

# Accessing Counselling Service and Achieving Career Goals for First-Generation Women University Students in Atlantic Canada

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## Abstract

This study is an institutional ethnography investigating whether university support services for undergraduate women students who are first generation in their family to attend are adequately supported in their transition to a career. Two groups were interviewed at two New Brunswick campuses who had experiences with university-based health and counseling services: one group of six students accessed health services primarily and were treated for their symptoms with anti-depressants; the second group of six students accessed counselling services after a number of women counselors were hired who focused on women-centered and strength-based counselling. The groups differed in their stated satisfaction with the two forms of service, their efficacy as students in completing their programs, their self-confidence and ability to achieve ongoing objectives in their career trajectories.

This research is an institutional ethnography aimed at questioning if student services are adequate to support first generation women students' transition to a career at two New Brunswick universities. Studying this population makes clear that there is a diversity of individuals and backgrounds with varying needs present at university. The university tends to offer services that assume a homogenous group in terms of gender, generation attending, and social class. With the exception of some recently added women-centered counselling services, university services have tended to orient to a more homogenous student body with the fall-back on medicalized services that are largely debilitating and disempowering to first

generation women students. I suggest that a more holistic approach to health that includes diversity-based assumptions concerning the student body would orient services more directly to first generation women students and their efforts to secure careers.

In the last two decades, publicly funded Canadian universities have undergone a restructuring, a process of corporatization, where university operations have shifted from a "professional" to a "business" model, after substantial federal funding cuts to the provinces and universities (Turk, 2002; Reimer, 2004; Cantano, 2009; CAUT, 2009; FNBFA, 2009). There has also been a recent influx of female students from rural areas who are first generation in their family to attend university (Reimer & Mueller, 2006). They cite a lack of supports for the transition from schooling to career while attending university. I find that student services are being cut at a time when non-traditional students need support for the career process more than ever given the increased competition for dwindling employment opportunities.

Cutbacks in the area of counselling in particular mean that students are more likely to get medicalized services than the kind of counselling they need, and so they are more likely to see doctors who are not counselors, but are able to prescribe anti-depressants. Thus students get services within the medical model of illness and sickness when they need a more holistic approach to health and the diversity of the student body. Throughout the past decade, significant research has been done by both public agencies (Ontario Student Drug Use and Health Survey, 2008; Canadian Campus Survey, 2004) and private researchers (Terenzini et al., 1996; Grayson, 1997; Tym, et al. 2004; Pas-

carella et al., 2004; Snell, 2008; Reimer and Ste. Marie, 2011) on the distinctively disadvantaged group of first generation university students. Extensively studied in terms of whether or not they begin and complete university, courses taken, familial support, how much they work, the kind and quantity of the social and cultural capital at their disposal, their general rates of success, and rates of cognitive development, this group has received much scholarly attention. Conspicuously absent from this work, however, is a prolonged qualitative analysis of the doubly disadvantaged first generation woman student who attends university. This author finds that the experiences of this group show them to be challenged in many of the aforementioned ways, but also of being more likely to be labeled as depressed and receiving medical treatment with anti-anxiety, anti-depression or anti-psychotic drugs.

The student demand for counselling is on the rise in surveys of student mental health (Benton et al., 2003; OS-DUHS, 2008; Fuller, 2008). The likelihood that women students and first generation women students will experience distress and turn to health and counselling services is much higher than for her male or middle class counterpart (Canadian Campus Survey, 2004). Yet, in comparing the experiences of first-generation students with primarily a medicalized treatment to those with women-centered counselling, students' underlying problems are not addressed in a medicalized format and the students are not nearly as successful in achieving their goals as those in the second group. First-generation students need a more holistic approach to health and to diversity of the student population (World Health Organization, 1946)



As a discernable group of individuals in the research, first-generation students were initially identified by the American TRIO group in 1978 while considering how to best facilitate financial assistance to those most in need (Auclair et al., 2008). Since then, TRIO's description of first-generation as those people whose parents did not complete their post-secondary studies has been accepted as the 'strict definition'. Utilized by only a few scholars and public institutions (Auclair et al., 2008), this definition has been usurped as primary by a more broadly used one which uses the model of an individual being the first in their family to attend a post-secondary institution (Auclair et al., 2008). Adopted in Canada most notably by Grayson (1997), Lehmann (2007), and Berger, Motte and Parkin (2007) this definition is based on the idea that if even one parent (apparently regardless of which one) attended a post-secondary institution of any kind then they would be able to provide enough social and cultural capital for the student's various disadvantages to be neutralized. For the purposes of this study, I will refer to first generation students as those whose parents have not attended university.

First-generation research has taken on many different forms since the late 1970's. It has most frequently been approached from a decidedly quantitative perspective (OSDUHS, 2008; Pascarella et al., 2004) where statistical analyses have been used to identify the sorts and frequencies of difficulties that first-generation students may encounter. Terenzini et al., (1996) concluded that in addition to the problems of finance and familial support that these students experience, they are also more likely to suffer from a host of various cognitive and developmental problems with respect to their educational experience. Indeed, similar studies (Nunez and Cucaro-Alamin, 1998; Striplin, 1999; Thayer, 2000; Choy, 2001; Schmidt, 2003; Vargas, 2004) have all come to the conclusion that, whether looked at from the perspective of drop-out rates, work versus school effort, support networks, completion timeline and success, personal integration, extra-curricular participation, successful entry into graduate school, or a general

sense of well-being, first-generation students are disadvantaged in numerous ways. As a result, a general call has been issued by scholars and public organizations that if universities consider retention to be their priority, then this group and their difficulties must be taken into consideration, especially considering the rise in the demand for counselling services (Fuller, 2007; Benton et al., 2003).

These disadvantages associated with first-generation students are exacerbated for women. Due to the fact that women show high rates of reported anxiety, depression, and medicalization in high school (as evidenced in OSDUHS, 2008), post-secondary first generation women may also face high rates in university; that is, one might assume that the cumulative disadvantages faced by families in the Atlantic region have parallel psychological impacts on young women as mentioned in the literature. A host of disadvantages, then, that they may face include a lack of familial and financial support, lower cultural and social capital upon entry, less time to participate and so receive the positive benefits from extracurricular activities, and low self-esteem. These difficulties are considered to lead inevitably to these women experiencing significant barriers in their attempts to map out a successful career path.

As portrayed in much of the literature (Canadian Campus Survey 2004; OSDUHS, 2008; Tym et al., 2004), upon entry into post-secondary institutions many women have already experienced heightened levels of perceived anxiety and depression, which are identified with issues of low self-esteem, drug and alcohol abuse, eating disorders, and thoughts of suicide. In addition, and perhaps directly related to this, they have also reported higher rates of medicalization. Given this variety of identified psychological problems and those generally associated with being first-generation, these students likely require greater assistance from the university in transitioning into post-secondary studies, maintaining their well-being while in attendance, and, most notably, in choosing a course of action which will help them in establishing a clear career path. Similar to "second chance" students, it is the institution's responsi-

bility to respond to the needs of this group (Looker and Thiessen, 2008).

