Communicating Disability- Exploring the experience of immigrant women through art
by
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Abstract

Through the utilization of art-journaling, this participatory arts-based inquiry was completed with a small group of immigrant women with the intention of creating knowledge around the experience of communicating about disability. A focus on collaboration and sharing stories led to the emergence of a number of themes. These themes highlighted many of the barriers faced by immigrant women living with disabilities in accessing adequate medical care and social services. In addition to the identified barriers, this research highlighted the incredible strength and resilience of the participants through each stage of the research process. The findings point to a need for systemic changes, which were highlighted by art works, discussions, and recommendations of the participants in the study.
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There is no question that women living with disabilities confront multiple structural, attitudinal, and informational barriers in accessing medical care (Gibson & Mykitiuk, 2012). Immigrant and refugee women are faced with even greater obstacles in accessing services given the economically driven immigration system in Canada which Dossa (2005) described as both sexist and racist. The complexity of disability and the inherent marginalization of immigrant and refugee women are such that traditional methods of communication within a medical environment are often ineffective in creating a thorough understanding of the patient’s experience and new strategies to understand disability must be encouraged (Ten Have & Bilj, 1999). This is not to suggest that we must engage with the public discourse of “disability as tragedy” (Dossa, 2008). In fact, the aim of this research is contrary to that notion. Health care and disability service providers have an opportunity to respond to barriers faced by their clients in a meaningful way. Through acknowledging their clients as the expert in their own social location, i.e., a racialized woman living with a disability, providers can begin to deconstruct marginalization and provide a better approach to service. This decentralization of power and meaningful opening up of dialogue enables a sense of empowerment for the patient or client.

It is impossible for social service providers or medical practitioners to adequately meet the needs of marginalized populations without first understanding the experience, strengths, and limitations of those they are seeking to serve. Canada welcomes over 200,000 immigrants per year, at least 10% of who are refugees (Province of British Columbia, 2014). Statistics Canada (2013) reported that in 2012 over 3.5 million Canadians were living with some form of disability that restricts aspects of their daily living. The Canadian Immigration Act includes a clause that has been highly criticized by
disability advocates as being discriminatory, which states an applicant for Permanent Residence in Canada must undergo a medical exam to determine if they would or might reasonably be expected to cause excessive demands on health or social services (Larios, 2013). Refugee claimants are both exempt from the requirement to undergo a medical examination and are more likely to experience disability (Larios, 2013). Moreover, because disability is more likely to occur later in life it is reasonable to determine that, of the over 200,000 immigrants welcomed to Canada each year, many will experience some form of disability at some point in their life (Statistics Canada, 2013).

This participatory arts-based inquiry explores the experiences of communicating about disability for immigrant and refugee women in order to compile meaningful data surrounding the intersection of marginalization faced by these women. The aim of this study is to draw from and contribute to the subfield of disability communication (Aulagnier, Verger, Ravaud, Souville, Lussault, Garnier, & Paraponaris, 2005; Post, Cegala, & Miser, 2002; Yorkston, Johnson, Beoflug, Skala, & Amtmann, 2009) as well as interdisciplinary studies relating to women’s disability and access to medical care (Dias, Gama, & Rocha, 2010; Dossa, 2008; Gibson & Mykitiuk, 2012) with a focus on immigrant and refugee disability and access to medical care (Fennely, 2006; Grieger, 2001; Panos & Panos, 2000; Michaelsen et al., 2004; Suurmond & Seelemen, 2006, TenHave & Bijl, 1999). However, because research in this area has primarily been quantitative in nature (Dias, Gama, & Rocha, 2010), it commonly focuses on the perspective of the practitioner and not the client or patient (Fennelly, 2006; Grieger, 2001; Michaelsen et al., 2004), or it does not address the unique challenges faced by immigrant patients (Aulagnier, et al., 2005; Post, Cegala, & Miser, 2002; Yorkston et al,
2009). For this reason, I intentionally chose to focus on compiling data that highlighted the voices of immigrant women living with disabilities. An exploration of the intersection between race/culture, gender, and disability, through a lived experience perspective, serves to enrich the field of disability studies and provide a cultural lens to highlight how disability is currently viewed as a “dimension of normal difference” (Atkin & Hussain 2003). Thus providing a more thorough analysis that highlights the complexities of these intersectionalities and the importance of understanding how they impact the experience of the individual or patient.

