Therapist may focus on presenting problems such as eating disorders, depression, substance use and abuse. Children exhibiting symptoms of forgetfulness, being easily distracted, having difficulty sleeping, mood swings, anxiety and hyperactivity or fatigue may be mistakenly diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) / Attention Deficit Disorder (ADD) because of the similarity of these symptoms with those of PTSD (the Sidran Traumatic Stress Foundation, 1995-2000).

Recognition of PTSD among women survivors of childhood physical and sexual abuse, rape and sexual violence did not come overnight (Peterson, Prout and Schwarz, 1991; McCann & Pearlman, 1990). Nevertheless, there is a growing body of research on women's experiences of violence. Various kinds of healing programs have been developed and women now work towards recovery by acknowledging the trauma, building and strengthening self-image and relationships (Miller, 1994). Among the many professionals who have contributed to research about issues of trauma and the experiences of women, Lenore Walker remains a pioneer who began developing

understanding around the “battered woman syndrome”. Judith Herman (1996) has also added to this body of knowledge and suggests that disempowerment and disconnection are core experiences of psychological trauma. She notes that the first principle of recovery is “the empowerment of the survivor.” (p.134) She also emphasizes the notion of “restoring control to the traumatized person” (p.134).

Much of the literature discusses the symptoms and feelings of women who experience trauma related to rape and sexual violence. This literature describes women’s experiences of intense fear, tearfulness, anger, shame, helplessness, numbness, confusion, disorientation, and re-victimization (Nass, 1977) following events. A significant amount of attention is also paid to the context within which this violence occurs. That is, accounts of experiences of rape, sexual violence, sexual and physical abuse of women and their experiences of PTSD, also discuss the political, economic and social conditions within which events occur, and calls for political action to deal with the source of violence and trauma.

As already noted, violence against women and children is now recognized as a common occurrence in the lives of many women and their families. Researchers addressing the issues related to immigrants and refugee women have paid special attention to the incidence of rape and sexual violence during war and during flights to safety. However, childhood sexual and physical abuse, rape, sexual violence and other forms of violence against women and children, occur in situations not related to war. In this study, particular attention has been paid to research on the experiences of women in situations of war. Brief comments will be made concerning the research on other forms of violence.

### **4.8 Physical and Sexual Abuse Among Immigrants and Refugees**

The National Centre for PTSD (200) describes the prevalence of rape during war and the consequences. They note that, in war, rape is an assault against the individual the family and the community. The Centre reports that rape in war has occurred in countries such as Korea, Bangladesh, Liberia, Uganda and Southeast Asia. Bosnian refugees have reported stories of public rapes and of villagers fleeing to escape these atrocities (National Centre for PTSD, 2000). Human Rights Watch activists have also reported incidents of rape and other sexual violence during the Rwandan genocide and of these crimes being committed by Hutu militia groups and the Rwandan military. Refugees from these countries have suffered loss of home, displacement, and other horrors (Human Rights Watch, 1996).

Clark and Lewis (1977) also speak of the re-victimizing nature of reporting rape and note that there was considerable silence around a crime that had been occurring with alarming frequency.

*This silence no doubt reflects the common belief that rape doesn't happen very often, but it also reflects the opinion that even if rape does occur, it should not, and therefore it shouldn't be made public. As far as the victim*

*is concerned, the prevailing attitude is that rape is shameful and degrading to her, and the less said about it the better. Advertising the fact that one has been raped is an open invitation to social disaster.*  
(Clark & Lewis, 1977).

This tendency towards silence was demonstrated in a report written by Bumiller in a June, 1999 *New York Times* article. Bumiller reported that Serb military raped Kosovo Albanians and that refugee Kosovo and Albanian women and their families did not report the incidents because of the stigma attached to rape. Similarly, a study by Kozaric-Kovacic and others described a situation involving 25 Bosnian women who had been raped and who attended a clinic in Zagreb. Nine (9) were pregnant and received abortions. Five were pregnant but unable to obtain abortions because of having been retained by Serb military until it was too late in the pregnancy to perform the abortions. These women had generally tried to hide the fact of their rapes from doctors and relatives and had refused counseling (Kozaric-Kovacic, unknown). In one Tanzanian refugee camp a survey showed that about 26% of the women had experienced sexual violence at the hands of soldiers, fellow refugees and Tanzanian nationals since becoming a refugee (Ndua & Goodyear, 1997).

Overall, women are particularly vulnerable to Post Traumatic Stress Disorder than men because of the violence that is so prevalent in their lives (Levin, Blanch & Jennings, 1998). Baldwin (2000) notes that individuals may be more susceptible to developing Post Traumatic Stress Disorder if they had experienced early traumatic experiences and especially if these incidents had been prolonged or repeated as in the case of many of the situations involving childhood sexual and physical abuse.

There is increased recognition of the high rate of childhood physical and sexual abuse among women (McCann and Pearlman, 1990). A 1984 study reported that 38% of adult women had experienced at least one incident of incestuous or extrafamilial sexual abuse in childhood (McCann & Pearlman, 1990).

## **4.9 The Physiology of Post Traumatic Stress Disorder**

Of all the research on PTSD, some of the most promising is the work being done on effects on bodily processes. There are two main categories of research in this direction: 1) identifying persistent chemical changes initiated by trauma and 2) developing drugs that address these changes.

In the past, there has been a tendency on the part of physicians and other caregivers to take the attitude that physical health problems related to stress, including PTSD, are “all in the mind”. The implications of this attitude are that one can control ones thoughts, that one only needs to do so to be free of the problems, and that failure to do so indicates that one is at least weak and maybe crazy. However, recent research would seem to dispel these myths.

Recent research has discovered that: a) specific changes in the way the physical body functions result from PTSD, b) these changes do not result from other forms of stress and are different from other psychiatric disorders (Yehuda & McFarlane, 2001), and c) these changes persist long after the stressful event (van der Kolk, 2001). Although the biological changes involved are not yet fully understood, the greatest changes are to the hormones involved in the stress response (corticosteroids, catecholamines, serotonin) and the endogenous opiates. In short, research indicates that PTSD actually effects the physical body and the body in turn effects the mind.

Van der Kolk has been interested in how the effects of these hormones may explain some of the symptoms experienced by those who suffer PTSD. Corticosteroids decrease immunity and may explain the many infections experienced by PTSD sufferers. The effects of catecholamines, (adrenalin and nor-adrenalin), are described in two studies van der Kolk reports in which flashbacks and panic attacks could be brought on by these hormones. Endogenous opiates are the natural pain-killers produced by our bodies in times of stress. Van der Kolk found that “Two decades after the original trauma, people with PTSD developed ... analgesia in response to stimulus resembling the traumatic stressor.”(p.6). He believes these opiates may explain why many PTSD victims feel emotionally numb. He also reports that increased Serotonin is associated with impulsiveness and aggression, obsessive thinking, preoccupation with traumatic memories and overreaction to the environment. (van der Kolk, 2001)

Prior to these discoveries, medications used to treat PTSD were aimed at the symptoms (e.g. depression) rather than the cause. The discoveries just discussed have enabled the development of drugs that address the underlying physiological causes of symptoms. Drugs that target serotonin (Selective Serotonin Re-uptake Inhibitors or SSRIs) have been found to be the most effective overall and especially in treating flashbacks. “Other symptoms that may be controlled by this group of drugs are rage, impulsivity, suicidal intent, depressed mood, panic symptoms, obsessional thinking and ...alcohol and drug abuse” (M.J. Friedman, 2001 p.3) while drugs that act against the catecholamines reduce nightmares, flashbacks, angry outbursts, and insomnia and improve mood .“(M.J. Friedman, 2001, p.4)

Understanding the physiological effects of PTSD increases the likelihood of appropriate care. Although those who have PTSD do not all require medication, these discoveries make more effective drugs available for those who do. And understanding that symptoms are real and not imagined can go a long way to increasing the self-confidence and self-esteem of all sufferers.

### **4.10 Treatment/Intervention**

With respect to treatment and intervention, some literature on PTSD describes clinical and group work as forms of practice to address PTSD. Other literature describes traditional and complementary therapies including use of drugs and self care methods. Still other literature discusses the integration of human rights and political perspectives in understanding and intervening with immigrant and refugee women. Additional material

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highlights the fact that immigrant and refugee sufferers also need assistance dealing with the daily challenges of settlement and integration. Therefore, governments and communities must continue to be responsive to the settlement and integration needs of immigrants and refugees, and must see the connection between these needs and the healing needs of PTSD sufferers.

Peterson, Prout and Schwarz (1991) suggest that modern treatment tends to be brief or time limited. For example, Marmar Horowitz (1988) developed a brief therapy model following single traumatic events. This model was modified from a 20-week program in which clients were seen weekly to a 12-week program. This was designed to encourage clients and therapists to be goal oriented and make termination more realistic. Horowitz felt that this brief therapy program was not suited to all clients and concluded that a long-term and multifaceted treatment program may be more appropriate for those who had experienced multiple traumatic events. This approach would also work for those who showed chronic symptoms many years after the event. The range of treatment options for these individuals could include individual psychotherapy, support groups, couple therapy and in-patient programs. Support groups are popular in various parts of the world. Emergency services provided by relief organizations are also available in some locations.

With respect to intervention when dealing with rape trauma, Foa and Rothbaum (1998) talk about the importance of accurate assessment. The goals for assessment include diagnosis, providing a record of response to intervention, validating, normalizing and educating. The methods include self-monitoring, clinical interviews and standardized measures. Some of the difficulties involved in assessment include non-compliance by clients, reactivity (self-monitoring may be inaccurate as a baseline measure because the client is overly aware of her behaviours), secondary gain and shame. Types of treatment for rape victims include individual counseling, short-term debriefing, group treatment and medication. Preventative measures and education also form a significant part of the work involved in addressing this issue. Professionals have provided information and products related to contraception in an attempt to address the issue of rapes that occur in refugee camps.