First-generation women, as a discernible group among any student population, require a very specific kind of assistance. As opposed to the medical model, where illness is often dealt with through invasive pharmaceutical treatment, the literature shows (Harvard Mental Health Letter, 2006; Devlin, 2006; Ruddick, 2008) that solution-focused counselling, wherein problems are 'normalized' (as opposed to labeled) has had significant success with a student population (Coogan and Chen, 2007). As such, first-generation females who are attempting to directly confront their various problems, and so establish a clear path into and through post-secondary education, prove to benefit more from the empowerment granted in these types of sessions. In contrast to this, those who are medicalized receive a label (such as 'depressed') which subsequently disempowers them (Lafrance, 2007) by handing the responsibility of their difficulty over to an (often male) authority figure (Lafrance, 2007).

Stoppard and McMullen argue from a feminist perspective that women's depression must be understood in its social context (Stoppard and McMullen, 2003). From their familiarity with rural women's interviews, they see women's depression not as an individual condition, but in terms of societal expectations of women and the devaluation of women's work and mothering (McMullen, 2003). As with other feminist analyses, they point to how the medicalization of women's problems cuts them out of their social context in which they make sense. They argue that more appropriate would be strategies that allow women to communicate their distress in order to discover coping strategies in a more collaborative framework.

Women-centered counselling has existed as a common approach to women's needs in the university context and draws from the literature on women's specific needs and approaches to the social world that were first identified in moral philosophy and psychology (Miller, 1976; Miller, 1991). Miller underlines the importance of appreciating the social relations of families where traditional expectations for



women frame the kind of support for the concerns of girls and women. An array of psychological techniques from creative visualization to psycho-cybernetics may be used to help young women get in touch with their feelings about the social support they receive for their ongoing goals and aspirations. Solution-focused therapy is a common approach that works well with women-centered assumptions in counselling and allows “clients” greater latitude as co-collaborators or equals in addressing the problems they face in achieving their goals.

Also known as “solution-focused brief therapy”, this is a type of counselling based on “optimism and expectancy for change”, and has “no real interest in psychopathology or in labeling people’s problems” (Ruddick, 2008, p.34). As such, it operates on the central assumptions that a person’s difficulties can be overcome by them facing their problems (Devlin, 2006, Magolda, 2008) and addressing the positive effects of their own resourcefulness and strategies they are already utilizing (Burwell and Chen, 2006). Through this process of normalization, the therapist mobilizes hope (Ruddick, 2008) and restores belief in the client that they are capable of solving their own problems and achieving their goals.

In direct contrast to the traditional psychotherapeutic model, wherein the ‘expert’ assigns a name to the patient’s illness and medicates accordingly, “solution-focused therapists do not make diagnoses... [but] encourage the client to recognize and implement alternatives” (Harvard Mental Health Letter, 2006). The client, then, is taken as the expert or author of her own reality (Devlin, 2006; Burwell and Chen, 2006) and is seen as being entirely capable of proposing the necessary course of action. Understanding “that the expectation that something will happen correlates strongly with something actually happening” (Ruddick, 2008, p. 34), solution-focused therapy empowers individuals by acknowledging that they may be already have the solution to their problems without being readily cognizant of it (Harvard Mental Health Letter, 2006).

As a kind of empowerment based therapy, solution-focused therapy falls

within the 1946 WHO statement regarding the necessity to address holistic health issues. If first generation women university students’ counselling issues are to be addressed successfully, particularly in regard to their well-being while students who are attempting to set out a clear career path, then there is a need for an alternative to medicalized health services where anti-depressants appear to this author to be administered routinely. Women-centered counselling is also an alternative that promotes women students’ well being (Stoppard and McMullen, 2003); it also situates young women as co-collaborators at a time when finding their own voice may be an integral step in defining and achieving career objectives [Fieldnotes, July 23, 2008]. In these two frameworks, empowerment, normalization, acceptance of self-authorship, belief in internalized strategies already present, and focus on positive change which achieves clear goals are some of the necessary building blocks upon which an effective counselling service for first-generation women is based. These approaches offer a basis for addressing first generation women’s problems in a way that minimizes the cost to their career success.

### Method

#### Institutional Ethnography

In this study, institutional ethnography was used to see how people working for universities actively organized and shaped the processes resulting in unequal access to education (Smith, 2005). The institutionalized support services in health or counselling are in limited supply and their contact with the university agency will organize students differently in relation to the biomedical discourse. Studying women’s experiences with university support services provides a social grounding to their difficulties in relation to the work practices and the dominant discourses of the university agencies they encounter.

This institutional ethnography involved an analysis of dominant discourses in a context of work practices that create the relations of accessibility to career options. The study focused on

the social underpinnings of the career path, and the counseling approaches that help students to address their needs in working to achieve career goals. The social relations of support that allow students to achieve self-reliance and self-confidence are evident in this study of twelve students. An institutional ethnography is concerned with identifying the social relations which have a translocal or ruling character, which is commonly connected with dominant discourses of professional and managerial work organization. Though interviews, observations of local work practices and the institutional discourses associated with these, this study assesses the impact of discourses of psycho-pathology versus student-centered and women-focused therapies. The dominant approach to diagnosing and treating depression in medical and psychological communities is the biopsychosocial approach (Luyten et al., 2006). Depression is considered to be an outcome of genetic, personality and life stress factors. A common focus is on the physical causes of depression, such as imbalances in the brain, that are mediated by an individual’s genetic disposition and are enhanced by the stress she experiences as well as overall flaws in her personalities (Luyten et al., 2006). Because of the legal requirements universities face in relation to high risk students who come into Student Counselling, the Diagnostic and Statistical Manual of Mental Disorders (the DSM) categories of mental illness are used in the intake process to evaluate potential high risk students.

More commonly, students are considered “depressed” and “high anxiety” and are questioned to determine if they are functioning; i.e., eating, sleeping and attending classes. An assessment in relation to DSM enters students into a priority system, in which students are assigned to different categories, e.g. “emergencies” were seen the same day while some others with “anxiety”, were assigned a three month wait for counselling; or, at “Health Services”, a student would be given a fifteen minutes “one-concern-per visit” appointment with a doctor, where many of these students were given anti-depressants. Peden et al., (2001) claim that depression is significantly higher among uni-



versity students and that more than one third of female students are affected. The work practices of counselors and doctors varied greatly in relation to the bio-psychosocial discourse given that those who do women-centered counselling are more likely to be critical of the mechanized model of the human body that neglects the wholeness of the patient and the social contexts of illness (Evans et al., 2005). The students who self-selected to be interviewed after seeing an ad were in Cohort 2, and they were the only ones who were counselled by the women counselors with alternative approaches to the common medical model.