This research was my own concerns about the effects of restrictive disability and immigration legislation, increasingly limited funding for social service organizations, and the negative impact on the individuals they serve. In my work as a disability advocate, I have observed how these concerns have a particularly detrimental effect on immigrants and refugees living with disabilities, an observation which was echoed by Dossa (2005) and is evident in the explanations of the participants in this project. That said the women in this project have demonstrated considerable strength and resilience in the face of significant systemic barriers they experience simply by the nature of their social position. I believe in the responsibility of government and society to ensure the well-being of every citizen and that through education, empowerment, and legislative changes, justice and equality can be achieved. Therefore, this research was guided by my belief that empowerment and genuine representation of the participants’ experiences can create knowledge that leads to social change with a larger collective goal of social justice.

**Literature Review**
Immigrant and refugee women living with disabilities are faced with a unique set of challenges in negotiating their identities within the aforementioned multiple cultural and social locations, i.e., a woman, an individual with a disability, and an immigrant or racialized woman. This is an intersection of what Dossa (2008) emphasized were of the lowest status in the hierarchy of individuals with disabilities. She explained that, because of their status as both a woman and a racialized woman, the resulting assumption is that the individual is “non-contributing” and should not be in Canada in the first place, regardless of their immigration status (p. 2535). Dossa (2005) explored the intersectionality of these various social locations and the significance of this demographic being ‘othered’ in either of their social location, thus contributing to further marginalization, but also allowing an opportunity for development of a body of knowledge where the social and cultural combine. Before this greater analysis can occur it is important to first explore the concept of disability as it relates to this study.

Disability

It is necessary to understand the notion of disability and the role it plays in the marginalization of individuals in Western society. It is generally accepted by disability scholars that the concept of disability is socially constructed through a normalized philosophy of what it means to be human (Dossa, 2005). The resulting power relations which serve to marginalize those who do not meet these social constructs is the cause of inequality, marginalization, and the determination of self location (Dossa, 2005; Goggin, 2009). As a result, one of the primary focuses of the disability movement is to engage members of the disability community to speak out and normalize the conversation in an effort to dissolve the existing power dynamic between the able-bodied and non-able-
Therefore, one of the primary considerations in understanding the experience of individuals with a disability is the act of listening. Not only does the act of listening deconstruct the flawed social construct of what it means to be normal, it is essential in providing disability related services (Goggin, 2009). It is widely accepted that proper treatment of chronic pain or disability, and positive health outcomes depend on effective communication between the health care professional and patient; or the ability to listen across difference (Dreher, 2009 as cited in Goggin 2009; Post, Cegala & Miser, 2002; Yorkston et al., 2010). Regrettably, individuals living with disabilities can lack the ability to effectively communicate their experience to physicians (Post et al., 2002), and health care professionals lack the skills to genuinely listen to individuals living with disabilities (Goggin, 2009). While effective communication on the part of a patient or client may assist in ensuring greater outcomes in health care or social services, it is both problematic and unrealistic to imply that the onus rests solely with that patient (Post et al., 2002). Aulagnier, Vergner, Ravaud, Souville, Lussault, Garnier, and Paraponaris (2005) asserted that there is an inherent bias present for many doctors, resulting in doctors treating their patients with disabilities with discomfort or even hostility. Similar allegations are echoed throughout disability research, particularly when cultural differences are present (Geiger, 2001; Goggin, 2009; Michaelson, Kransik, Nielsen, Norredam & Torres, 2004; Scheppers, Van Dongen, Dekker, Geertzen, Dekker, 2006). This points to the necessity of additional training in effective listening and communication for any practitioner providing medical or social services to individuals living with disabilities with the aim of a “genuine understanding of what listening to
people with disabilities necessitates” (Goggin, 2009 p. 491).