Other treatment for PTSD falls into three categories, namely drugs, self-care and alternative therapies. M. Friedman (2001) reviewed research concerning the effectiveness of drugs in common use and recommends those that address the physiology of PTSD (e.g. Selective Serotonin Re-Uptake Blockers). Dr. Philip Friedman (1999) reviewed a number of alternative therapeutic and self-care techniques useful in treatment of PTSD. He reported the importance of first of all "...listening carefully to clients describe their problems, distress and stories" (p.1). Useful approaches that are familiar to most therapists include Cognitive Behavior Therapy, Hypnosis, and Marriage, Family and Relationship Therapy. Less well known are Thought Field Therapy and Tapas Acupressure, both of which utilize acupressure points to decrease stress. He describes Eye Movement Desensitization and Reprocessing which involves having the client focus on external stimuli while thinking about the source of distress. Self-care strategies recommended include: Imagery, Yoga, Meditation, and Assertiveness Training.

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Another aspect of intervention that is invaluable is recognizing what Good and DelVecchio Good (Miranda & Kitano, 1986) refer to as the "the cultural context of diagnosis and therapy" (p.1). 13 years later, Morrow and Chappell (1999) expand this view noting that when therapists allow their diagnosis to be overly influenced by ethnicity, the results may not be accurate. Other researchers such as Nader, Dubrow and Stamm (1999) emphasize that some problems are political and economic in origin. According to them, "When consultants fail to talk about the historic context of problems, local people often feel demeaned and misunderstood" (Nader, Dubrow and Stamm, p.xix). These researchers suggest the need to include discussion of human rights and political change as part of the process of intervention. Sharpe (1996/7) also stresses the importance of ensuring that professionals have an understanding of "the phenomenon of human rights abuse and its consequence" (p.19). He urges nurses to take a lead in acquainting other health care professionals about these issues.

Literature regarding immigrant and refugee women's experiences of war and disaster also demonstrate their resilience in the midst of devastating experiences. Spouse (1999) talks about the difference between being "victim" and "survivor" and of the importance of being aware that individuals have different ways of coping. She also notes that once a refugee is resettled or moves to another country, that there is still need for one or more forms of support (economic, social, medical and psychological). One study by the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988) notes that, while migration alone may not threaten mental health, other related risk factors including negative public attitudes do affect the health of immigrants and refugees.

Knowledge that one is supported within the new country is particularly helpful. Sharpe (1996/7) notes that countries sometimes appear to be reluctant to accept refugees and that this may be reflected in certain negative policies and attitudes toward refugees. He also suggests that many countries are developing "cross-cultural" training for professionals and social service providers, and paying less attention to "the social, political and historical experiences of many of our diverse clients" (p.19). Likewise, Soroya & Stubbs (1998) suggest "conflicts cannot be addressed exclusively in terms of ethnicity, but must be discussed in terms of specific economic and political crises" (p.304). In short, these researchers are urging professionals and service providers to be careful not to re-victimize clients and potential clients by omitting to address external factors that are the source of much trauma.

### **4.11 Summary**

There is a wealth of information and research on the topic of Post Traumatic Stress Disorder. There is also a growing body of research on the experiences of Post Traumatic Stress Disorder among immigrants and refugees. Much of the new research is identifying the need for service providers to pay attention to key issues such as trust and to using approaches that do not recreate/regenerate experiences of abuse and trauma. The literature on PTSD among immigrant and refugee women has not focused solely on the

medical aspects of PTSD but has moved to include social and political components by addressing the root causes of women's experiences. These developments have contributed positively to healing. They acknowledge women's resilience in the midst of trauma and place some emphasis on creating change in the larger environments, not just within the women themselves.

With respect to the experiences of visible minority women, this current literature review has not identified material addressing the issues of racism and PTSD. However the literature has included discussion about ongoing needs of immigrant women during settlement and integration. The present study points to the need to do more research on this dimension.

As noted from the above overview, professionals and researchers studied the phenomenon of response to extreme trauma from various angles and each contributed to the growth of knowledge regarding PTSD. It is hoped that the present study will extend research in this direction and add to the growing body of knowledge regarding this disorder, especially as it relates to the experiences of immigrant, refugee, and visible minority women living in Saskatchewan.

## 5. DATA FINDINGS

### 5.1 PTSD: The Women's Stories

Women recounted diverse stories about the experiences of Post Traumatic Stress Disorder. They described their experience of Post Traumatic Stress Disorder in terms of the depression they had suffered. They described physical symptoms such as lethargy, body aches and headaches, weight gain, Fibromyalgia and vomiting. Fear was a common thread that ran through all the interviews.

One woman spoke of her life following a car accident. Those women who came from war-torn countries or countries where there was political persecution and oppression could relate horrific stories of witnessing violence and torture, witnessing disaster, living in situations of extreme violence, fear of death, witnessing and being informed of deaths. They talked about feelings of anger, and about fear, panic attacks, nightmares, memory loss, flashbacks, sadness, loneliness and isolation, unhappiness, depression, and suicidal ideation.

At the same time, I do have problem with the smallest things. Like it's funny even now like if we went to the store, or whatever, you know. I have a problem deciding on those kinds of things...like you know what I mean. Sometimes I run around the store, and end up not buying anything, because I cannot make small decision. (Gloria)  
I ended up feeling like I was 80 years old in a body of a 25-year old....I decided to kill myself...I was suicidal for quite a while and desperate. (Gloria)

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Okay, depression is one of the most significant problems. Like when we were talking about deep, deep depression.... constant level of depression. And there are times extremely bad. (Gloria)

The other thing that I cannot do, for example, is- I could not sit [with] my back to a door....I have never been able to do that, you know, easily. (Gloria).

...I would just fall asleep just a few minutes and some fears would wake me up. I'm not sure what but then I would be scared I would [be] sweating and shaking so many times I felt like dying...(Bernie)

Like I said, it, it started in October 97' when I was first having that panic attack. I would just, it just scared me something that I was actually...my first symptoms was.... I got to sleep and suddenly something wake me up and I'm so dizzy I, I think I will faint. (Bernie)

You just hate yourself, you just don't think of yourself. You just hate yourself. You just hate yourself so much you just don't want to look in the mirror, really. No, I'm so useless, I'm so worthless, ..I got scared..(Pat)

I didn't leave my house. I didn't have any contact with anyone, didn't talk to anyone...it was so awful...there was no reason to live...They were both killed...their mother screamed so hard, ...loud...how do you live...cope with that, all that...and in October, and ...every year I wish I could jump it. (Nancy)

The women also spoke about their nightmares.

I am not sure [if the same thing] is happening with everyone, but to me I just started to have this problems when I came here. When I left, when I was safe, when I was out of that problems. When I just came, I was having nightmares, and I would get scared of something that I didn't know. (Bernie)

.... you know when you have some weird dreams and something. Sometimes it's war, sometimes somebody wants to kill me, sometimes it's related to war, ...not in the war, just somebody trying to kill me or kill my kids or something but sometime it's related sometimes I'm dreaming real war. Sometime I'm dreaming that I'm in Canada and that somebody is trying to kill us or something. (Bernie)

And yet it has been so many years. But I still have nightmares, you know. I still have, not as frequent. And my nightmares are, my most difficult nightmare that I have for example, is their running after me. Which happened many times including the days that I almost died...and then you know, I kind of get into walls or something and there is no way out. ..(Gloria)

It was to the extremes the nightmares, you know...sometimes I ..thought I was awake. That was so vivid...even when I was having a nap. That was the point I didn't want to fall asleep, because I thought, oh my God, ...I was frightened...I remember one of the nightmares I had. Like this man ... I never saw the face, I knew that it was ...immediately, no face that's coming like this, choking me, you know...choking and I knew that man had gun...I thought it was real and that was one of the dreams...because it didn't stop. So when I came here I thought my feelings would stop. ...but again, it was, the fear was there. (Orlane)

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These women described a range of physical symptoms.

She has problem with stomach with ulcer and they give some medication that you, you know you can relax and all this. What to do with just medication just...nothing help you. (Ernestine)

My blood pressure started going up...I was losing weight, I was totally tired all the time and I ...was isolating myself. ...I wasn't coping with the socializing, ...I wasn't coping without sleep...(Lenore)

I feel sick. I feel like something is wrong. Cause I start crying and I don't know why ...and I feel inside of me and I wish it would stop, you know. (Ailsa)  
I sleep too much or I sleep very little. ...And my moods are going...they are no good...sometimes I feel I rather be dead, you know. (Ailsa)

While women's traditional roles have served to keep them "strong" and to ensure that they go on with their lives because of care-giving roles, it has also been a block to their addressing their own pain. A common thread among the women was their concern for the safety and well being of their children and family. Those women who had come from countries of extreme violence, war and political unrest spoke about the sense of never having enough to eat and their concern for their family's health. Several interviews involved women talking about the experiences of their children and focusing less on themselves. At least three (3) women were concerned about help for children who had been traumatized by the war as well as by the process of migration and settlement.