**The Interviews**

The researchers conducted interviews with twelve students and seven personnel (a doctor, a nurse, four counselors) -- three of whom were administrators for counselling and health services) and an independent local feminist counsellor. The counselors were psychologists or held a masters of education in Counselling Psychology, and the administrators held doctorates in psychology and one was a medical doctor. The students had all used counselling and/or health services for health and personal difficulties. Eight of the students were from New Brunswick, two from Newfoundland and Labradore, one from Nova Scotia and one who grew up part of her childhood in a developing country and the rest in New Brunswick.

Of the twelve students, the diversity was quite typical for Atlantic Canada, not a mecca for diversity. One student was a visible minority and also a third world immigrant. One was a status aboriginal, with a non-native, francophone mother. Three of the others were an "invisible" minority, in families where one parent was a Francophone and the other an Anglophone. All of the rest were Caucasian with names that are typical of British ancestry.

Two cohorts of first generation women students illustrate the diversity of institutional supports that students receive: Cohort One was restricted to primarily Health Services where they were prescribed anti-depressants. The students in Cohort Two were able to get

counselling and were able to benefit from women-centered counselling techniques that addressed their ongoing growth as individuals. This cohort came from the academic years 2007-2008 and fall of 2008-2009, after a number of women counsellors were hired at Student Counselling whom they accessed. Their experience of a non-medically oriented counselling built on their strengths and encouraged them to complete the strategies they were pursuing while acknowledging the challenges they faced.

I refer to the counselling services as "Student Counselling" for two adjacent university campuses when discussing the effects of cutting back on service: the service was considered "full service" prior to 2004 when one counsellor was available for every 1000 students; by school year 2004-2005, this was downgraded to "limited service" with one counsellor available for every 1500 students, and; by 2005-2006 service was characterized by one of the counsellors as "not acceptable" with one counsellor for every 2000 students [Fieldnotes, May, 2006].

**Results**

**Cohort One**

To contact this group of six students, the snowball technique was used within a network of women who were social science majors.\* They ranged in age from twenty-one to forty-eight and were predominantly in their final year or the year after graduation from an undergraduate program. All six were first generation to attend university, where five came from families with blue collar or service sector wage jobs, with one having a father who had a certificate in English as a Second Language and who had taught in a community college.

An honours student addresses the problems many women face in rural Canada where the university's formal "gender blind" stance is problematic:

The fact that the university is gender-blind towards the differences in the lives of its women and men students cannot be overstated...Throughout the course of my five year Lib-

eral Arts program I have had countless encounters with women students who must manage the sexist expectations of their families while completing their studies. In particular, the parents of women students do not see their daughters' education as stepping stones to competitive, empowered career opportunities. Their education is devalued as a means to a low-level position; in particular, in a care-taking context. So, women students enter the university reinforced with the notion that their education is a means to a low end. This places women students at a significant disadvantage; they learn not to be competitive and not to 'talk back' to the often 'chilly climate' of the university (Ste-Marie, 2007).

The problems highlighted here are typical of many female students who are first generation. Their contact with Health Services led to their accepting a medical interpretation of their situation as requiring medication and subsequent delays in their careers. Ronnie, for example, did not receive academic or emotional support from her family -- who wanted her to obtain a university education and to become a housewife like her mother upon graduation. She faced many problems with her family: for example, they threw her out the third year after Christmas for getting a piercing and defying their control. Typical of many first generation students, Ronnie panicked in the third year, fearing that she would not be able to meet the requirements of graduation. She worked late into the night, consuming large amounts of coffee, caffeine pills and cigarettes while attempting to raise her grades.

In Health Services, she explained to the doctor that her stomach pains were stress related as she had not been eating very much due to her state of panic. She couldn't relax and felt she was going to fail. "I told (the doctor), I can't deal with the university, the stress and everything. I said, I know that's life, we have to deal with stresses in life; I



can't do it... I'm going to be this huge failure [Fieldnotes, May 14, 2007]."

The doctor asked if she had ever been on anti-depressants. He suggested, "Why don't we try putting you on them and see if this helps with everything you are dealing with, and calm you down?" She took the anti-depressants as he advised, and was perfectly willing to accept the argument that she was unable to manage her stress without anti-depressants. She stated that she saw herself as having a chemical imbalance in her brain, and saw this as a part of life.

Interestingly, she argued that what caused her stress was "pressure put on me since I was a child". She goes on to say:

You know, I know with myself, I think a huge portion of the stress is because it's partially the way that I was raised in my household. I came from an extremely sexist family. Women stayed home and cooked and cleaned. Husband goes out and does the work and comes home. His wife shouldn't be leaving the house; they have no need to leave. But, at the same time, when growing up I was enforced on those rules however when I graduate high school it was: You're going to university and then you're going to make someone a housewife. You're going to learn to cook and clean. So, I think because of that in the back of my mind, I'm at school and I kept thinking, you know, that I don't want to become my mother [Fieldnotes, May 14, 2007].

The doctor told Ronnie to take a week off of school while her medication built up in her body. Her absence led to her being even more behind in her schoolwork. In addition to Ronnie, three other interview participants also experienced severe side-effects from their medication, such as constant drowsiness, severe headaches, vomiting and chest pains. The side-effects affected their ability to perform in school. Two of the other six were prescribed anti-depres-

sants, one by her family doctor, which resulted in her situation being viewed temporarily as a medical condition.

In Ronnie's case as well, being prescribed medication meant that she was never able to address her underlying issues. The doctor's six month follow-up was as brief as the initial meeting: rather than talk therapy, he only asked if the medication was working and if she wanted to continue on it. When she was asked if she would have benefited from a workshop with a female psychologist using feminist coping strategies, she replied:

Beyond belief, especially coming straight from that sexist house, where a woman wasn't allowed out, and then having me at school struggling to prove my family wrong; to prove their way of life is wrong... to see a woman psychologist doing all of this, I think that would have been a huge impact on myself. I think I would have gotten the understanding of what I was trying to do. By balancing things out like that, I wouldn't have needed the medications; I wouldn't have had such stress on myself and such high expectations [Fieldnotes, May 14, 2007].

Most interesting was her response as to whether she would have liked some feminist counselling:

More choice. I wish they would have said: how about we send you to have a conversation with somebody, and if you don't feel like that is helping, come back and see us and we'll see where we can go from there...If you're depressed, I think the options of medication, psychiatrist, psychologist and family sit down should be an option, the same as if you're pregnant, there's abortion, adoption, or keep them. But some options, especially when it comes to anti-depressants, don't get talked about... I didn't know the school had all

these psychologists until I found out that they hired the female... a woman who I could have sat down and expressed my thoughts and issues and beliefs with and gotten someone else's perspective [Fieldnotes, May 14, 2007].