Political structure, complex and restrictive legislation, and a lack of resources further perpetuates existing challenges with communication in disability services. This is evidenced by individuals living with disabilities being tasked with completing complex and lengthy applications for services or benefits related to their disability which force them to attempt to describe their disability in the terms of an able-bodied medical professional (BC Coalition of People with Disabilities, 2007; Panos & Panos, 2000; Yorkston et al., 2010). For example, in order to qualify for provincial disability benefits in the province of British Columbia, applicants must first apply for income assistance and then complete a 23 page application which forces the doctor to describe the individual’s disability in terms of their restrictions in completing activities of daily living (BC Coalition of People with Disabilities, 2007), information which is virtually impossible for a physician to know without effective communication with the patient. This, in conjunction with the restrictive nature of disability legislation, results in an alarmingly high denial rate of disability benefits and contributes to growing poverty or further marginalization of individuals with disabilities in British Columbia (BC Coalition of People With Disabilities, 2007).

**Immigrant and Refugee Women**

The traditional approach to disability services is especially problematic for immigrant and refugees, or racialized women, who are also dealing with the barriers of “displacement, migration, resettlement and social inclusion” (Dossa, 2008) while navigating their inherently marginalized social position. In addition, obstacles such as language, cultural differences, level of acculturation, varying approaches to medical care,
communication style, religion/spirituality, and family involvement (Panos & Panos, 2000; Scheppers, et al., 2005) further inhibit communication and are particularly problematic for both women and new immigrants who are more likely to live in poverty or social isolation (AMMSA, 2013; Dias, Gama, & Roacha, 2010). There is a direct relationship between the prevalence of poverty in new immigrant populations and hidden homelessness resulting in health concerns and disability (AMMSA, 2013). These additional barriers faced by racialized women means they are more likely to fall through the cracks of social and medical services or choose not to access service at all (Ten-Have & Bilj, 1999), resulting in an already marginalized segment of society becoming more vulnerable (Geiger, 2001). Therefore, the complexity of disability and the inherent inequality faced by immigrant and refugee women are such that traditional methods of communication within a medical environment are further complicated and often ineffective in creating a thorough understanding of the patient’s experience (Ten Have & Bilj, 1999).

Like the aforementioned disability legislation in British Columbia, legislation surrounding entitlement and rights for immigrant and refugee women is similarly restrictive and problematic. For example, eligibility requirements for disability benefits in the province of British Columbia are extremely limiting, particularly for newcomers to Canada. In short, before a newcomer can even attempt to complete the 23 page Persons with Disabilities application they must meet the citizenship requirements for benefits (Ministry of Social Development and Social Innovation, 2014). This means they must be a Canadian Citizen, a permanent resident, a convention refugee, a temporary resident under the Immigrant and Refugee Protection Act, in the process of having a refugee claim
determined, or subject to a removal order that cannot be executed (Ministry of Social Development and Social Innovation, 2014). Similarly, one cannot access the Medical Services Plan in British Columbia unless they can prove residency and citizenship status.

The restrictions on these services and supports leaves individuals without status, such as those on a temporary resident permit, or those who have had their refugee application rejected, extremely vulnerable (West Coast Leaf, 2012). Of those who do not have status in Canada there is particular concern for individuals who have been sponsored by a spouse but whose permanent residence status has not gone through; this group, which is more commonly comprised of women, has been shown to be considerably more vulnerable than those who have status in Canada (West Coast Leaf, 2012). These individuals without status are solely dependent on their sponsor, both financially and to maintain their precarious immigration status in Canada, thus creating an unhealthy power dynamic which leads to high incidents of abuse (West Coast Leaf, 2012). These unhealthy, predatory living environments are further complicated by a significant lack of organization in place to support the needs of women and children leaving an abusive sponsorship relationship in Canada (Larios, 2013). For example, a single mother leaving an abusive sponsorship relationship is unable to apply for social assistance while awaiting an application for permanent residence on compassionate grounds unless her children are Canadian citizens (West Coast Leaf, 2012).

This considerable lack of access to services is further evident when exploring the needs of refugee claimants in Canada. The Immigration and Refugee Protection Act was passed in Canada in 2002 and implemented a strategy to address the requests of those most in need first (Larios, 2013). This means that refugees to Canada are no longer
considered based on their ability to integrate, like other potential immigrants, and results in refugees facing multiple barriers to settlement such as low literacy, considerable mental or physical health concerns, and trauma (Larios, 2013). While there is no doubt that this change in legislation was positive on humanitarian terms, what is problematic is that the provision of services has not been changed to meet the additional needs of this new demographic of refugees (Larios, 2013). These already vulnerable refugees are faced with additional barriers such as cuts to refugee health care, long delays in family reunification, and limited access to legal representation (Canadian Council for Refugees, 2012).