It was hard and I had all this [concern] about money and coping with myself and my family and my...it was just awful. (Lenore)

And when they have to left their home, you know, when they [were] forced to left their home, since that time all three youngest children, they have problem...every night...The eleven year old girl? She's still dreaming about the Kosovo, how the war it was in Kosovo. (Ernestine)

I'm very sick, I'm sick and I'm homesick. She's homesick. She [her daughter] stays alone in her room and listens to music when she is very sick. (Ernestine)

She suffers a lot because of her daughter...like she's crying lots...her daughter very bothers her. (Mona)

You know, when you are a single parent, you are kind of scared of future. You don't have any family here. I only have my girls and I was always scared what will happen to them if I get sick or die. (Bernie)  
I knew I had to be very strong, that I have to survive, that I had to protect my kids. (Bernie)

War situations were not the only identified sources of Post Traumatic Stress Disorder. Four (4) participants described the extent to which their experiences of racism and discrimination were immobilizing and destructive.

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And there is no room where there is no understanding for people that are not born and raised here, for people that haven't done things their way.... I found at first a lot of teasing and a lot of laughing as to the way you say things. (Hannah)

I was talking to the guy. He told me the reason that he was laying me off is because he doesn't think that my writing skills and my English skills [are] not good enough for them. ...But more than anything else it affected my self-esteem a lot...I had come long ways, yet every time there is a job opening that I want to apply for, there's this voice inside of me that tells me, "you need better English, you will just never be good enough." ...and I find it difficult to get over that....Yet there is that feeling that you can never measure up, ...follows you all the time, and I find that acutally, you know, the hardest thing for me. (Hannah)

Such a difficult time for me. I was a total mess. I couldn't cope ...I couldn't sleep. If I managed to sleep, I would wake up at night. I would be..., you know, really scared. Like I don't know what was going on ...something that I'd never experienced before. I would pace up and down, up and down in my room, or you know, I couldn't concentrate, I couldn't do. I was just so frightened for reasons I couldn't figure out. ...I was elevated to this position that I could not cope with...I was crying lots...I couldn't cope with my work...I was so unconfident about things that I knew how to do. I was afraid of people, you know, especially management. I was walking on air...sure sure what to do about anything. (Lenore)

It was awful. Sometimes someone would say something that could trigger all this same subject I'd gone through. And I'll go through the motion of what I went through that time and there is just so much pain I went through. (Lenore)

And always verbal abuse too, calling names...Yet sometimes you know even there, there is a racial comment here. (Jane)

"Jane" also talked about working in an environment that always felt unsafe:

But the thing is always the same, even now. I didn't see any change. I have been working there for many years. But there is always fear. (Jane)

While many women spoke about missing their traditional support networks (particularly extended family), one woman ("Vivian") spoke about the pressure from her cultural community to remain in an abusive relationship. When she eventually got out of that relationship, she felt ostracized and therefore further isolated. Unfortunately, because of difficulties with respect to audiotape qualities, we have been unable to provide direct quotations from "Vivian's" interview.

Other accounts of prolonged or ongoing exposure to violence or threat of violence, including stories of childhood abuse and domestic violence permeated many of the stories. There were accounts of alcohol abuse within families of origin and within couple relationships in three situations. One of the Aboriginal women spoke about a long history of abuse and addiction. She described experiencing many of the symptoms of PTSD. It was clear that her experience was part of a long history of multiple oppression. She felt that her experiences with counselors and social workers were good because they challenged her to make positive changes in her life.

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Unfortunately I cannot say that any part of my life was ...happy. I had [a] really hard childhood. My father was very abusive father and person. And I was ..growing up with fear. Because when my father would be angry, he would beat up my mom and us...My husband was an alcoholic...I couldn't say my life changed totally at that time when war came. I wasn't a person without any problems then my life suddenly changed. (Bernie)

At three I remembered the first incident. Now I don't remember anything between three and about maybe five. So there is a block in there and then after that it was continuous, continuous abuse almost back to back. With one person it was almost everyday, almost everyday. (Carolyn)

But there was a lot of emotional abuse in my childhood. A lot of it. And I think, I think a lot of the problems I'm experiencing now probably have to do with that. You know, like my father always put me down. Like we were never...my brother and I were never going to amount to anything. You know, we will be useless...it was me being th girl, being the youngest and stuff. You know...such a sexist society and stuff...I guess I got it worse in many ways. (Gloria)

He drank a lot and ...during two, or three years, I have really terrible life. When I came home and saw my drinking husband and you know a lot of bad stuff. And it wasn't pleasant...But it was for long time maybe. I ....used to suffer, you know. But really it was you know, it's like your husband takes everything from your house to sell and to buy something to drink and ...it's really terrible. (Franka)

"Nancy's" account of her experiences coming out of a war-torn country, described how some families might have been healthy and how war could change this overnight.

You know, living a very normal life and all that. And overnight that changed. But everybody who come in the war, we all lived...it was awful. Everyday we would say good-bye to each other...I know how happy we had been. ...Very close. I had very good childhood and family. I never had loss before the war, never had anyone close to me die. And then such a horrible way. (Nancy)

Franka's story also described how women's perception of what had caused the trauma was varied and how women were at various stages of understanding their trauma.

I didn't have big problems...my job was good, not bad...of course, my country hurting now cause lots of problem. Because sometimes people don't really get money, like salary, every month. Sometimes to get money it takes maybe half year. It's really difficult but it was very sad because I had to find another job, you know, which could help me to give my family. But I have support from my mother and father and I could not say my life was really terrible, you know. Nobody, nobody tried to kill me. Nobody try to shoot me...some people, it may be. Sometimes I think that maybe it will be better that something huge happen ... (Franka)

Only five of these women had been diagnosed with Post Traumatic Stress Disorder by a professional. One of these women came to Canada as a refugee several years ago. The psychiatrist seemed to have attributed her experience of Post Traumatic Stress Disorder to a relatively new incident. It was not reported whether the psychiatrist discussed her experience of witnessing violence and killings in her war-torn country of origin and

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during her journey as a refugee. One of these women was diagnosed in another province and another outside of Canada.

Those women who were diagnosed or who believed they were sufferers of Post Traumatic Stress Disorder spoke about how they felt before and after they learned about Post Traumatic Stress Disorder.

I thought that I'm emotionally or mentally sick. Or whatever, but I would, would never think that.... I knew it could be related to the war all my life. But I would never think was was post-traumatic stress. ...I had a lady...I am not sure if she is a psychologist or something. ....she said it doesn't mean that I'm going crazy... (Bernie)

Actually, you know, to be honest, I did not know what was happening to me. I didn't know. I was asking myself what is going on...like I wasn't sure whether it was because of what happened at work. Oh it was just me, I didn't. Actually, I thought I was going crazy. (Lenore)  
Actually when I started going to this counselor...she gave me a book to read...and I think that helped me. (Lenore)

You know, I think I heard about it, I'm pretty sure after the Gulf War. It was either in the newspaper or in a magazine or something. There was an article about that...about you know, people going to the Gulf War. Something like that. Or maybe it was the Vietnam war. But it was not long ago...it was something like that. And I started reading about the symptoms and I said, "oh, that's me." And I mean, it was almost exactly like all of the symptoms I thought. And I don't remember them now, but you know, you know exactly. But that's what I felt and it was, you know, like...in terms of being startled about nothing. Like when someone comes into my office and stuff and I will ...depending on the shoe they are wearing...just jump..[on the] roof. ....I remembered when I read it at that point I said, "that's me, that's me." (Gloria)  
I realized it was probably a liberalizing thing...around here...like knowing, you know, how it is when you know what you have or what you might have...it's kind of a liberating experience. (Gloria)

Yes, when she find out from ..., it was helpful for her. ...I want to be ...more relaxing. (Ernestine)

In short, after thinking they were going crazy, women were able to talk about the relief they felt when they learned about Post Traumatic Stress Disorder. This knowledge seemed to play a major role in their healing journey. Nevertheless, those women who had this knowledge were often women who were more comfortable with English and who were less isolated because of language skills.

### 5.1.1 Experiences with Service Providers

Few of the women interviewed had sought help from psychiatrists, psychologists, counselors or other mental health workers. Most of the women spoke about the stigma attached to mental health services and problems. Several noted that mental health services were not known, used or a familiar feature of their own cultural backgrounds.

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Those who used services were not always comfortable with the location of mental health services and felt it was too identifying. One woman spoke about not being honest with her counselor about her extreme depression, suicidal thoughts and fear of losing her children. Others were not impressed with the quality of services of the professionals.

And I have been going to counselor and I haven't told her that. Cause I'm afraid what she will do, you know. (Ailsa)  
And I didn't feel like going there. And then, they have it on the fourth floor. (Ailsa)

...and those counselors I went [to]. Kick them out of there...I have to change three or four. ...like two years of counseling of starting in Regina, or whatever, and you're a social worker, and you can counsel me? They are not for me, they are not trained enough to counsel..(Pat)

For one thing, \$35 to see her. And she uses more psychology, you know. Things that I could read from the book. (Ailsa)  
...but she doesn't go deeper. I wish she would try to help ..(Ailsa)

Actually to me, I don't know...maybe it's me. ....When I was, when I would be talking to that lady, I would just tell her and she was giving some kind of instruction how to breathe, you know. With breathing to help but that didn't help me. (Bernie)  
You can be very, very good psychologist, but you still...that person who you are counseling still don't think that you can understand her if you wasn't there in that situation. If you didn't experience something like that. (Bernie)

Four of the women noted that their physicians were not helpful. This included those who did not feel listened to and supported by their physicians. One of these women suggested that her physician would not be helpful because he did not share her background and would have little understanding of her experiences.

