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# Refugees' Perceoved Mental Health Post-Migration To Canada: Afghans, Colombians And The Karen (Burmese)

Fatima Sidiqi
*Ryerson University*

# REFUGEES' PERCEIVED MENTAL HEALTH POST-MIGRATION TO CANADA: AFGHANS, COLOMBIANS AND THE KAREN (BURMESE)

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## ABSTRACT

This study seeks to understand the factors that influence the perceived mental health of Afghan, Colombian and Karen (Burmese) refugees post-migration to Canada. It also examines what the differences and commonalities are among and between these groups with regards to the factors that influence their perceived mental health. Moreover, it explores whether these groups perceived that, as a result of their exposure to pre-migration trauma that they are at a high risk for developing mental health problems when they experience post-migration stressors. This study found that contextual factors, discrimination, and lack of resources and support affect refugee groups' perceived mental health post-migration to Canada. Another finding was that only the Karen (Burmese) participants (some) reported that, a result of their exposure to pre-migration trauma that post-migration stressors affect them greatly. The information found in this study could potentially be used to inform policies and programs that protect refugee health.

Key words: refugees, perceive, mental health, pre-migration, post-migration

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## Introduction

Rates of international migration have reached exceptional levels, and Canada has been receiving large flows of migrants. Canada received as many as 98,380 refugee claimants in 2010 (Statistics Canada, 2010). Refugees have been originating largely from non-European regions including, Latin America, Asia, Africa, the Caribbean and the Middle East, in the recent years (Schwartz, Unger, Zamboanga, & Szapocznik, 2010). According to the Refugee Convention 1951, refugees are ‘‘persons outside their country of origin who are unable or unwilling to return because of a well founded fear of persecution for reasons of race, religion, nationality, membership of a particular social, or political opinion’’ (UNHCR, n.d., para. 3).

The non-European regions “have replaced so-called traditional sources of immigration; [however,] Canadian societal institutions – the economy, education and health – have been slow to respond” to this change (Beiser, 2005, p. 31). Lack of understanding of refugees’ needs and experiences can negatively affect the perceived health of refugees. Thus, one of the objectives of this study includes, understanding the factors that influence refugees’ perceived mental health post-migration to Canada. The groups this study focuses on include, Afghans, Colombians and the Karen (Burmese). These groups were from the top four refugee source countries in Canada as of 2006 (Simich, Pickren, & Beiser, 2011), yet they are understudied. The rationale for using the data for three groups is to gain a better understanding of the factors that affect the health of newcomer adult refugees after migrating to Canada and to find out commonalities, as well as ethnic and individual differences (if any), between and within the groups.

According to literature (e.g. Beiser, 1999), refugees are at a great risk for developing mental disorders as they have suffered from pre-migration stressors. Thus, this study also seeks to examine whether these groups perceive that, as a result of their exposure to pre-migration trauma that they are at a high risk for developing mental health problems when they experience post-migration stressors.

This qualitative study is based on a parent study on resilience, acculturation and integration of adult migrants, conducted by Simich et al. (2011), which sought to understand the cultural strengths of recent refugees. In this major research paper, I will use a subset of the qualitative data collected by Simich et al (2010). I chose to use the data for Afghans, Colombians and the Karen (Burmese) to ensure there is diversity in the data.

The sections below include a literature review on the factors that have been found to affect the mental health of refugees pre- and post-migration to their receiving societies; the current study's research questions; the method outlining how the current study's questions are approached; the results revealing the findings of this study; and, a discussion revealing how the findings relate to current theories and recent research.

## Literature Review

**Historical overview.** Historically, in Canada, refugees, as well as some non-European immigrants and Aboriginals, were labeled as ignorant, unhygienic and prone to disease, insanity and criminality. In addition, it was thought that their assimilation to Anglo-Saxon ways would diminish these problems through intellectual evolution and modernization (Escobar, Nervi, & Gara, 2000). It was also thought that acculturation would enhance health and well-being. To date, the assumption that it is likely that ethnic minorities have impaired health due to the "inferiority" of their cultures, or to the distress of intercultural contact, or acculturative change, persists (Rudmin, 2009), negatively affecting refugees' health.