It is evident that the legislation and policy surrounding the rights of immigrants and refugees in Canada fails to consider the complexities of these individuals’ lives and, as a result, does not adequately meet their needs. In addition to the discussed challenges in communication, problematic legislation, and access to services, the discourse surrounding racialized women is problematic in itself. For example, the label of immigrant or refugee is more readily applied to women who are of a visible minority regardless of their immigration status (Dossa, 2008). This label can result in exclusion from services more readily available than those who appear to be of the dominant culture; an example of white privilege (Dossa, 2008).

The Intersection of Disability and Immigration

It is impossible to explore the intersection of racialized women and disability without also understanding the correlation of poverty inherent within these social locations. New immigrants to Canada are three times more likely to live in poverty than those born in Canada (AMSSA, 2013), and individuals with disabilities are far more
likely to live in poverty than those without (Council of Canadians with Disabilities, 2014). British Columbia, the province in which this research was conducted, has the highest poverty rate in Canada (AMMSA, 2013). Statistics Canada (2013) classifies families and individuals as living below the poverty line when they spend 20% or more than the average of their after-tax income on food, shelter and clothing. This definition of poverty fails to account for disability-related expenses for medications, services, mobility aids, assistive technologies and other disability-specific costs (Council of Canadians with Disabilities, 2014). Unfortunately, the intersection of disability and being a racialized woman often results in a greater risk of extreme poverty. For example, a single mother with two children on disability benefits in British Columbia would be entitled to just $1454.56 per month for rent, bills, food and all other expenses (Ministry of Social Development and Social Innovation, 2014). This level of poverty, particularly for immigrants and refugees who are inherently more vulnerable, results in an increased risk to health, danger of homelessness, and considerable risk to children who statistically experience lower education and literacy rates as a result of living in poverty (AMMSA, 2013; Baker Collins, 2005; Fennelly, 2006; Larios, 2013; Scheppers et al., 2006; Ten Have & Bijl, 1999).

Both the disability movement and the civil rights movement have progressed with the same goal of seeking equality and social justice; the disability movement by the normalization of individual bodies through the rejection of the medicalization of disability and the civil rights movement through an emphasis on combating oppression on the basis of race (Dossa, 2005). In other words, a larger goal of increasing awareness and inspiring social change through empowerment and giving voice to an inherently
marginalized population, exists in both of these movements and in this research. The process of social change is not possible without the unique perspective and significant involvement of those it is seeking to impact; voices that are often silent in research.

Method

Given the aim of empowerment and giving participants an opportunity to give voice to their own experiences, the research goal was to ensure that the project was participatory, collaborative, emergent, and artistic in nature - making the research process equally as important as the findings (Foster, 2007).

Participatory Action Research (PAR) exists in the professional and academic sphere in a variety of forms and is distinctive for its involvement of participants as well as the constructive and pragmatic nature of the research. Both PAR and arts-based methods aim to allow individuals to develop a deeper understanding of issues that directly effect them, build communities, and serve as a catalyst for social change (Finley, 2008; Hanson & Hanson, 2010; Reitsma-Street & Brown, 2001). The cyclical format of PAR allows the researcher and participants to work together through identifying needs, planning and implementation, observation, completion, and re-evaluation in order to ensure desired outcomes are met (Baker-Collin, 2005; Huesca, 2002; Reitsma-Street & Brown, 2001). Participatory research allows “practitioners [to] attempt to close the distance between ... researcher and researched to enter into a co-learning relationship guided by action and reflection” (Huesca, 2002) and “provide a view from below” (Collins, 2005), creating an environment conducive to research that is transferable, pragmatic, leads to change or action, and empowers the participants.
The use of art-based research in PAR provides an opportunity to increase awareness of current relations of power to further deconstruct the inherent power dynamic in traditional forms of research in order to accurately represent the experience of participants; thus, creating accessible data for social change (Clover, 2011; Finley, 2008; Foster, 2007 Leavy, 2009). Furthering the constructive setting created through PAR, arts-based inquiry creates an environment with “therapeutic, restorative, and empowering qualities” (Leavy, 2009, p.9), which aids in further unlocking the real voice of participants. However, the goal of arts-based techniques is not simply to produce art for the therapeutic qualities but to engage in critical investigation of the response to the art (Clover, 2011; Finely, 2003). The result is the decolonization of the research process and the movement of research into a radical realm of data representation: a catalyst for social change (Finley, 2003).