I read something about this doctor. ...So I went to see him and I said, (you know it was like an act of desperation), like I am not doing well. I just want to see what you can do for me...And he looked at me and said. He kind of looked and frowned and stuff...and in any case, he said, "Well, I can't understand why you haven't gotten over this." And he said, "you aren't even ...you should see people from El Salvador coming here. They were mutilated and everything. You know what I mean? How could you not get over this? So I left that office. ...I was devastated because that increased my feeling of guilt and I think ...those were the feeling I had to deal with the most, you know, the guilt of having to survive. (Gloria)

I have gone [to] one and didn't like what he says. He says that my husband doesn't go out with me because he is embarrassed of me and I didn't like that. I didn't [go] anymore. ...And the other one, he just took note a lot and didn't say anything, and I didn't come back either. (Ailsa)

From the doctors she get help. But she way they was trying to help her, but it was not help because she just get medication..is trying to help, but...(Ernestine)

Those women who had relationships with service providers in community based organizations tended to have more positive attitudes regarding the services they received.

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They talked about feeling listened to and feeling that services were accessible. In particular, women were particularly appreciative of agencies where there were drop-in programs with other immigrant and refugee women.

I was in a total mess, that I was so glad to have someone listen to me. She listened to me a lot. I talked almost a whole hour, through the next hour. I talked and talked and talked and talked. And in that way, I felt it helped because I had shared what I was feeling [with] someone that seemed to be giving some concerns about me and wanted to help me... (Lenore)

Actually, after we started this project, I was thinking more and more about all of my situation and my case, about that. And I was talking to other people and they would help. Especially women from my country. We would be talking about that. (Bernie)

## 5.2 Experiences of Service Providers

Physicians and psychiatrists used the DSM-IV as a point of reference for understanding and defining Post Traumatic Stress Disorder. Psychologists and nurses seemed to have definitions of Post Traumatic Stress Disorder linked to the DSM-IV and/or gathered from other sources. Other service providers had some notions of a definition but were less precise.

Other service providers who were interviewed included a variety of mental health workers including psychiatric nurses, counselors and psychologists. They reported that they tended to work with a wide range of clients and client issues including eating disorders, depression, various kinds of psychoses, adult and childhood trauma. Many of their clients were dealing with multiple issues.

Mental health workers reported limited experience working with immigrant populations including immigrant women. This was related to the fact that very few immigrant women tended to access mental health services. One psychiatric nurse in one urban centre reported that over a twenty-year period, she could identify only one case of an immigrant woman accessing services as a result of post-traumatic stress disorder.

I can only think of one, one woman that we had inpatient, she was an immigrant woman. Yes, she was depressed. I know she had just come. And there were a lot of things she would talk about that led you to believe that there could be some post-traumatic stress disorder there. But at the time her major issue I think was not being recognized here as an individual. She was a professional in the country that she came from. (Jackie, Focus group speaker)  
She lived in a small community...very isolated. Neither she nor her husband could get, you know the type of work that they could get in the country they came from- where they [were] both highly respected individuals, and found that very difficult. (Jackie, Focus Group speaker)

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The account of this woman's situation also described how concerned she was about taking care of her family.

And at the time, it seemed like what was really hard for them, was that having arrived here and thinking, "yes, this is a safe place, but I have nothing here and I am not respected. That seemed to be more of a thing that was upsetting her and she would tell stories about the things that had happened on their journey and how she had to protect her daughter and all the rest of it. That seemed to be the big thing for her. (Jackie, Focus Group speaker)

Service providers in shelters, settlement agencies and other social agencies tended to have more contact with immigrant and refugee women. They reported that many of the women had low self-esteem and seemed to be living in or had some history of violence. These workers talked about the lack of worth and power that so many women seemed to have within their family units and relationships.

Many of these workers talked about feelings of inadequacy around dealing with immigrant and refugee women.

We had one lately, she is a different culture. ..I feel inadequate to help them because I don't understand their culture. Because her husband was very domineering and I think part of the problem was that for her. And she came in as agitated, depression, and it's just to get like that cultural thing to understand their culture. Like you know, versus mine, that kind of thing. And she was very guarded too so we don't know, you know, when you talk about post-traumatic stress disorder...maybe this woman did have something going on. But because of how guarded she was, we really ...may miss the mark. ...I think that when people come with different cultures like that, it's hard to understand because I [don't know where they are coming from]. To help somebody like that I don't feel I'm a good helper either ...But a lot of times...you feel is sometimes be helpful to learn about the different cultures. Like have more workshops about different cultures and beliefs. So at least we can understand where they are coming from. (Cindy, Focus Group speaker)

Another service provider suggested that it was difficult to understand what was Post Traumatic Stress Disorder and was the stress of being in a strange environment.

...to know how to separate post-traumatic stress from the stress of actually being in a strange culture and leaving the one thing that is constant, which is the family you know. ...(Liz, Focus Group speaker)

Language posed a tremendous barrier to the work they did. Several workers suggested that a key issue was the need to address the stigma that immigrant and refugee populations had towards mental health services.

And the translation thing is so difficult. Sometimes if they don't have English, explaining your ideas, your concepts to them, and explaining it back to you is very difficult. And also we have pamphlets in different languages, but we are realizing that the last one we had, we don't know what the pamphlet says. (Focus Group speaker)

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So we have our own cultural stigma to do with mental health and then I have no idea what the stigma is in other country with regards to mental health. I am sure it's big. (Focus Group Speaker)

Those who worked with community based organizations, reported that they would like to have choices about collateral services they could access. For example, several workers spoke about the need to have access to cultural or ethno-specific services. They also spoke about wanting to develop skills and knowledge that would allow them to respond more appropriately to immigrant and refugee women's needs. Several professionals suggested programs that would enhance their understanding and awareness of issues facing newer immigrants and various cultural communities.

While the research team did not meet with many Aboriginal women, they met with mental health professionals and service providers who talked about the fact that they were seeing large numbers of Aboriginal women.

Probably the biggest trends, and I am thinking about the native population where we see this trend. It is a lifetime pattern of being subjected to oppression and pretty much all types of abuse, usually influenced by alcohol and drugs. Or both. As for other people, we see a few of them, it's hard to see a pattern there.

(Dana, psychiatric nurse)

But with the post traumatic stress – the kinds of things...in my mind., if I put it in that category is we see so many young native girls that have been raped somewhere in the past. You know, whether they were six or ten or twelve or fifteen...it's always...alcoholic abuse, it's depression, it is this, it's that. It's you name it and in our history...as we go through it... they have to be prepared on day one to say to somebody as I am doing the intake, "yes, I was raped".

(Helen, psychiatric nurse)

These workers suggested that they were learning much about the issue of Post Traumatic Stress Disorder from their interaction with First Nations and other Aboriginal women and suggested that this learning might be useful when addressing the issues of immigrant, refugee and other visible minority women.

### 5.3 Experiences of Physicians and Psychiatrists

Four psychiatrists and one physician were interviewed. All of the psychiatrists worked as part of a 24-hour team. Most of these discussed the stigma attached to mental health and spoke about the lack of immigrant and refugee clients.

But when it comes to immigrant women, unfortunately, I would say I don't have much. We don't have much experience and I will explain the reason why that may be. Refugees are people who you will think has lots of trauma, different traumas and that they would present. But unfortunately, most refugees come from countries where seeing a psychiatrist may be, ...the stigma of seeing a psychiatrist is so big they don't want to come. In fact, they would rather, they would rather deny their symptoms than go and see a psychiatrist. So in that way, immigrant and refugees don't normally come. ...So when it comes to immigrant women, we don't have lots of experience. In fact, I would say that of all the women who have made a diagnosis of post-traumatic stress disorder, there has been no immigrant women, really. (Dr. Fona)

I've not been able to measure the problems, or you know, I've not been able to see anybody .so it's difficult to make recommendation when you have not been involved in planning or, you know, delivering care or whatever. (Dr. Toona)

Two doctors had some experience working with immigrant and refugee women who recently had come to Saskatchewan from eastern European countries. Three of the psychiatrists had experience working with Post Traumatic Stress Disorder outside Canada and one had experience in another province. Two of the psychiatrists were familiar with members of the immigrant and refugee communities within Saskatchewan but also confirmed that they were not seeing anyone within their practices. One psychiatrist suggested that he had no immigrant or refugee clients who had presented symptoms of post-traumatic stress disorder, despite the fact that his name had been recommended by one of his clients who was an immigrant woman who was self-identifying as suffering from Post Traumatic Stress Disorder.

Three of these doctors reported a belief that immigrant and refugee women were not informed/knowledgeable about Post Traumatic Stress Disorder. They believe that this also meant that immigrant and refugee women did not have the language to identify their situation. Even if they could describe their condition, they would be unfamiliar with the term Post Traumatic Stress Disorder.

No, they don't express it as post-traumatic stress disorder. Post-traumatic stress disorder is a sort of an affluent description. I mean I'm talking from experience in the past. I came from a cultural background where women are traumatized, okay. They [do] not even say that you feel guilt, or disgusted ...an ability to fulfill their social expectations. No, no the concept of post-traumatic stress disorder is more in the west. ... western women according to their exposure to media or education would use post-traumatic stress disorder. (Dr. Ona)  
I basically don't have lots of newcomers in my clinic, in my practice...I don't see there is a lot of newcomers here so I don't know whether their family physicians are dealing with that. (Dr. Ona)

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I don't think that many people of immigrant background would be that sophisticated they would know that, ...the health care person treating them would have to be sensitive enough to know that things like this could happen. It should be explored. (Dr. Feva)

Two doctors suggested that immigrant and refugee women might be more comfortable speaking with a family physician since there would be less risk of stigma.