While psychologist Michelle LaFrance has recently written a beautiful discursive analysis of women's medicalized accounts of depression, and the relief women experience with what they see as an "objective" diagnosis (LaFrance, 2007), I find that the students are quite outspoken in rejecting the validity of the medical model a year or two after diagnosis. For example, one of the most outspoken students was psychology major Maureen. In the third hour of interviewing her when we discussed her experience of sexual abuse and emotional bullying by her ex-common law partner, I asked if we should turn off the tape recorder. She stated "No, that's why I'm doing this, because if it helps someone then we can get away from the same old thing – the men going getting the education and the women staying home. Like, I'm all about equality [Fieldnotes, May 21, 2007]."

Maureen faced major anxiety much of her undergraduate experience. This was no surprise, with her traditional family expecting her to attend university and to then become a housewife, when her objective was to attend a community college program. Her parents made her feel "slow" compared to her older brother, and when she had mononucleosis in high school, she began taking anti-depressants. In her second year of university, she had a fight with her parents, who weren't fond of her boyfriend. She moved out to live with him, landing in a moldy apartment, poverty, emotional and sexual abuse, and increasing credit card debt.

After Maureen moved back home later that year, she dropped out of university. Although she did resume classes after that, her debt-adverse parents insisted she work long hours, which amounted to twenty hours per week, to repay the credit card debt. Working in a non-unionized grocery



store, she had an enormous workload with inadequate training, and because the manager harangued her daily, she usually began her shift crying over her situation. Like the others in Cohort One, she had a negative experience with Health Services as well as with Student Counselling. Although she was able to get into counselling, the counsellor sounded well intended but harried. She had been feeling down and hoped to discover some concrete coping strategies. But there was no follow-up on what the male counsellor asked her to do, or what her feelings were; he forgot to give her reading materials he promised and double booked her for an appointment with another student. The counsellor stated at that point that he thought she was doing fine and was finished with counselling. As she put it, she gave up on counselling because he gave up on her.

Maureen's experience with counselling reflected the common priority placed on functioning as a student: we see the counselor stating that she was coping much better by working and attending classes. Yet, her major conflicts with her parents remained unresolved, which included her immediate goal to attend community college, their dissatisfaction with her (her choice of boyfriends and her school performance) and their insistence on her paying them back immediately so that she felt compelled to accept a high workload at the grocery as well as to endure workplace harassment on a daily basis.

Maureen was also at Health Services for an illness; however, she was not able to find any workshops on "students and depression". In an interview, the administrator at Health Services stated that the university needs alternative ways of organizing services for women; for example, "student health fairs, a health promotions coordinator, workshops on drug education and all dimensions of wellness from spiritual to vocational" [Fieldnotes, May 11, 2007]. However, the universities had not allocated the resources for such services.

Maureen's career plans evolved from her own personal growth and the realization that you cannot count on anyone but yourself. Although she completed her major in psychology, she has a preference to steer clear of the job

of psychologist with its connections to bio-psychology and the medical model. Alternatively, she could see her strengths as a guidance counsellor, who focuses on a person's abilities, what they have accomplished, and what she or he wants to change. In this short quote, she talks about this approach to personal growth:

That's actually not talked about in psychology that much. Like when I took the psych classes, that was hardly mentioned. And it's getting more pronounced and it's – Like people are realizing that everything that was talked about in psychology is actually quite old-fashioned as opposed to like what we're talking about right now [Fieldnotes, May 21, 2007].

She identifies a student discourse in which she is a part that rejects deterministic psychology, as well as the assumptions of stress discourse, such as the idea that stress is normal and that you just have to learn to deal with it. As she disparagingly put it, "you just have to stick it out, it's okay if you hate your job". Maureen's spontaneous suggestions for an expanded student orientation included an array of relevant workshop topics, including coping strategies, problem solving, and student-friendly suggestions for how to market them, e.g., "Starting a fun adventure? Come and share your experiences".

The institutional ethnography is not claiming to be generalizable to all similar contexts. However, to conclude in relation to the current organization of student services that this rather small Cohort accessed, a tentative picture emerges. In both counseling and health services, the biomedical discourse dominates with a narrow focus on the breakdown of individuals coping in the construction of the depressed woman student. Once focused on the breakdown of individual coping and the treatment of depression, treatment often narrows to a discussion of stress management, and the functional realms of eating, sleeping and attending classes (Fieldnotes, May 14, 2006).

As Stoppard and McMullen argue, this common approach does not assist women to identify the practical issues they need to address within the social context of their lives. For first generation women students, this would involve seeing how, as students did, the personal experiences of depression are related to the social context of women's inequality in relation to their families and relationships, the workplace, and the classroom, and in a way that is supportive to their career goals. In order to move beyond the medicalized approach to depression, there must be the will to establish women-sensitive support services and programming. This path is less frequently taken in a university setting when women's needs remain invisible and where they face the competitive disadvantage of being medicalized and internalizing the responsibility for social inequality. This especially affects first generation women students in their transition to the workforce and to the much coveted career.

### Cohort Two

Cohort Two responded to advertisements on campus and were a self-selected group of students from twenty to thirty-seven years. Overall, their experiences were much more positive as they were a group that had only accessed Student Counselling and five of the six met with a woman counsellor who addressed her situation as a woman struggling to achieve her goals. After three more women counsellors were hired to replace departing male counsellors, the outcome clearly had changed for students who were fortunate enough to get in. Four of these six students were first generation students, providing some comparison to two students with university educated parents. From these interviews, we also get a strong sense of the disadvantages that first generation students face coming from a background with less education and from a lower income group. These students form a distinct group that often remains invisible to the university, as do their specific need for transitional supports for their career development and for distinctive support that is different from those of middle class or other students with "helicopter parents".



For example, when attending a parents' orientation at the beginning of the year, one got the impression that an assumed audience of parents existed with certain commonalities. An administrator informed the parent and student audience that it was "time to cut the apron strings" and to allow the child more latitude at university. When we begin to examine some of the first generation students' family background, a plurality of families comes to the fore. This is illustrated by "Liette", a status aboriginal raised by her single francophone working class mother. She stated that she was the first on both sides of the family to attend university. "...and stick with it more than half a year. In my entire family – both my dad's side and my mother's side...out of like fifty people. So it's a big deal [Fieldnotes, November 12, 2008]."

As for motivation to attend university, this honours student with university credits for two full "Academic Preparation" high school courses cited the following:

Looking at my family and saying "I'm not going to be like that." Because my entire family is on welfare...my mother was always the type where it's like, "Ugh, if you want to go to school today, you can. If you don't, don't bother...skip another class. That's fine!" Halfway through the summer – before I came here – when one of my teachers – I was walking by him at the mall and he said, "So did you apply to [university] yet? And I was like "Nooooo!" He was like "If you don't I will kill you". And cause I was kind of afraid, I did and got in [Fieldnotes, November 12, 2008].