While I am woman with a disability who has worked as an anti-poverty and disability advocate for years, I cannot dispute that my life has been lived with considerable privilege and despite my efforts to democratize the research process there is an inherent power dynamic between the researcher and subject which may have contributed to some initial challenges in participant recruitment (Hanson & Hanson, 2010). When I began to recruit participants for this project I aimed to recruit women who had not accessed services at the agency I worked for and to rely on my professional networks with other community agencies for recruitment. Unfortunately, this was not realistic given the size of the community I live in and limited services available to individuals in the demographic I was seeking to access. More importantly, women who were not clients of this agency were not familiar with me as an ally. Ultimately, the
women who chose to participate in the project were women who had accessed the
services of the agency where I am employed or had a relationship with someone who had.
This demonstrated the importance of trust between me and participants from the onset of
the research.

The project began with three participants although only two of the women
continued throughout the whole project. Each participant was a single mother of multiple
children and was a recipient of income assistance. Each woman was a visible minority
whose first language was something other than English and had been in Canada for three
years or less. None of the women were from the same country of origin. Interestingly,
although each woman lived with multiple disabilities and met the legislated citizenship
requirements, not one of the women was a recipient of provincial disability benefits.

Five workshops were held at a local settlement agency using art journaling
techniques from a variety of sources including: *Journal to the Self* by Kathleen Adams
(1990) and *Raw Art Journaling* by Quinn McDonald (2011). I both facilitated and
participated fully in each workshop in an effort to mitigate the power dynamic and
encourage reflexive dialogue. The use of art journaling provided for the use of words and
visual art techniques such as collage drawing, or poetry to express complex emotions that
might not be explored in a typical interview setting and allowed the participants to create
“enhanced meanings” (Sinner, Leggo, Irwin, Gouzouasis, & Grauer, 2006 p.1224).
Although participants were encouraged to attend every workshop, workshops were
conducted on a drop in basis in an effort to facilitate accessibility and account for the
complexities in many of these women’s lives (Clover, 2011). While this fostered the
creation of meaningful data, some participants did not attend every workshop, which presented some challenges in data collection and analysis for subsequent workshops.

During the first workshop, participants were given journals and asked to complete a brief demographics questionnaire. At the end of the first workshop participants were sent home with their journals and some introductory art journaling exercises to explore the first research question: What is your disability story? In the second and subsequent workshops, participants were asked to share their journal entry and identify themes and commonalities through reflexive dialogue that was recorded and later transcribed by myself. Participants left each workshop with some journal exercises to choose from and a question related to their own experience with their disability and accessing services. The fifth and final session was added partway through the research process in order to allow a more thorough discussion of the themes identified throughout the process and to discuss desired outcomes as a group.

Data analysis was completed with the ongoing input of participants (Baker-Collin, 2005; Huesca, 2002; Reitsma-Street & Brown, 2001) as co-researchers and participants in a larger project intended to enact social change. This was done through the discussion themes that emerged each week and were reviewed at the beginning of each session with the group, providing a space for active participation in data analysis and development. All names have been changed in the presentation of the data to protect the identity of participants.

**Group Discovery and Creations**

Throughout the research process two larger themes were demonstrated through the journaling and stories of each of the women: barriers and resilience. Though stories
differed and each woman had a different way of interacting with their own systemic marginalization, these larger themes were common throughout the process and highlighted a number of subthemes, demonstrating the commonalities and complexities of these women’s lives.

**Barriers**

Each participant in this project was living with multiple barriers as a result of her social location, which inhibited her ability to get her needs met in relation to her disability. This is consistent with the findings of previous research which indicates that both individuals with disabilities and immigrants are faced with increased barriers in accessing medical services (Aulagnier et al., 2005; Dias et al., 2010; Fennelly, 2006; Gibson & Myktiuk, 2011; Larios, 2013; Michaelsen et al., 2004; Scheppers et al., 2005; Suurmond & Seeleman, 2005; Ten have & Bijl, 1999; Yan & Chan, 2011; Yorkston et al., 2009). The barriers that presented as relevant to the experiences of the women in this project are divided into a number of subthemes below.