Well, I think for us as psychiatrists, one of the challenges would be the fact that most people don't come to us directly. They go to their family doctor and like I said, perhaps the family doctor deals with it somewhere and the fact that the family doctor is dealing with it, it's satisfactory enough for the patient and for their family. Because of the stigma we talked about. ....The other thing is that when refugees come to different countries, they usually, depending on how horrific it has been for them, they usually blend or stay with those who have been here before and those who have been here before may have a way of saying okay...this is what is happening. This is who we are going to see and you can deal with this, this way. (Dr. Fona)

This seemed to be confirmed by the sole family physician who was interviewed. This physician talked about the importance of building a relationship with all patients and especially with immigrant and refugee women and their families. He spoke about the approach within his clinic where all staff paid attention to language issues and spent quality time with clients, building trust. He also prepared clients for interaction with other medical practitioners such as psychiatrists.

Once you encourage doctor-patient relationship, that's the key to successful outcome. ...Speaking the language makes [a difference], ...understanding culture background makes a difference. Being upfront is also important. (Dr. Feva).

One doctor suggested that women seemed to be more willing than men to discuss their medical issues. Nevertheless, all of the doctors made reference to diversity among women's experiences, acknowledging the fact that this might not always be the case. They spoke about the need to recognize women's subordinate roles in many countries. These practitioners suggested that some immigrant women might not be willing to speak on their own behalf and others might not have the opportunity and/or independence to do so. In other situations, the process of migration, settlement and integration has demoralized many women who would have lived very independent and full lives prior to coming to Canada.

### 5.4 Sources of Support and Assistance

There seemed to be general consensus that immigrant and refugee women accessed support and assistance primarily from informal sources (including family, friends and community), community based organizations and from services that were not perceived to be "mental health" services. Two doctors suggested that women used the church, family and other community sources more readily than traditional mental health services.

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Other professionals suggested that there was a stigma attached to accessing traditional mental health services. Therefore, some women had accessed private practices. Two women spoke about the cost of accessing private counseling. One woman found the sessions extremely helpful but did not continue because she did not have the resources to do so.

Actually I went to a counselor one time and she was just too expensive for me. I think I went to three sessions ...I was so glad to have someone listen to me...but I could not afford to go there. I had to cope by myself. (Lenore)

Yes because it was with the government, I was scared, you know. If they found out I'm not feeling good, you know I'm so scared...that's why I go to private now. Even if it costs more money, you know. I feel more, more secure. (Ailsa)

I come from a culture that just mention a psychologist or psychiatrist is a taboo in my cultural [world]. (Nancy who self-identified as a sufferer and also as service provider)

Several of the women spoke about the support they received from their own ethnic or cultural communities. One woman spoke about the support she got from colleagues at her workplace.

It was really hard and I had so much support from my ...community, my colleagues at work. And I would pick up the phone and they had time for me or cry and take me out. They were there almost all the time. (Lenore)

My friends are the ones that come from our countries. (Ailsa)

She has...neighbor, church people. (Mona)

..it helped me that I was talking to my friends. I was sharing my feelings and my problems with my closest friends. And I guess my life was getting a little better. And I moved into the house so I wasn't scared about my future. I knew that somebody there who will protect me. Who will help me. (Bernie)

When you talk, you feel like you...I'm not sure how I would explain it. But when you are sharing with your friends something you feel, you are...losing all of these problems, that you are getting [rid of it], yes, getting rid of that, yes. (Bernie)

Nevertheless, not everyone had access to communities where there was a meeting place specifically serving the needs of immigrant and refugee women. For example, there was neither a settlement agency (Open Door) or active immigrant women's organization in one community. One of these women, "Pat" also noted that many residents seemed to be ignorant about people from different cultural backgrounds. She noted that residents of that community would ask questions and make statements that reflected this ignorance. She was frustrated with this. "Pat" and "Mona" expressed feelings of isolation and spoke of the need for some kind of organization that would meet their needs and those of other immigrant, refugee and visible minority women.

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And there isn't anyone to help them. And they don't understand, you know. (Mona)  
No, no help in school. Teacher say they don't have time to help her, or very little...no help. ...The teachers won't take the time to help her, no. (Mona)

Women also expressed how important it was for them to speak with other women and individuals especially those from their own countries of origin and those coming from backgrounds where there were similar experiences. Those who had the opportunity to meet in groups, support programs and at one another's homes, were extremely appreciative of this. Those women who had not had this support were aware of this need:

Well, my physician is a very good man. So I appreciate him for this. But taking depression pills is not enough, you still need that friend to talk to, and you need a best friend. So you don't have to go to the counselors. (Pat)

She is thinking but if you are in group, you know, and talking with people and sharing their problems, it will help a lot. (Ernestine)

It would be big help, I think so you know, so each people can...to take time from psychologist. I think it [is a ] good idea, it's not bad...it's very good, I think so sometimes you need to tell..don't keep inside yourself. (Franka)

What I think would be useful is that] there would be a group, that they phone these people. You know, [ask] how you [are] doing. Just to say, " how are you doing?" or meet for coffee or something, you know. (Ailsa)

Moreover, the sense of being listened to and supported provided overwhelming healing benefits to women. For example, those women who had family and partners who believed and listened to them in a non-judgmental manner felt that this was a significant part of their healing journey. As well, those women who had family in close proximity in Canada were less isolated and therefore better able to heal. Overall, a safe, supportive environment seemed to be key to women's growth.

## 5.5 Barriers to Women's Healing

### 5.5.1 Language

English was not a first language for many of the women who were interviewed. They had varying levels of comfort with the language and most appeared to struggle with the language. Over and over again, the lack of ability to communicate in English posed a strong block to women's ability to identify and address issues. Everyone who was interviewed (service providers, mental health workers and the women) raised the issue of language. Many of the women who were interviewed described their feelings of isolation, loneliness and frustration over not being able to express themselves or understand others.

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Therefore, they were often not able or willing to seek help since they felt unable to describe their situation. Those who attended ESL classes or tried to learn English, did not always have pleasant experiences.

It was hard. Actually I was kicked out of class one time because I couldn't keep up. ...And the lady said she was sorry but I wasn't keeping up with the class, and she was offering another student to come and help me but she had an accent too. And I said she isn't going to help me that much and I didn't take it so I just stayed home. (Ailsa)

Sixty to seventy per cent of my English I had to learn that in two weeks...(Hannah)

Ah, that was so bad. The first year in Canada was so bad because I couldn't talk. I couldn't understand. And I was bad in myself. When I couldn't speak English or couldn't understand.. And I remember every day I come home with a headache. (Kadine)

All these things together sometimes makes me upset. And of course, it doesn't help me to learn English. It's my big problem...the knowledge of English. (Franka)

Service providers talked about having to be resourceful and use whatever means necessary to achieve goals of communication. This included using interpreters, informal sign and body language, and drawings. One doctor explained that his staff received ongoing instructions about being patient with immigrant clients, taking time and not rushing patients/clients and encouraging and praising clients/patients when they expressed themselves. At the same time, service providers and doctors noted that their methods were not always satisfactory. For example, there were times when workers resorted to using family members as interpreters and this was not always appropriate. Sometimes they would have liked to have an interpreter but one was not always available.

### 5.5.2 Lack of Knowledge of Post Traumatic Stress Disorder and Not Reaching Out

One of the most difficult tasks of the researchers was reaching women who were willing to be interviewed. While the consensus among those who participated in the study was the need to have a forum where women could meet, share their stories and receive support from one another, not all women were ready to engage in this sharing. Many participants spoke about their concern around confidentiality, especially since the cultural/ethnic communities were quite small and they did not want to be "identified". For example, when asked about the most difficult aspect of seeking help, "Ailsa" answered:

Trusting. That's the biggest thing for me. I'm afraid you know, they are going to find out I am not well adjusted. Because they are going to take my kids away. And you know that...I am afraid because I don't know how things work here. That's my problem. (Ailsa)

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Because it was with the government, I was scared, you know. If they found out I am not feeling good, you know I am so scared. That's why I go to private now. Even if it costs money, you know. I feel more, more secure. (Ailsa)

Sometimes I want to have a friend, you know, talk to them and tell them about [my problems]. I feel like I don't trust anybody. (Kadine)

I got information, I started reading information...cause you don't trust, that's number one. What am I going to tell or what if they know...(Orlane)

Other women who agreed at one time to participate in the study, would later state that they were not ready or able to talk about their experiences. It was not always evident that these women had ever accessed any kind of service or support network. The location of mental health services and the stigma attached to accessing these services, seemed to discourage some women.

And I didn't feel like going there and then, they have it on the fourth floor. (Ailsa)

## 5.6 Issues of Aboriginal and First Nations Women

The research team interviewed two Aboriginal women as a first step towards exploring parallels among Aboriginal, First Nations Women and immigrant, refugee and other visible minority women. At this stage, because of the small number of women interviewed, the researchers are unable to make significant statements about parallels. One of the women who was interviewed spoke about the long history of abuse and addiction. She described experiencing many of the symptoms of Post Traumatic Stress Disorder. It was clear that her experience of trauma was part of a long history of multiple oppression. This woman felt that her experiences with counselors and social workers were good because they challenged her to make positive changes in her life.

While, the research team did not meet with many Aboriginal and First Nations women, they met with mental health professionals and service providers who talked about the fact that they were seeing large numbers of Aboriginal and First Nations women rather than immigrant and refugee women.