This student learned from the affluent students at high school in part the value of an education and the need to work hard. Her single mother's low skill wage-labour job did not provide career knowledge and how it is something that the student has to develop by making it a priority, even by researching the possibilities in the labour force. What may not be visible within the university pro-

gramming without transition programmes for first generation students, is that many of these students have defied the odds to even have made it to university. For example, four of the students cited fundamentalist churches as having an impact on their lives, including such religions as Jehovah's Witnesses and Pentecostal denominations, which are quite common in rural Atlantic Canada. This was the case with "Janice":

So I think I found – even at a young age, I found um it very cultish. Like we weren't allowed to bother with worldly people and we were to keep to ourselves..But I remember coming home one day when I was in – I think it was grade nine and I was all excited because I had a Career Day and I came bursting through the doors and I said "Oh my goodness – listen Mum. Listen to all these things that I can be when I grow up." And they sat me down and said that I shouldn't have an interest in that because we weren't going to be here long enough to worry about a career. Because Armageddon was coming...so that was squashed right there...If you are here even long enough to finish high school your main concern is to ... get out and – and witness. Preach the work to help people. You know, find the truth.. And get married and have a family and yeah. Just worship God – like that's your calling and nothing else is your calling [Fieldnotes, August 21, 2008].

Although she would not accept the family's ultimate plan for her, she had not been expected to do well or to value education in elementary and junior high; basically she was not to worry about it. Janice stated that she was rebellious once and, just shy of age sixteen, she left home with her boyfriend and was married at sixteen.

Like Janice, another interviewee, "Shirley" was a mature student and also came from a family with low literacy. Her parents had been teenagers when she

was born and getting a job at a fast food restaurant would have been an accepted long term strategy. She married young, and worked for many years as a teaching assistant, and had a child in her late thirties. She had begun an editing business from home, and when she gave birth was able to access federal training while coming off of maternity leave. She had two difficulties, one being she lacked confidence to do the marketing required for her business, and the second was dealing with her husband's disapproval of her taking university courses, when he had once been unsuccessful, prior to becoming an electrician.

Shirley explained that what helped her was the counselling offered on campus. She credited the counsellor, "Amanda", with being able to address the difficulty of returning to school as a problem that had a lot to do with "being female":

Especially because coming back to school – especially at my age – it's such a risk...and not with the support of Charlie. He's against this – he thinks I should wait until Trina is in school and ...So I can't ask for any help at home...I'm doing something that he doesn't agree with so I better be able to handle it without any extra help because he is willing to – support the family and all I have to do is care for Trina. And why won't I just stop [university]? (laughs).

That's where that self-confidence comes in is that with Amanda (counsellor) well I know – I can stand the – discomfort of him not being happy. That's too bad that he's not happy but it's – really, he'll be all right and so will I. There's a different confidence now because before, in my twenties, if Charlie had disapproved, which he did, um, but I don't think that was a major factor but I wonder if it did play in there I would have given up – easier. Right? Because it upset him [Fieldnotes, November 14, 2008].



Shirley described a course of eight counselling sessions that were necessary to address the deeper issues that affected her self-confidence. She identified Amanda's approach as different and better than the usual cognitive behavior therapy she had encountered previously with a psychologist. Not only did this take longer than the "five sessions you will get on Blue Cross", but like other women with positive experiences in counselling, her strengths were addressed, and she was given the time to delve into underlying issues that involved the unconscious. Amanda took her on a different exploration that included drawing pictures, making inferences and seeing the connections about some very traumatic childhood experiences. Shirley was quite positive, as were other women, about counselling that focuses on one's strengths:

I didn't even realize that was on purpose. But at the end of each session she would note – ah just make a short recap of all the strengths she saw and, ah, how capable I was as a person and the things I was doing and – just – I just assumed that was just the wrap-up or whatever. But it did have an effect. And it – cause it did – she almost mirrored for me the beliefs I need to have in myself to be functioning and capable [Fieldnotes, November 14, 2008].

She went on to say how having a discussion regarding her "boundary" issues with the counsellor had been so important, as she sorted out what her educational priorities are and how to set boundaries with other students at university. She concluded that some of the male-female issues that surround one's education must be sorted out and she was helped to operate from a place of self-confidence rather than always depending on the priorities of her spouse and child. She hopes to return to counselling with Amanda to address the complications of being a mother and having to struggle with time management, a common problem of "juggling" for women students, in terms of being able to put your own priorities first

when dealing with other family members.

### Discussion

#### "Juggling" Priorities and Finding a Voice

This problem of "juggling" priorities is a significant issue for first generation women, when family members do not realize the demands of university. For example, a third year student, "Marie-Jose", has been juggling her family of origin's priorities ever since her father became ill and eventually died. She was first to attend university from a rural New Brunswick family whose parents were a woodsman and nurse, her mother francophone and father anglophone. She made contact with Student Counselling in her first year when she had to face the year without her boyfriend, who returned to another province at the end of summer. She had to learn to be happy on her own, and she realized that this involved something basic about her own self-confidence. She was extremely positive about her counselor, Mary Ann, who saw her the better part of a winter semester. They used a book to do exercises that related to being a strong woman:

Working on just not having to have anyone else. Just to be happy. I mean confident. And I think a lot was self-esteem. We talked a lot about that. And I remember we talked about some breathing exercises and stuff cause I was having panic attacks. I remember drawing lots of things (laughs)... Going there and having that experience made me realize that – I won't feel like that forever [Fieldnotes, November 12, 2008].

The optimism that she gained from counselling provided her with the self-confidence that she was looking for her first year, that is, the confidence to be happy on her own: and her relationship with her boyfriend ended as well. Marie-Jose would have appreciated some initial workshops on the career process rather than spending five years,

and taking an additional year of credits to be able to teach in French-immersion. In career terms, she now wants to gain experience in teaching that will contribute towards entry into an education program, however, she is torn between helping the family, after her father died, and moving ahead and gaining career-related experience. She identified what she learned about being a woman as part of what is keeping her from moving ahead on career plans. She comments on how similar she is to her mother:

She's just very giving and – she always puts like other people before herself? I think I'm a lot like her. And I think (coughs) and I think that's part of the problem because that always – like people who put themselves – put others before themselves sometimes don't – don't always think about themselves, right? Like I really want to go to France and teach. But I wouldn't because I feel like I should have to take care of my mom and my brother [Fieldnotes, November 12, 2008].

The issue of helping the family comes up for single and coupled women students alike. Janice, who left home at sixteen and started a family, later found that when she began reading on transition and self-efficacy in her Bachelors of Education program, she encountered heavy resistance from her military husband. In and around Fredericton, the military has a heavy presence with a military base that was the largest in the Commonwealth until quite recently. The process of finding a voice is not always as obvious as this one, but Janice's progression to a Masters in Education very likely depended upon her ability to stand up for herself.