**Time.**
According to Gibson and Myktiuk (2011), women with disabilities are faced with considerable structural barriers in accessing adequate healthcare services and result in time-consuming processes to ensure their needs are met. This is especially true in the case of my own research where I found participants talked about the time consuming nature of the medical system on a weekly basis. The concept of time was presented as potentially the largest barrier to accessing services and having needs met. It also proved to be a barrier in the research process itself that, ultimately, speaks to the complexity of these women’s lives. As each of the participants was a single mother of multiple children, living in poverty with a disability meant their lives are consistently spent by first ensuring the needs of her children are met and then attending to her own needs. This accounted for some of my initial difficulty with recruitment, absences from the project, and challenges scheduling workshops. Efforts to be low barrier ensured that there was considerable
flexibility with these matters from start to finish but there is no doubt that the complexities of the participants’ lives and their lack of time had an impact on findings.

The theme of time, or lack thereof, exhibited itself repeatedly when participants spoke about their day-to-day lives. Evelyn described this as “the responsibilities with children, life etc. attending to own needs comes last. Sometimes it’s never coming”.

Evelyn’s concerns were not unique; each participant expressed concern over meeting the needs of their children, the demands of social assistance, other external demands, and finally attending to their own health needs. This highlights the need for policy reform that focuses on ensuring eligibility and access (Fennelly, 2006; Larios, 2013; Scheppers et al., 2005). Attending to their own needs, particularly in relation to their health, was further described as time consuming in itself, thus restricting their access to disability services.

Similar to the findings of Scheppers et al. (2005) all of the women portrayed a struggle to find time to attend necessary appointments with doctors and other professionals for simple tasks such as completing forms for disability or obtaining the appropriate medication for symptom abatement.

**Communication with medical professionals.**
Throughout the project there was considerable concern about challenges in communicating with medical professionals, particularly physicians. This experience of frustration in communicating with the medical doctor is echoed by Yorkston et al. (2009) who described patients as feeling that they have to convince health care professionals of the presence of pain. Maria, a single mother of young children who is living with multiple disabilities, describes her frustration with meeting her doctor: “The doctor never seemed to care, the doctor never seemed to have the time to listen to what I was saying”.

Participants described their experiences with their doctors as a frustrating and disheartening experience for a number of reasons.

One of the primary concerns in regards to communicating with the doctors was the time limit placed on appointments. As mentioned, simply finding the time to get to
the doctor’s office was a barrier for participants and for immigrants throughout the literature (Scheppers et al., 2005). Once participants were able to attend the doctor’s office they were under the, incorrect, assumption that they could “go over every single issue that [they] were dealing with” (Maria, 2014). Unfortunately, this has not been the case for participants who found that time limits placed on appointments and a policy that only one concern could be discussed per appointment left them feeling unsupported and misunderstood.

The unwillingness of some medical processionals to adequately consider the patient’s medical records from her country of origin, or the account of the patient themselves, contributed to the participants’ feeling of being misunderstood (Gibson & Mytiuk, 2011; Fennelly, 2006; Scheppers et al., 2005). This is particularly problematic when considering the essential role of the medical professional in conferring disability benefits upon a participant or referring them to a specialist or other service (BC Coalition of People with Disabilities, 2007).

**Cultural considerations.**

It is impossible to adequately meet the needs of racialized women living with disabilities without first and foremost considering the cultural implications of the professionals approach to practice (Fennelly, 2006; Panos & Panos, 2008; Scheppers et al., 2005; Suurmond & Seeleman, 2004; Yan & Chan, 2011). Participants often felt that a lack of understanding about their culture on the part of the medical practitioner or social service provider left them misunderstood. Evelyn described this feeling in relation to explaining her medical history to a doctor: “I’m from Pakistan they think I live in a cave or a dark age but I know better”. It was essential to participants that their culture and
beliefs were respected. Although participants had developed strategies for explaining cultural considerations, cultural competence is an ongoing process that requires mindfulness and education on the part of the practitioner (Dias et al., 2010; Fennelly, 2006; Geiger, 2001; Michaelsen et al., 2004; Panos & Panos, 2008; Tan Have & Bijl, 1999; Yan & Chan, 2011).

Poverty.