Probably the biggest trends and I am only thinking of the native population where we see this trend. It is a lifetime pattern of being subjected to oppression and pretty much all types of abuse, usually influenced by alcohol and drugs. Or both. As far as other people, we see a few of them, it's hard to see a pattern there. ( Dana, psychiatric nurse)

But with the post-traumatic stress , the kinds of things ...in my mind, if I put it in that category is we see so many young native girls that have been raped somewhere in their past. You know, whether they were six, or ten, or twelve or fifteen. ...it's always ...alcoholic abuse, it's depression, it is this, it's that. It's you name it and in our history...as we go through it, ...they have to be

prepared on day one to say to somebody as I am doing the intake, “yes, I was raped.” (Helen, psychiatric nurse)

These workers suggested that they were learning much about the issue of Post Traumatic Stress Disorder from their interaction with First Nations and Aboriginal women and suggested that this learning might be useful when addressing the issues of immigrant, refugee and other visible minority women.

## **6.0 ANALYSIS OF DATA**

### **6.1 Introduction**

This research has demonstrated that the experiences of Post Traumatic Stress Disorder among immigrant, refugee and visible minority women cannot be separated from their overall situation as immigrant and refugee women globally and within Saskatchewan.

The interviews showed the wide range of experiences and therefore diversity among immigrant and refugee women's experiences. There were stories of students, academic, professional and other women whose lives and careers were halted and changed in one split second by the sudden onslaught of war in countries of origin. There were stories of women who had been activists in their countries of origin and who had lived with fear and oppression over a sustained period of time. There were stories of ordinary women who lived in poverty all of their lives because of ongoing war and unrest in their countries of origin. There were accounts of how racism and discrimination had created devastating effects on the lives of immigrant and refugee women. There were stories of women who had lived in Canada for several years and who had never accessed help to deal with issues of trauma and who still seemed to have unresolved issues. And there were stories of violence and abuse that permeated so many of these stories.

While the experience of Post Traumatic Stress Disorder can be crippling, many immigrant, refugee and visible minority women attempted to function to the best of their abilities within their communities. While women talked about the extent to which their fears caused them to hide indoors or to avoid going out, they also suggested that they had to force themselves to continue with daily activities, often because of family responsibilities or their own will to survive.

The analysis will be explored under the following headings:

6.2 Language

6.3 Education and Awareness

6.4 Trauma and the experiences of settlement and integration

6.5 The problem of identifying and understanding the immigrant, refugee and visible minority woman.

6.6 Knowledge, understanding and intervention

## **6.2 Language**

The stories described the frustration of immigrating or fleeing to Saskatchewan and of not being able to communicate in order to have one's needs met. Language was one of the first barriers that women identified. Many of the women who were interviewed seemed to be frustrated and hampered at having to discuss with care givers a topic that evoked such extreme emotion in a language that was not their mother tongue.

Lack of comfort or ability with the language meant that women did not always access services and were unable to get the information they needed. As frustration with language grew, so did the feelings of isolation and the desire to return to their countries of origin.

## **6.3 Education and Awareness**

A total of twenty (20) women were interviewed during this research. A professional had diagnosed only five women with Post Traumatic Stress Disorder. All of the other women participated in the research because they self-identified based on the description of post-traumatic stress disorder given by the research team. This information had been given through posters, meetings and conversations with women and other individuals within the province.

As already mentioned, several of the participants in one location had been part of a workshop that had been presented by the provincial organization, Immigrant, Refugee and Visible Minority Women of Saskatchewan, Inc. This workshop seemed to have served as a tool for educating women about the topic of Post Traumatic Stress Disorder. The women who attended the workshop and who were interviewed for this study, spoke about the sense of relief they felt when they began to understand what they were going through.

Despite the fact that this workshop was useful in terms of building awareness, there is no evidence to suggest that women followed up with visits to the physicians. Therefore, none of the women seemed to have been "diagnosed" by a medical practitioner as a result of the session.

All of the women could identify situations of trauma, but it was not always clear whether they would have been diagnosed as sufferers of post-traumatic stress disorder. This dilemma supports the belief of a need to build bridges between immigrant and refugee women, immigrant and refugee women who are suffering from post-traumatic stress disorder, medical practitioners and other service providers. Many others had visited physicians who dealt with various kinds of symptoms but never seemed to have suggested that they might be suffering from Post Traumatic Stress Disorder. That is, none

of these women reported having been referred for mental health services. None of them said that they had been given information about Post Traumatic Stress Disorder by medical practitioners or service providers.

### **6.4 Trauma and the Experiences of Settlement and Integration**

When many immigrant and refugee women arrive in Saskatchewan, they bring with them much of the pain that caused them to leave countries of origin. Their experiences of trauma do not end on arrival in Canada because the experiences of settling and integrating can be equally traumatic. The stories of women's encounters with racism varied, depending on how they experienced the intersectionality of race, class and gender. Otherwise, the apparent lack of awareness or understanding of different cultures by "mainstream" Canadians, was a source of irritation for at least two women.

During the interviews with women, with service providers and doctors, the stories that were shared often dealt with the reality of leaving one country, coming to another and starting over. Repeatedly, there were accounts of the difficulties encountered in finding employment because out of country certification and experience were not recognized. Many women talked about starting over and how challenging (especially financially) this was for them. Most women spoke about having to adjust to climate, about missing family and especially extended family networks. They spoke about the culture shock, and not knowing or understanding the health or social systems. Most women stated that they knew that returning to their countries of origin was no part of their life plan and that life would not be better there.

Some were concerned with basic survival and providing for their family's needs. In other situations, women did not have the luxury of many years of education because of poverty and unrest in countries of origin. Women also spoke about the way in which political instability and war changed their lives overnight and cut short careers or education. Many found it difficult having to live with the loss of status, jobs and careers as a result of moving to Saskatchewan. All of the stories helped the research team to understand the diversity of needs among this population.

Several women spoke about the stigma attached to "mental health" and of how alien the notion of accessing mental health services was to them. These women did not always have the opportunity to meet in a safe place, share stories and begin to deal with the extreme emotions. Their lives became more caught up in the day to day reality of having to adapt to a new environment, often without the language skills and without the support of close family and community. Therefore, their experiences of Post Traumatic Stress Disorder become enmeshed in their struggles as immigrants or refugees trying to integrate/adapt to their new homeland. Professionals and other service providers were also aware of the stigma.

## **6.5 Identifying and Understanding the Immigrant and Refugee Woman**

As already mentioned, the research team had a challenging time identifying immigrant and refugee women who were willing to participate in this study. Some of the reluctance seemed to stem from the nature of the study. Many immigrant and refugee women were not aware or knowledgeable about Post Traumatic Stress Disorder. The terminology might not have been one that was familiar to many. Others did not want to relive the experiences or were not ready to do so (in one situation, one woman changed her mind when the researchers arrived and apologized about not being ready to speak). It may also have been that many women were not comfortable with being “researched” and “interviewed”, or were tired of being researched. Certainly issues of confidentiality would have played a role in their reluctance to participate.

What was not addressed during the interviews, was how physicians and service providers were defining “immigrant” women. This is not a new question. As already mentioned, one psychiatrist did not identify one of his clients as “immigrant”. This woman was extremely appreciative of the care she received from this psychiatrist but also noted that he had not immediately diagnosed her with Post Traumatic Stress Disorder. One would wonder whether the fact that she had lived in this country for very many years, meant that she was no longer an immigrant in his eyes. How then were other psychiatrists and service providers defining “immigrants”? If length of stay and comfort with language determined this, then those women who had been living in Canada for several years and who were more comfortable with the language might not have been identified as immigrants. As well, there might be an assumption that length of stay could be equated with integration. As such, psychiatrists and service providers might neglect to address unresolved issues related to the immigrant or refugee experience. In short, the experiences of immigrant and refugee women trying to settle in and and/or integrate, might be part of a continuum of oppression that contributes to experiences of post-traumatic stress disorder.

## **6.6 Knowledge, Understanding and Intervention**

Those psychiatrists and physicians who were interviewed were able to give very solid explanations and definitions of post-traumatic stress disorder. Therefore one might suggest that they may not be able to convert theoretical knowledge into recognition of the disorder in actual practice because of a number of factors. These include:

1. The difficulty in identifying who an immigrant and refugee person is;
2. The fact that they may not have built a sufficiently strong relationship with their clients to be able to know the background of the client;

3. The client might not have disclosed enough of their history to alert the psychiatrist of the potential for post-traumatic stress disorder;
4. Immigrant, refugee and visible minority women do not often/always access mental health or psychiatric services.
5. Lack of awareness among psychiatrists of the needs of immigrant and refugee women.

## 7.0 CONCLUSION

The research therefore makes a strong call for particular attention to the needs of immigrant and refugee women. There is clear evidence that immigrant, refugee and visible minority women experience symptoms of PTSD and the trauma experienced by these women was caused by external conditions not created by the women. It was also apparent that the women themselves were capable of identifying the cause of their health problems once they were given information about PTSD. The risk of further oppression and traumatization a) during immigration and settlement and b) by labeling PTSD as an illness rather than a normal response, were also identified. The women interviewed have clearly managed to survive and continue to provide for their families in spite of PTSD, because of their own resiliency.

Women identified the need for a variety of services and information. Few understood what PTSD. They experienced great relief once they knew it was a response they shared with many other women. All immigrant, refugee and visible minority women need to receive information about PTSD. The need for ready access to mental health and support services was identified. Many of the women spoke about wanting to have support programs such as drop-in groups where they could meet with other women of similar backgrounds. They also spoke about the difficulty in having themselves understood and of the need to have more language programs available to them. There were several instances where it was clear that immigrant and refugee women had inadequate information about their legal rights and about other services that were available to them.