If I wanted to talk about something he didn't want to talk about, he didn't even want to look at me, he would just....put the hand in my face...very, very, very controlling and intimidating. And I think what happened with us is about four



years ago, when I started to read up on, transitioning and self-efficacy and that type of thing, I drew upon my own strengths in being able to stand up for myself and saying, “No I’m not going to agree with that, just to make you happy. You know I understand where you’re coming from but I really don’t think that it’s good for our family so we should talk about it.” And he didn’t like that. So as soon as I started to have a voice. There! That’s what I’m looking for...then his response was um, “Well you – you’re gonna do what you want anyway. What’s the point of talking about it?” Like it was just a really bad attitude [Fieldnotes, August 21, 2008].

The process of developing a voice takes place over time, and the more Janice was able to speak on her own behalf, the worse her relationship got until it disintegrated. Re-settling with her three children was a task in itself, and fortunately the graduate advisor pointed her in the direction of Student Counselling, where she was counseled by “Katherine” on how to help the children transition. She was also encouraged to begin to appreciate her strengths by Katherine:

She said you’re still here, I mean everyday you get up and you come in here and you know the fact that you’re coming to -- to counselling or coming to talk to somebody -- is not a sign that you’re breaking down or you’re becoming weak. It’s you looking for the help or support that you need to keep on going. So that’s a strength in itself – that you’re able to reach out for help. So that was good, cause you ended up leaving the building feeling like “Okay that was a good thing to do”. People aren’t going to be thinking you know, “Look she had to go for counselling” [Fieldnotes, August 21, 2008].

Through women-centered counselling, Janice was being appreciated for her strengths, countering her ex-husband’s message to her family that she was “mentally ill” for finding a way to speak up. While Janice continued on medication, as I found was true nine of the eleven women who were prescribed anti-depressants, she was benefitting from what one counselor called the process of “normalizing” her experiences. By the counselor framing her decisions in relation to the notion of how typical and ordinary these types of problems are for women, the student came to appreciate how her actions are practical and to be expected in achieving her educational goals.

Of the six students responding to the ad for students who had contacted Counselling Services, two were graduate students who were non-first generation students. I interviewed them in order to have some comparison to make to the experiences of first generation students. These students’ parents both had university educations, and had greater resources to support themselves financially – including on-campus jobs that were using skills that a parent or brother may have had, or on-campus work in a company owned by family friends. And certainly, they had a lot more knowledge of the career process that surrounds entry into medical school or other graduate work. Still, in a very competitive graduate environment, they had some of the same needs and expectations for support from a good counselor, as “Emily” comments:

I guess I would expect – hopefully – someone who could help me to realize – I mean I know my strengths but to really believe in myself a little bit more. And how to connect with people – I think, too, is a big thing. I’m often isolated – by choice a lot of times...um, social skills. [Fieldnotes, August 27, 2008].

She goes on to say that she does not appreciate the approach of the medical model where a doctor or counselor probes to discover illnesses, rather than asking “how can I help you” and then really listening to a person’s situation.

I’m not just this person who doesn’t sleep and – you know, who’s crying. I’m this person who, you know, takes photos and, you know, is interested in people. I’m doing my own reading on strength-based resiliency theories... that’s something that I’ve done this summer that’s also changed my whole perspective on – on life and how I approach Education and everything. Definitely, that’s what’s needed [Fieldnotes, August 27, 2008].

More than two weeks after the initial intake interview at Student Counselling, Emily was still waiting to see a counselor and was quite discouraged that she was not contacted sooner. While she has a long psychiatric history, she may suffer from appearing stronger than she feels, with her Masters in Nursing underway and her on-campus job; these may mask the fact that she is quite lonely and is reaching out for help and for social networks.

The second graduate student with university-educated parents was the only one out of eleven women students who were offered to take anti-depressants and decided against continuing with them; in her case, she quit four days after starting them, as they put her to sleep prior to taking the Graduate Record Exam. Both of these graduate students were more geographically mobile than the others, with scholarships and attendance at three or more universities. For “Ruth”, a doctoral student, her positive counselling experience was at her last university in Quebec, where she was helped to deal with exam-anxiety after an ambitious schedule of preparation for the exam and employment related to her field. She felt that she had benefited greatly from five months of cognitive-behavioral therapy to address her negative thinking, her tendency to take on too much, and just to learn how to relax. Similar to strength-based counselling that the women in Cohort Two discussed, Ruth learned to focus on what she can do, and how to improve those areas where she lacked confidence, and on how to give herself credit for those things at which she is successful.



This course of counselling stood out as quite positive and perhaps involving strength-based counselling techniques as well. It motivated Ruth to seek counselling once she arrived on campus in New Brunswick, for which she had waited four months due to bureaucratic matters. The extensive counselling that Ruth was offered at the research university where she completed her masters appeared to involve a strong allocation of university funding to support students through cognitive-behavioral and strength-based counselling. Ruth is confident that she will receive the same kind of beneficial counselling again and is investigating international agencies where she might work upon completion of her doctorate.

**Comparison of Cohort I and Cohort II: The Benefits of Student Counselling**

The first generation students in Cohort I differ markedly in the outcomes they experienced from those of Cohort II. While all of the Cohort II students recently accessed counselling, and two graduate students were through the intake process and awaiting counselling, they overwhelming spoke about the benefits of solution or strength-based counselling that focused on their strengths as women. With the exception of the one student who discontinued counseling after one session, the other five spoke of the benefits they accrued from being supported in sessions that were often spread out over an entire semester, and allowed for in-depth discovery of underlying issues that they were unaware were affecting their coping abilities and goal achievement. Three of the four first generation students, in second to fifth year or recently graduated, were positive about their experiences and, like the two non-first generation students, stated that they would be going to Student Counselling in future to address difficulties that remain.

Cohort One students were quite a bit less successful and received a different kind of service at Health Services, and for one, through her family doctor. The approach they described was organized around seeing if the student was physically functioning, attending

classes, eating, etc. When students spoke of symptoms of depression or anxiety, all six were given prescriptions for anti-depressants. Their ineffective strategies led to poorer performance in courses, with five of the six taking an additional year to complete. While five did complete their degree, of that group one received Academic Probation and two received Academic Dismissal (one of which was successfully appealed). Two went on to graduate school after receiving mentoring from professors. However, these students' ineffective strategies led to a lack of information, late graduation, low marks and academic sanctions. Most of them voiced a desire for alternative programming for women within student services or student orientation, and specified a desire for counselling that addressed their situations as women.

Student Counselling and Health Services administrators indicated their own struggles with professional to student ratios, underfunding and a desire for greater programming. Perhaps when large numbers of students receive services where professionals are unable to devote much time to each student, a more "functional" approach is taken. Medicalizing a student's problems is least constructive in terms of the students' ability to function well in their programs, but possibly the most familiar route for the doctors in Health Services. Were there more of a commitment to provide women-centered counselling to more students, the students in Cohort One may have experienced very different outcomes. For example, given a collaboratively-constructed long-term plan to realize her goals, Maureen might have avoided the third year panic and the side-effects of medication. She could have been advised that it would require her another year or two to rectify her transcript so that she would be more competitive for graduate school.