**Refugee health.** Refugees have complex health needs (Grove & Zwi, 2006; Harris & Telfer, 2001; Steel & Silove, 2001). They often experience struggles that may jeopardize their health (Besier, 2005; Steel & Silove, 2001). For instance, they are compelled to leave their homes and settle elsewhere to ensure survival (Malkki, 1995). Many pre-migration factors contribute in their decision to leave, including political and economic issues. To elaborate, pre-migration stressors include loss of family, war, rape and earthquakes, which can cause post-traumatic stress disorder (PTSD) and may have a lasting effect on refugee mental health (Beiser, 1999). In addition, they may be exploited even by those who are supposed to protect them, including the United Nations peacekeepers and settlement workers. Exploitation includes demanding sex in exchange for basic services. Refugees experience ongoing fear of persecution from authorities in refugee camps and in their new countries (Grove & Zwi, 2006).

Steel et al. (2002) and Silove et al. (2007) have also found an association between pre-migration stressors and risk of PTSD, in their study of Vietnamese refugees living in Sydney. Pre-migration stressors, especially torture, was found to be a risk factor for PTSD among Tamil refugees in Australia (Silove, Steel, McGorry, Miles, & Drobny, 2002) supporting previous evidence that torture is a major risk factor for PTSD and depression (Mollica et al., 1998). Moreover, Fenta, Hyman, & Noh (2004) have found a lifetime prevalence of depression among Ethiopian immigrants and refugees of 9.8%—this is higher than the rate in Ontario (7.3%)—and pre- and post-migration stressors were found to be risk factors for depression among this group. Furthermore, in a study of Somali refugees in the United Kingdom, each pre-migration stressor increased the risk of anxiety and depression (Kinzie, 2006).

According to Beiser, Simich, Pandalangat, Nowakowski, & Tian (2011), about one in ten refugees suffer from PTSD in resettlement countries. They further reveal that among the Tamils in Toronto, the rate is about two points higher. Beiser (1999) also states that each pre-migration stressor increased the risk of mental health problems for refugees, specifically during the early period of resettlement- the first twelve months after arrival to Canada.

It is important to note that upon arrival in Canada, the majority of migrants (more than 90%) report their health as either good or excellent (McDonald & Kennedy, 2004; Newbold, 2009; Ng & Statistics Canada Health Analysis and Measurement Group, 2005; Perez, 2002; Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008). In addition, they "display health characteristics that equal or exceed those of Canadian residents" (Gushulak et al., 2011, p. 955). Canadian literature on migrant health reveals that some of these beneficial

health indicators become less pronounced and refugee health deteriorates with length of residence.

According to literature, the factors that influence the settlement process and in turn health, include origin and culture, language barriers, lack of an already established like-ethnic community and social isolation (Beiser, 1999) and socioeconomic status and discrimination (Rudmin, 2009). In addition, context of reception constrains and directs the settlement process (Beiser, 1999; Berry, 2006; Rohmann, Piontkowski, & Van Randenborgh, 2008). It is important to note that the settlement process may operate differently for different individuals or groups. The following section will elaborate on the factors that influence the settlement process.

**Origin and culture**. Many contemporary migrants to Western countries are from non-European backgrounds. They originate largely from regions where collectivism is emphasized over individualism and settle primarily in societies where *individualism* is emphasized more than collectivism (Triandis, 1995). As a result, there are gaps in cultural values between many migrants and their receiving western societies (Schwartz et al., 2010), including Canada (Beiser, 1999).

Berry's integration category, also referred to as "biculturalism" (Benet-Martínez & Haritatos, 2005)—where both the heritage and receiving cultural streams are prominently endorsed (Schwartz & Zamboanga, 2008)—has been associated with the most favourable psychosocial outcomes (e.g., Coatsworth, Maldonado-Molina, Pantin, & Szapocznik, 2005; David, Okazaki, & Saw, 2009). Biculturals integrate the different cultures they come into contact with. As a result, it is suggested that bicultural individuals tend to be better adjusted.

**Language barriers**. As a shared language is part of national identity, migrants who cannot speak the language of the country or region in which they are settling, for instance English in English-speaking Canada are considered a threat to national unity (Barker et al., 2001; Schildkraut, 2005). According to Beiser (2009), language proficiency is important in making one's way in a new environment. In addition, research in the United States has shown that these migrants encounter more struggle and stress compared to migrants who come from English speaking countries and are otherwise fluent in English (Schwartz et al., 2010). Not surprisingly then, lack of proficiency in English or French in Canada is associated with reporting poor health (Pottie et al., 2008). Consequently, among other factors, permutations among ethnicity and cultural similarity, as well as language barriers, affect health.