When the research began, we were concerned that physicians, psychiatrists and other members of the medical and helping professions were not knowledgeable about Post Traumatic Stress Disorder. The conclusion of this research is that there appeared to be strong theoretical knowledge of Post Traumatic Stress Disorder among medical practitioners who were interviewed. However, this knowledge may not always be translated into practice, since physicians and psychiatrists may not be recognizing symptoms of Post Traumatic Stress Disorder among immigrant, refugee and visible minority women clients. Among those psychiatrists who were interviewed, there were those who had worked in other locations where they had direct experience working with immigrant and refugee women who suffered from this disorder. While these particular psychiatrists appeared to have a strong empathy and openness to working with the

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immigrant population, they were not usually able to do so since many immigrant and refugee women did not attend mental health services.

Other professionals such as psychologists and nurses (especially psychiatric nurses) also seemed to have an understanding and awareness of Post Traumatic Stress Disorder. However, few could actually speak of having much direct experience working with immigrant and refugee women. Other service providers especially those in community based organizations suggested that they would like to have more training/education around the issue of Post Traumatic Stress Disorder and about intervention skills and strategies. All of the service providers and professionals spoke about the need for increased understanding and training around the issues and needs of immigrant and refugee women. They spoke about needing to have choices around referral and support services.

A common theme among all professionals within the mental health field and service providers within community based organizations was the need to build/enhance relationships with immigrant and refugee women and to address the stigma attached to accessing mental health services. As well, they spoke about the need to build awareness of the availability of services. Several individuals spoke about needing to be more creative with how services are delivered and about the need to explore doing more home visits, outreach and decentralized programming, based in more welcoming and accessible locations. That is, professionals talked about the possibility of taking services out to the community.

Overall, the research described the experiences of immigrant, refugee and visible minority women living in Saskatchewan who self-identified as suffering from PTSD. The research concluded that those medical practitioners and service provider who were interviewed had minimal experience working with immigrant and refugee women suffering from PTSD and living in Saskatchewan. The research also described some of the barriers facing these women. These include language barriers, lack of knowledge among immigrant and refugee women about PTSD, lack of understanding and awareness of the experiences and needs of immigrant, refugee and visible minority women on the part of professionals, and the stigma attached to accessing mental health services. We believe that the recommendations made respond to the concerns and needs expressed by the women as well as medical practitioners and other service providers who were interviewed.

Finally, and perhaps most importantly we found, as did Judith Herman that

*The traumatized person is often relieved simply to learn the true name of her condition. By ascertaining her diagnosis, she begins the process of mastery. No longer imprisoned in the wordlessness of the trauma, she discovers that there is a language for her experience. She discovers that she is not alone, others have suffered in similar ways. She discovers further that she is not crazy; the traumatic syndromes are normal human responses to extreme circumstances. And she discovers, finally, that she in*

*not doomed to suffer this condition indefinitely; she can expect to recover, as others have recovered.* (Herman, 1996, p 158.)

While the research describes much of the pain of these women, it also identifies the strength and resilience of immigrant, refugee and visible minority women who continue to play significant parenting/nurturing and breadwinning roles in spite of their experiences.

## **8.0 RECOMMENDATIONS**

Based on this research, the research team recommends that this research be used as a basis for helping medical practitioners, mental health workers and other service providers improve services to immigrants and refugees who are victims of Post Traumatic Stress Disorder. The following specific recommendations are made.

### **8.1 Policy Change**

1. That policy-makers use this research to build awareness of Post Traumatic Stress Disorder by ensuring that training about the issues of Post Traumatic Stress Disorder be integrated into all programs aimed at serving the needs of immigrant, refugee and visible minority women.
2. That Saskatchewan Health, Health Districts and Mental Health service organizations develop policies of commitment to enhance the recognition and treatment of PTSD by health care workers.
3. That admission forms used by physicians, hospitals and mental health clinics be amended to include a section requesting information about experience with traumatic events.
4. That this research form the basis for developing a mechanism for involvement of immigrant, refugee and visible minority women in the development of policies related to Post Traumatic Stress Disorder.
5. That Saskatchewan Health, Health Districts and Mental Health service organizations develop policies of commitment to enhance access and utilization of mental health services by immigrant, refugee and visible minority women and the recognition and treatment of PTSD by health care workers. Ensuring that there be adequate funding to community based and government agencies, to provide outreach and education awareness programs to immigrant, refugee and visible minority women, could help to achieve this.

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6. That Health Canada provide support to research and health promotion to address issues of Post Traumatic Stress Disorder and that they move beyond torture to recognize the diversity of experiences of Post Traumatic Stress Disorder among immigrant and refugee women.
7. That Immigration Canada play a role in ensuring that refugees receive recognition of, referral and treatment for Post Traumatic Stress Disorder.
8. That policy-makers and decision-makers explore the possibility of providing more community-based programming for immigrant, refugee and visible minority women in all locations, particularly smaller communities. This could be delivered through existing organizations that may be providing services to this population.
9. That adequate funding of medical and nursing education be encouraged to enhance information about Post Traumatic Stress and practical experience with immigrant service organizations.
10. That those agencies and organizations serving the needs of immigrant and refugee women continue to explore developing workshops and educational programs that would build and enhance knowledge and awareness of the issue of post-traumatic stress disorder as it affects immigrant and refugee women.
11. That partnerships be developed with psychiatrists, psychologists and physicians, who have particular knowledge and expertise working with immigrant and refugee people so that these individuals can be used as resources to develop and deliver educational and awareness programs.
12. That policy-makers continue to build awareness of post-traumatic stress disorder by ensuring that training about the issues of post-traumatic stress disorder be integrated into all programs aimed at serving the needs of immigrant and refugee women.
13. That helping professionals recognize that children of refugees experience symptoms of Post Traumatic Stress Disorder (e.g. nightmares, fears) and develop specific programs to meet the needs of these children.

## 8.2 Language

14. That adequate funding be allocated for English as a Second Language (ESL) programs since language was identified as a key to integration.
15. That adequate funding be made available for programs to be able provide levels of language training and length of programming that would reflect the diversity of needs.

### **8.3 Other Barriers**

16. That those agencies and organizations serving the needs of immigrant, refugee and visible minority women begin/continue to integrate anti-racist strategies into all programming and that particular attention be paid to how the intersectionality of race, class and gender manifests itself among this very diverse population.

### **8.4 Further Research**

17. That organizations and agencies serving the needs of immigrant and refugee women build partnerships with First Nations and other Aboriginal women's organizations to explore further research about the parallel issues of post-traumatic disorder within their communities.
18. That Immigrant, Refugee and Visible Minority Women of Saskatchewan pursue a program of related research, including the examination of Post Traumatic Stress Disorder among immigrant children, elderly and lesbians.

### **8.5 Community Action**

19. That organizations serving the needs of immigrant, refugee and visible minority women develop partnerships and take the lead in stimulating policy change by meeting with :
  - Policy makers to ensure development of prototype policies to meet the needs of this population;
  - Health agencies to identify changes needed in intake forms;
  - Saskatchewan Health, Health Districts and Mental Health service organizations to develop policies of commitment to enhance a) access and utilization of mental health services by immigrant, refugee and visible minority women and b) the recognition and treatment of PTSD by health workers.;
  - Policy-makers and decision-makers to communicate the need for more community-based programming in all locations, particularly smaller communities.
  - Primary Canadian publishers of medical and nursing textbooks to lobby them to request inclusion of expanded content related to immigrants and PTSD by authors who write regularly for them;
  - Deans of the Colleges of Medicine, Nursing, and Education, University of Saskatchewan and the Deans of Education and Social Work, University of Regina to facilitate curriculum enhancements;
  - Psychiatrists, psychologists and physicians who have particular knowledge and expertise with immigrants and refugees to develop partnerships;

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- The Association of ESL Instructors to develop an action plan for expanding the scope and availability of ESL instruction.

## Glossary of Terms

**Attention Deficit Hyperactive Disorder (ADHD)** - sometimes referred to as **Attention Deficit Disorder (ADD) or ADD/ADHD:**

A clinical diagnosis applied to children and adults who consistently display certain characteristic behaviors excessively which create a real handicap in the person's life, beginning before age seven and persisting over a long period of time. These characteristics include:

- Poor ability to sustain attention to tasks
- Impaired ability to control impulses and delay gratification,
- Excessive activity and physical restlessness.

*(DSM-IV Diagnostic and Statistical Manual  
of the American Psychiatric Association)*

**Class:**

Hierarchical ranking of society into groups. Some people are from the privileged class while others fit into other levels with people who have similar status.

**Culture:**

A common system of values, behaviors, beliefs and relationships which create a sense of community among individuals. These have developed in response to historical, political, economic and social realities.

**Disorder:**

A condition in which there is a disruption in normal thought processes.

*(Diagnostic and Statistical Manual of Mental Disorders,  
3<sup>rd</sup> Edition. Washington, D.C.: American Psychiatric Association)*

**Ethnicity:**

The political and social construct used by individuals and communities to define themselves and others. It implies the consciousness of having a shared history, nationality, language, religion, or life-experience based on such factors.

*(The Canadian Association of Schools of Social Work:  
Anti Racist Training and Materials Project Resource Inventory)*

**Immigrant:**

A **Landed immigrant** is a person who seeks lawful admission to establish permanent residence in Canada.

*(Immigration Act [2])*

**Landed** status may be acquired if an applicant's sponsor is willing and eligible to sponsor the applicant and the applicant is a member of the "family class".

*(Immigration Regulations)*

**Mid-size urban centre:**

Cities smaller than the major ones for the particular province. In Saskatchewan, this refers to cities smaller than Saskatoon and Regina.