Figure 3 – “you have to go through the process, through the pain of being ignored in order to get some kind of help”
There is a demonstrated relationship between poverty, disability, and newcomers to Canada which necessitates highlighting the role poverty plays in creating additional barriers for these women (AMMSA, 2013; Larios, 2013; Scheppers et al., 2005). Simply put, income assistance and disability rates in British Columbia are far too low to meet the needs of families. Furthermore, the higher rate of poverty for new immigrants highlights the need for greater support for these families in order to ensure successful integration (AMMSA, 2013; Larios, 2013). As each of these participants was a recipient of social assistance, themes of poverty and limited resources surfaced throughout the project.

Evelyn describes the challenges in meeting the needs of her family with a limited income:

So this is how when you are an immigrant, when you are with kids. You have to buy bus passes; you have to buy them some sort of calculators or their laptops because they need it. You have to buy those things so when you are grocerying you have to save some amount for those purposes only. So the doctor is like: who cares. You don’t have, it’s your luck.

There is an intersection between poverty and each of the barriers these women face. Their dependence on social assistance requires that they meet the demands of the social welfare system, a process that is a time-consuming and dehumanizing endeavor (BC Coalition for people with Disabilities, 2007; Hanson & Hanson, 2010). These demands can make individuals feel as though they are “living under a microscope”, thus diminishing human dignity (Baker Collins, 2005 pp. 22-23). They also place unreasonable expectations on physicians to complete forms in the Ministry’s terms for patients whom, in the case of this research, they already have a strained relationship with. Finally, there is considerable stigma attached to being an income assistance recipient that often results in shame and
discrimination and can prevent recipients from asking physicians for the forms they need in order to have their needs met (Clover, 2011; Baker Collins, 2005).

Figure 4- “The only thing that bothers me is the people’s response. The doctors response or the Ministry’s, they think that I’m just their servant… it doesn’t matter how painful your situation is”

Resilience

In response to the barriers discussed, a strong theme of resilience emerged during the project. The theme of resilience is evident throughout literature surrounding marginalization and highlights not only the inherent strength and determination of each participant but also the incredible learning that can take place when stories from the margins are shared (Baker Collins, 2005; Clover, 2011; Dossa, 2005; Dossa, 2008;
Hanson & Hanson, 2010). As an outsider to these women’s experiences, I was impacted by two key components of their incredible resilience. These sub-themes are discussed below.

Figure 5 – “These lines always help me to live and go forward… when they are dry I feel: oh my god this thing this problem…but when they bloom up… they got new life, I can have too!”

**Strategies for Self- Empowerment.**

Both Hanson and Hanson (2010) and the participants in this study highlighted the need for an effective strategy in navigating the social service system. The methods used came through considerable experience and trial and error. These strategies, though not convenient and, at times somewhat unorthodox, demonstrated the considerable resilience and outright determination of participants. They also shift the power dynamic and allow participants to have more control of their lives; resulting in a sense of empowerment (Clover, 2011). Maria describes her experience in developing a strategy to ensure her voice could be heard:
You have to get the help somehow and even if you feel discouraged all the time you have to continue. If I weren’t to see this doctor and that doctor and another doctor…I have bad experiences with a lot of doctors and if I sat at home waiting for who knows, I wouldn’t have met my nurse practitioner…I am very happy that I met her because I am able to now fix my health issues and talk to her about everything and I feel free to do so.

Maria’s solution to not being heard was to find a nurse practitioner that could adequately address her medical concerns. Each participant expressed a favorable experience with seeing a nurse practitioner for their medical needs; this favorable experience was primarily because the nurse practitioner took the time to listen to concerns and validate the experience of participants. Another participant responded to her negative experience with her doctor by going to a walk in clinic on a certain day when she knew she could see a doctor who had more time for her. Unfortunately, these solutions have significant limitations; nurse practitioners are not able to complete forms for disability like a physician and doctors at the walk-in clinic are reluctant to if they have not built a relationship with the patient (Ministry of Social Development, 2014). This results in immediate needs being taken care of but no long-term solutions for patients.

Outlook.
Figure 6 – “So when I see someone is fully involved in the life, my thinking are just like those… So for the hope you only hope but I have to work to keep my hope positive”

Like the women discussed by Baker Collins (2005), Clover (2011), Dossa (2005), and Hanson and Hanson (2010), this group of woman demonstrated considerable strength in the face of adversity and marginalization. Their commitment to their children, their faith, their future, and their quality of life showed determination. Evelyn describes the need to remain positive despite the barriers she has faced:

I am just like an old person. So my bones are getting out. Everything is turned because I am doing the most I can do. But I don’t have negative thoughts in my
mind… the ministry is just like a little bridge so if you are smooth you can cross it, but if you yell you can fall down.