Given a similar long-term plan, Ronnie may have obtained confidence to collaborate openly with her parents, addressing a long-term plan to re-pay her parents and to switch to a major that was more to her liking. Such a long-term plan could have addressed her parents' fears about accruing debt and staying within disciplines that are considered 'safe'.

**Conclusion**

**Alternative Programs for First-Generation Women**

Failing the institution of a transition program for first generation students, universities could hold orientation workshops where students and parents could jointly explore feasible career path options and debt repayment/salary level comparisons. Rather than assuming that career planning fits an individualistic model, the university could acknowledge that some students have parents who are involved on an ongoing basis in their child's university education.

Since at least 2006 the needs of first-generation students have been gaining attention in universities from Memorial in Newfoundland to Simon Fraser in British Columbia. Transition programs in these provinces, as well in Saskatchewan, Manitoba and Ontario, address issues of financing, basic orientation and the technical skills required to successfully navigate university – and very likely have to be customized to address regional specificities. McMaster University, for example, has initiated a series of programs through their First Year Experience Office which seek to mentor their first year first-generation students by pairing them with more senior first-generation students. Acknowledging the fact that 30% of their applicants fall into this group, they are seeking proactive ways to encourage self-confidence and promote the well-being and achievement rate of their students (Pereira, 2008, p. 9-10).

Since women students comprise approximately 60% of undergraduates across Canada, addressing the fact that a great number of these will also be first-generation students requires special attention. By developing women-sensitive workshops which would consider issues of importance to women, especially regarding the career process from first year to post-graduation, universities would both enhance the general well-being of their student population and increase the success rates of their graduates.

Understanding that specific problems require equally specific solutions, counselling and mentoring, especially regarding the stressful and important



area of career path options and decisions, are the most effective ways of dealing with the social difficulties of university education. Although medicalization is often the first choice of health services in dealing with the symptoms associated with anxiety, both the literature and the narratives of the women interviewed in this study conclude that a solid support network of first-generation women and women-centered workshops would preclude medicalization and make the career process more transparent.

While one parent presentation during orientation week encouraged parents to back off from their children's shaping of their university education [Fieldnotes, September 2008], this stance assumes that parents have been intensively involved and now it is the student's turn to take control. However, the interviews show that first generation parents who lack knowledge of the career transition are involved in decisions about a range of issues central to career planning, including the number of hours students worked in paid employment, their loan repayment schedules, and sharing in care-taking and emotional support of family members. The all too common individualist discourse that underpins university policies does not adequately assist students and their parents in coming together and learning the school-to-work process, and perhaps, reaching agreed-upon, or at least mutually respected, expectations.

Many of the students who were interviewed retain close ties to their families and are still economically dependent. Their narratives included, for example, students who faced defying their parents with life choices, student difficulties in care-taking for family members, and in dealing with mental health issues on one's own. Not only are students encouraged and expected to deal with career strategizing alone, but they may face their families' expectations that they work hard in university while maintaining a thirty hours-plus work week. This is true despite the Student Handbook recommendation that students undertake no more than ten hours of paid work a week. So students who lack the resources to focus solely on their schooling and parents who are debt-adverse are at a disadvan-

tage unless they are made aware of what is at stake should they forego accessing available student loans.

Were the university to work in a more collaborative fashion with first generation students and their families, a program would be needed to make the university-to-career process more transparent. The importance of the "ten hour work cap" and its effect on maintaining a competitive grade point average could be highlighted and documented for first generation families. The fact that students who work long hours regularly take five years to complete university – and often with lower marks – is useful information, and has serious ramifications with the new student loan caps requiring a four year completion rate to qualify for student loan forgiveness. The advantages of gaining volunteer or work experience that fulfills the entry requirements for professional programs such as Education and Social Work, could be communicated as some of the "hidden requirements" of the post-graduate programs.

Such orientation would be extremely useful to women students who often overexert themselves in relation to families' expectations. Students then present themselves in counselling believing that they are suffering from depression, when exhaustion and unrealistic role expectations are the root of their problem. For women students who are less aware of the career process, first year university can feel a bit like groping in the dark. In quite an individualized environment focused on achievement, students intuitively blame themselves for poor performance. Research on first generation drop out rates shows that many drop out despite good marks because they sense a lack of "fit" or cultural capital between themselves and other students (Lehmann, 2007).

As one counselor pointed out, what most students lack is self-confidence [Fieldnotes, February 18, 2009], and this is magnified when the disjuncture between family and university expectations arise. Women-centered counselling introduces and reinforces the need for a woman student to take her situation in hand, to listen to her developing voice, and to normalize her actions in relation to the sometimes unrealistic assumptions others make re-

garding her possible contributions, be it to family or the workplace. In the context of a social disjuncture between the school-to-career preparation students receive in high school and university orientation, women-centered counselling becomes the fall-back for the first-generation student who is aware that she isn't able to resolve her doubts on her own or with the help of friends and/or family members.

While universities are being polarized in terms of the available funding between the well financed and the least, it would be a shortsighted policy indeed that failed to note the connection between the large number of first generation women students and their requirements to remain in university and fulfill their career aspirations. Medicalization, as the literature suggests as being the first line of defense that many women will take in dealing with their difficulties, needs to be reconsidered in terms of its usefulness. First-generation women students need to have their social, familial, and financial problems addressed in a supportive, holistic manner (Magolda, 2008).

Transitions are never simple affairs (Murff, 2005), and while attempting to maintain their financial needs, address their lack of social and cultural knowledge, establish an acceptable career path, first-generation women students require administrative attention that acknowledges their very specific problems without relying heavily on available medical services. Universities that break with the past may enhance their "women-friendly" reputations in a way that benefits everyone.