*(Lamba, Mulder & Wilkinson's and Task Force on Mental Health Issues Affecting Immigrants and Refugees' definitions)*

**Neuroendocrine system:**

Endocrine system in which chemical messengers (hormones) are released by neurosecretory neurons, specifically the hypothalamus and pituitary glands, through the circulation system, to other body cells. Often involved in stress reactions. (e.g. [www.animal-info.net/gloss\\_eng/definitions.html](http://www.animal-info.net/gloss_eng/definitions.html) )

**Psychophysiology:**

Refers to the branch of physiology (science that deals with living organism) dealing with mental phenomena.

**Refugee:**

An involuntary immigrant. Any person who by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion,

- a) is outside the country of the person's nationality and is unable or, by reason of that fear, is unwilling to avail himself of the protection of that country, or
- b) not having a country of nationality, is outside the country of the person's former habitual residence and is unable or, by reason of that fear, is unwilling to return to that country, and

*(United Nations 1951 Convention, and its 1967 Protocol)*

**Stress:**

The process of adjusting to circumstances that disrupt, or threaten to disrupt, a persons equilibrium.

*(Bolander, V.R. (1994). Sorensen and Luckman's Basic Nursing, 3<sup>rd</sup> Edition. Toronto: W.B. Saunders)*

**Sympathetic nervous system:**

Part of the autonomic nervous system that consists of nerves that supply the internal organs, blood vessels and glands and balance the action of the parasympathetic nervous system (associated more with calmness and rest than with alertness).

*(Canadian Oxford Dictionary, 1998)*

**Trauma:**

An emotional or psychological shock that may produce disordered feelings or behavior.

*(Tabers Cyclopedic Medical Dictionary, 2001, 19<sup>th</sup> Edition. D. Venes, Ed. Philadelphia: F.A. Davies)*

**Visible minority:**

Persons of color who are visibly different from the dominant group and who are non-white or non-Caucasian in race. The term is also used to define persons who are, because of their race or colour, a visible minority in Canada. Racial minorities include the following groups: Black, South Asian, Chinese, Korean, Japanese, Southeast Asian, Filipino or other Pacific Islander, Arab or West Asian, Latin American.

*(Women in the Labour Market (1993), Ontario Women's Directorate)*

Within the immigrant, refugee and visible minority community, this term is used to distinguish persons who, by ancestry, belong to a visible minority but who were born in Canada.

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## **Appendix A: The Teams**

### **Members of the Research Team**

Lead Researcher	Judy White MSW Social Work, University of Regina
Operations Consultant	Sherrie Tutt M.Ed. RN, Science Department , Saskatchewan Indian Federated College
Research Assistants	Darlene Rude New Horizons First Nations Administration, Nekaneet First Nation Betty Mutwiri African Women's Circle
Administrative Assistant	Oudalay Senevonghachack

### **Members of the Participatory Action Team**

Coordinator	Erika Cancino, Immigrant, Refugee & Visible Minority Women of Saskatchewan
Core Members	Bula Ghosh, Immigrant, Refugee & Visible Minority Women of Saskatchewan Cypress Hills Community College  Nayyar Javed Immigrant Women of Saskatchewan, Saskatoon Chapter Mental Health Clinic of Saskatoon  Bozana Cosic Immigrant Women of Saskatchewan, Regina Chapter  Anna Mambo Immigrant, Refugee & Visible Minority Women of Saskatchewan  Tharadevi Maharaj Immigrant, Refugee and Visible Minority Women of Moose Jaw  Judy White, Immigrant Women of Saskatchewan, Saskatoon Sherrie Tutt, Saskatchewan Indian Federated College
Contributing Members	Debbie Mpofo, IWS Saskatoon Joyce Still, SIFC Science Patience Elabor-Idemudia, University of Saskatchewan Anne Moola, International Women, Swift Current Ila Sarkar, Immigrant Women of Saskatchewan, Saskatoon Chapter

**Pictures of The Team in Action**



## Example of a Typical Meeting of the Participatory Action Team

Minutes of the PAR Team Meeting held Nov. 4, 2000 at SGEU

In attendance:

Bula Ghosh, Erika Cancino, Judy White, Anne Moola, Anna Mambo, Sherrie Tutt (chair, recorder), Darlene Rude, Betty Mutwiri

Absent: Nayyar Javed, Bozano Cosic, Ila Sarkar, Tharadevi Maharaj

1. Members of the Research Team were welcomed. Bula expressed the pleasure of the Team to see things moving forward.

2. PTSD Brochure -

There was a general discussion of the intended purpose of the brochure. Information may be obtained through the research that should be included. The consensus was that, if Nayyar has not already done the brochure, it should be considered a product of the research to be completed at the end of the project.

**Action:** Judy White will check with Nayyar

3. Focus groups

a) Dates: Focus groups will be conducted in January.

Anne advised that one of the psychiatrists in Swift Current will be away in January.

**Action:** Anne Moola will find out the exact dates the psychiatrist will be away and advise Judy.

a) Facilitators: Judy will conduct all focus groups.

**Action** Research Assistants will arrange focus groups and interviews as follows.

Betty - Saskatoon, Yorkton, Prince Albert

Darlene - Regina, Swift Current and Moose Jaw

a) Billets - Budget was revised to include accommodations.

No billets will need to be arranged.

Hotel accommodations will be needed as follows

Swift Current - NONE

Yorkton- Accommodations for Betty only

Regina and Moose Jaw - None needed

Prince Albert - Accommodation needed for Betty only.

4. Potential Participants

Mental Health Clinics in Saskatoon and Regina have committed to assisting in participant identification.

Process: A discussion was held regarding the process of obtaining and contacting potential participants.

1. It was decided that participant information (name, address, phone, E-mail address) should be sent to Judy who will then contact participants.

**Action: All** members will:

- a) Find out how the participant prefers to be contacted - (phone, mail or other means).
  - b) Find out the language the participant prefers be used for the interview.
  - c) Forward this information PLUS the person's name, address and phone number to Judy.
5. Revised Schedule:  
The revised Critical Pathway was reviewed briefly.
- a) Data will primarily be collected during January.
  - b) Targeted completion date is July 1.
6. Communication
- a) Periodically updates will be placed in the News link of the new IRVM Web Site <http://go.to/irvm>. Team members are encouraged to keep up by reading these reports. The first will be entered in late December.
  - b) Judy will circulate information via E-Mail to all Team Members who have E-mail. Otherwise, hardcopy will be faxed or mailed by the Admin Support Officer.
  - c) A meeting will be held during the summer to review the report before it is finalized.

Otherwise, it was decided that meetings would only be called if an issue arose that needs Team discussion.

7. Interpreters

Darlene and Erika will develop training for interpreters with input from Judy and Betty.

The following languages were identified as potentially requiring interpretation.

Serbian, Albanian, Croation  
Ukrainian  
French, Erethrian, Somali, Swahili  
Persian  
Spanish  
Vietnamese.

**Action: All PAR Team Members**

Send names of potential interpreters to Darlene and Erika

## **Appendix B: Examples of Traumatic Events**

1. assault
2. military combat
3. floods
4. earthquakes
5. car accidents with serious physical injury
6. airplane crashes
7. large fires
8. bombing
9. torture
10. death camps
11. other disasters
12. threat to one's life or physical integrity threat
13. harm to one's children spouse or other close relatives
14. threat to one's life or physical integrity
15. serious threat or harm to one's children, spouse
16. serious threat or harm to relatives and friends
17. sudden destruction of one's home or community
18. seeing another person seriously killed or injured as a result of violence or accident
19. learning about a serious threat or harm to a close friend or relative.
20. exposure to war and political violence that is massive in scale, repeated, prolonged and unpredictable.
21. witnessing violence towards caregiver.

## **Appendix C: Research Questions**

1. What were the traumatic events experienced by immigrant, refugee and visible minority (IRVM) women over the age of 18 living in Saskatchewan?
2. What was life like for IRVM women prior to the traumatic event?
3. What health problems have been experienced across the life span by IRVM women who have experienced PTSD?
4. How have IRVM Women perceived their experiences prior to being made aware of Post Traumatic Stress Syndrome (PTSD)?
5. What kind of help has been received by IRVM women to assist them in dealing with PTSD? What category of professional provided help? What was the result?
6. What barriers have been experienced by IRVM women in seeking help for PTSD?
7. What is the knowledge level of professional caregivers with respect to Post Traumatic Stress Disorder?

## **Appendix D:**

### **Questionnaires Used as Interview Guides**

#### **Questionnaire for women who have experience traumatic stress**

1. Briefly state the nature of the traumatic event or events you experienced. What was your approximate age when it occurred?
2. Describe yourself, your life and health prior to the event.
3. Describe yourself, your life and health since the event
4. Have you ever sought help for health problems since the event? If so, what were the problems? Whose help did you seek? What help was provided? What was the result?
5. When did you first learn about Post Traumatic Stress Disorder? What did you think about your situation before you learned about this disorder?

#### **Questionnaire for non-physician mental health professionals**

1. What is the nature of your profession?
2. Tell us what you can about Post Traumatic Stress Disorder. What is it? What are its causes and effects?
3. What are some of the traumatic events described to you by women who have come to you for help?
4. Describe some of the problems for which these women seek help.
5. How would you describe their mental, emotional, physical, spiritual and social health?
6. What has been the nature of the help you provided? What has been the outcome.

#### **Questionnaire for physicians**

1. Tell me what you can about Post Traumatic Stress Disorder.
2. What is it?
3. What causes it?
4. How would you diagnose it?
5. What is the prognosis? What factors influence prognosis?
6. How have you treated it? What has been the outcome?
7. Briefly describe cases you have treated.