Each of these women saw solutions to the barriers they faced through persistence and positivity, highlighting the power of discourse and outlook on marginalization and the concept of normalcy (Dossa, 2005).

Figure 7 - “But these things are just like painful shots in your mind… at last you are human. Somehow you are going to be tired of all these things… so I just wash my mind again and again and I see ok.”

In the final workshop, Maria shared an exercise in her journal. The journal page showed a map with a series of dots and lines she had drawn. Maria’s explanation of her journal entry exemplified the strength in spirit these women have:

This is my map. These dots represent all the roads and places I have to go and I am just here. I have to go through so much before I can achieve my goals… I am not giving up. Even though the road is so hard and so tough I am not giving up, I keep on climbing from the very bottom to the top.
One of the primary reasons for the creation of this project and the participation of each individual was to tell her story in order to enhance understanding, to learn from one another, and to make recommendations for reform. Though the research was done in the context of a small community in British Columbia, the aforementioned statistics on immigration within Canada and the nature of globalization worldwide means the importance of intercultural competence and skill in meeting the needs of newcomers with disabilities is essential. The supportive environment created through the sharing of stories created a space to share strategies and think about social change. These recommendations are the voice of a small group of women and further research should be done to represent a larger sample; however, there are meaningful solutions that should be considered in a wider context in order to better meet the needs of immigrant and refugee women living with disabilities.

- **Recommendation 1** – More education for professionals surrounding intercultural competence and the intersectionality of poverty, disability, and immigration. This should include a basic understanding of how legislation and policy affects immigrants and refugees as well as those living with disabilities (Yan & Chan, 2011).

- **Recommendation 2** - Allow nurse practitioners and other paraprofessionals to complete forms related to disability benefits of social assistance. This would alleviate the pressure on doctors as well as ensure that the person who is the more familiar with the patient is completing the form.
• Recommendation 3 - ensure authentic participation marginalized individuals in the policy making process to utilize the unique learning that can take place and confirm realistic policies are being created.

Conclusion

The findings of this project are limited in their ability to encourage large systemic change given the small sample size. However, many of the themes identified through the work of the participants are themes that have emerged in other research in disability and cross-cultural studies. The need for increased competency in communication between newcomers and medical and social service professionals is widely accepted as a tool for providing a better standard of care (Dossa, 2008; Fennelly, 2006; Geiger, 2001; Michaelsen et al., 2004; Panos & Panos, 2008; Scheppers et al., 2006; Suurmond & Seeleman, 2006; TenHave & Bijl, 1999; Yan & Chan, 2011) as is a need for increased communication competency and an analysis of the complexity of disability for professionals (Aulagnier et al., 2005; Dossa, 2008; Goggin, 2009; Yorkston et al., 2010).

The detrimental effect of poverty and restrictive legislation surrounding social assistance and disability benefits on individuals is incontestable in the stories of the participants in this project and previous research in this area (Baker Collins, 2005; Clover, 2011; Hanson & Hanson, 2010). This is particularly concerning for immigrants and refugees, thus validating the findings of this research and demonstrating a need for larger research that is more conventional and ultimately legislative reform (AMMSA, 2013; BC Coalition for People with Disabilities, 2007; Fennelly, 2006; Larios, 2013; Scheppers et al., 2006).

The use of art-journaling and participatory methods encouraged genuine representation of the participants; a voice that is not only absent in more conventional
research methods but is certainly not included in any meaningful way in the policy and legislation process in British Columbia. This empowering process highlighted the resilience of participants and marginalized individuals and the need for creativity in the quest to get basic needs met (Hanson & Hanson, 2010). This need for strategy and creativity emphasizes the need for legislative reform.

The data compiled throughout this project demonstrates the importance of including those affected for more nuanced work on the effects of policy and legislation surrounding immigration and disability, in order to further enact social change. Ultimately, it is impossible to enact social change without first understanding the experience of the group you are seeking change for and it is improbable to understand this experience without the active participation of the group itself.
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