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### References

Ad Hoc Working Group on Women, Mental Health, Substance Use, and Addictions, Women, Mental Health and Addictions in Canada: An Overview. Retrieved



- May 8, 2006, www.cwhn.ca.
- Auclair, R. et al. (2008). Transitions: Research paper 2 – First-generation students: A promising concept? Montreal, The Canada Millennium Scholarship Foundation.
- Benton, S. A. et al. (2003). Changes in counseling center client problems across 13 years.
- Professional Psychology: Research and Practice Vol. 34(1), 66-72.
- Bodnar, A., & Reimer, M. (1979). The Organization of Social Services and its Implications for the Mental Health of Immigrant Women in Toronto. Toronto, Secretary of State Report.
- Burwell, R., & Chen, C. P. (2006). Applying the principles and techniques of solution-focused therapy to career counselling. *Counselling Psychology Quarterly* Vol. 19(2), 189-203.
- Canadian Campus Survey 2004. (2005). Adalf, E. M. et al. Toronto, Centre for Addiction and Mental Health.
- Cantano, V. (2009). Reserving higher education for the elite. *C.A.U.T. Bulletin*. Vol. 56(5).
- CAUT. (2009). Provincial budgets earn mixed reviews. *Bulletin*. Vol. 56(41).
- Choy, S. P. (2001). Students whose parents did not go to college: Postsecondary access, persistence, and attainment. Washington, DC: U.S. Department of Education, National Center for Education Statistics.
- Coogan, P. A., & Chen, C. P. (2007). Career development and counseling for women: Connecting theories to practice. *Counselling Psychology Quarterly*. Vol.204(2), 191-204.
- Devlin, M. (2006). Solution-focussed work in individual academic development. *International Journal for Academic Development*. Vol. 11(2), 101-110.
- Evan, K. M., et al. (2005). Feminism and feminist therapy: Lessons from the past and hopes for the future. *Journal of Counselling and Development*. Vol.83, 269-277.
- FNBFA. (2009). New Brunswick to lose millions in Canada Social Transfer cash? Reflections. Vol. 32(1).
- Fieldnotes, 2006-2009, from the author's research indicates that quotes were taken from interview transcripts on a given date with administrators, counselors and students from the SSHRC Research Development Initiative grant, "The University to Work Transition for Young Women in New Brunswick" and the New Brunswick Innovation Fund.
- Fuller, R. (2007). What we know about the relationship between counseling and student retention. UNB Counselling Services, University of New Brunswick.
- Grayson, P. J. (1997). Academic achievement of first-generation students in a Canadian university. *Research in Higher Education*. Vol. 38(6), 659-676.
- Harvard Mental Health Letter (2006). Solution-focused therapy.
- Lehmann, W. (2007). "I just didn't feel like I fit in": The role of habitus in university drop out decisions. *CJHE*. Vol. 37(2), 89-110.
- LaFrance, M. N. (2007). A bitter pill: A discursive analysis of medicalized accounts of depression. *Journal of Health Psychology*. Vol. 12(1), 127-140.
- Looker, D. E., & Thiessen, V. (2008). The second chance system: Results from the three cycles of Youth in Transition Survey, Ottawa, Human Resources and Social Development Canada.
- Luyten, P. B., et al. (2006). Depression research and treatment: Are we skating to where the puck is going to be? *Clinical Psychology Review*. Vol.26(8), 985-999.
- Magolda, M. B. B. (2008). Three elements of self-authorship. *Journal of College Student Development* Vol. 49(4), 269-284.
- McMullen, L. M. (2003). Depressed women's constructions of the deficient self. In J. Stoppard & L. M. McMullen (Eds.), *Situating sadness: Women and depression in social context* (17-38). New York: New York University Press.
- Miller, J. B. (1976). *Toward a New Psychology of Wmen*. New York: Beacon Press.
- Miller, J. B. (1991). The Development of Women's Sense of Self, in J.V. Jordon (Ed.), *Women's Growth in Connection*. (11-26). New York: Guilford Press.
- Murff, S. H. (2005). The impact of stress on academic success in college students. *The ABNF Journal*. September - October, 102-104.
- National Institute of Mental Health. (1990). *Clinical training in serious mental illness* (DHHS Publication No. ADM 90-1679). Washington, DC: U.S. Government Printing Office.
- Nunez, A., & Cuccaro-Alamin, S. (1998). *First generation students: Undergraduates whose parents never enrolled in postsecondary education*. Washington, DC: U.S. Department of Education, National Center for Education Statistics.
- OSDUHS. (2008). LeMar, J. et al. Ontario Public Health Association.
- Pascarella E.T., et al. (2004). First-generation college students: Additional evidence on college experiences and outcomes. *The Journal of Higher Education*. Vol. 75(3), 250-284.
- Peden, A. R., et al. (2001). Preventing depression in high-risk college women: A report of an 18-month follow-up. *Journal of American College Health*. Vol.49(6):299-306.
- Pereira, A. M. (2008). First-generation students. Retrieved June 4, 2009, from <http://fye.mcmaster.ca/first-gen.html>
- Reimer, M. & Bodnar, A (1979). *The Organization of Social Services and its Implications for the Mental Health of Immigrant Women in Toronto*. Toronto, Secretary of State Report.
- Reimer, M. (Ed.). (2004). *Inside Corporate U: Women in the Academy Speak Out*. Toronto: Sumach Press.
- Reimer, M., & Mueller, A. (2006). Accessing the transition to careers for female undergraduates in the restructured university in New Brunswick. *Canadian and International Education*. Vol.35(1), 81-89.
- Reimer, M. & Ste-Marie, M. (2011). "Denied Access: The Focus on Medicalized Support Services and "Depressed" Women Students in the Corporate University", *Resources for Feminist Research/Documentation Sur La Recherche Feministe*, Vol. 33 (3 & 4), 137-159.



- Ruddick, F. (2008). Hope, optimism and expectation. *Mental Health Practice*. Vol. 12(1), 33-35.
- Schmidt, P. (2003). Academe's Hispanic future: The nation's largest minority group faces big obstacles in higher education, and colleges struggle to find the right ways to help. *The Chronicle of Higher Education*. Vol 50(14).
- Smith, D. E. (2005). *Institutional ethnography: A sociology for people*. New York: Alta Mira Press.
- Ste-Marie, M. (2007). *Denied Access: Women Students Resist Construction of Themselves as Depressed in the Corporate University*. (Honours thesis in Sociology, St. Thomas University, 2007).
- Ste-Marie, M. and Reimer, M. (2011). "Denied Access: The Focus on Medicalized Support Services and "Depressed" Women Students in the Corporate University", *Resources for Feminist Research/Documentation Sur La Recherche Feministe*, Vol. 33 (3 & 4), 137-159.
- Stoppard, J. & McMullen, L.M. (Eds) (2003). *Situating sadness: Women and depression in social context*. New York and London: New York University Press.
- Striplin, J. J. (1999). *Facilitating transfer for first-generation community college students*. ERIC Digest.
- Terenzini, P. T., et al. (1996). *First-generation college students: Characteristics, experiences, and cognitive development*. *Research in Higher Education*. Vol. 37(1), 1-22.
- Thayer, P. B. (2000). Retention of students from first generation and low income backgrounds. *Opportunity Outlook*, 2-8.
- Turk, J. L. (Ed.). (2000). *The Corporate Campus: Commercialization and the Dangers to Canada's Colleges and Universities*. Toronto: James Lorimer and Company Ltd.
- Tym, C., et al. (2004). *First-generation college students: A literature review*. Texas, Research and Analytical Services.
- Vargas, J. H. (2004). *College Knowledge: Addressing Information Barriers to College*. Boston, MA, College Access Services: The Education Resources Institute (TERI).