Unfortunately, many newly arrived migrants in Canada, including refugees, lack proficiency in both written and spoken English and French. In 2005, 36% of newly arrived migrants in Canada reported lack of proficiency in both English and French (Gushulak et al., 2011), making even health information (presented in English or French) inaccessible to these migrants.

**Lack of an already established like-ethnic community and social isolation.** According to literature, refugees who do not have pre-existing like-ethnic communities are at a risk for mental health problems (Beiser, 2009; Noh & Kaspar, 2003; Simich, 2003). Those who also lack social support are at a higher risk for mental health issues (Beiser, 2009; Berry & Blondel, 1970; Hirschfeld & Cross, 1982; Brown & Harris, 1978; Noh & Kaspar, 2003). As a result, some of the sixty thousand refugees from Vietnam, Laos and Cambodia who were admitted to Canada between 1979 and 1981 developed

mental health issues including depressions and anxieties (Beiser, 1999). Beiser (1999) found that when these refugees came to Vancouver, they did not have already established like-ethnic communities. In addition, some of them did not have a spouse (social support). Those who were lacking an already established like-ethnic community and did not have a spouse, had the highest levels of depression, especially during the early period of resettlement (Beiser, 1999). Stewart et al. (2010) also found in their study of 60 Chinese immigrants and 60 Somali refugees in Canada that lack of support negatively influenced their health.

**Discrimination and socioeconomic status (SES).** In addition to being disadvantaged as a result of language barriers, those migrants who belong to racialized groups are not regarded favourably and are discriminated against (Cornelius, 2002). According to Beiser (1999), refugees in Canada have been discriminated against; and visible minorities are more likely to be in low paying jobs and to receive lower pay in Canada compared to non-minorities.

Discrimination and racism affect mental health at least indirectly as it makes it difficult to gain or maintain employment. In his study of Southeast Asian refugees, Beiser (1999) found that when these refugees were asked if they were discriminated against because of their race, one in four answered 'yes.' He also revealed that most of the participants reported experiencing discrimination at work.

Discrimination affects mental health directly as well, as perceiving discrimination can negatively affect self-esteem and feelings of efficacy (Beiser, 2009). Noh and Kaspar (2003) also found a significant association between perception of discrimination and depressive symptoms, in their study of adult Koreans in Canada.

Additionally, Cornelius (2002) found that native-born Americans regarded European and Canadian migrants (most of whom are 'White') the most favourably. Another study also indicated that European-origin migrants are regarded more favourably than ethnic minorities (Simon & Lynch, 1999). According to the U.S. Census Bureau (2001), despite the rapid population growth among racialized ethnic minorities, Whites have remained economically advantaged. As a result, racialized ethnic minorities are more likely than European-origin migrants to experience, or at least perceive, discrimination from the receiving society.

According to Rumbaut (2008), when ethnic minority groups experience discrimination, the result is *reactive ethnicity*. Reactive ethnicity refers to resisting acquisition of the receiving culture and holding even more strongly onto one's heritage culture. In other words, from Berry's (1980) perspective, discrimination encourages ethnic minorities and their children to remain separated from the dominant receiving-culture, making the settlement process more difficult, negatively affecting their health (Beiser, 1999).

The idea that the settlement process is distressful may occur from failure to control for the negative effects of discrimination and low SES, which often arise with settlement (Rudmin, 2009). Perceived or actual discrimination has sometimes been confounded as a major component of the settlement process (Gee, 2002). Schwartz et al. (2010) found in a Finnish study of six immigrant groups and in a Spanish study of five immigrant groups, that perceived discrimination was strongly related to psychological distress. Also, in a large Swedish study, comprised mostly of non-minority Swedes, perceived discrimination was found to be a strong predictor of psychological distress, and

25% of this effect was explained by low SES (Schwartz et al., 2010). Both perceived and actual discrimination, not surprisingly, have a negative influence on health.

Low SES is also a major predictor of ill health among minorities (Moyerman & Forman, 1992). In a meta-analysis of 49 studies, it was found that lower SES samples had more increases in symptoms and conflict during the settlement process (Rudmin, 2009). Unfortunately, refugees often tend to come from low socioeconomic class backgrounds. Economic deprivation and poverty are more common among this group (Curtis, Setia, & Quesnel-Vallee, 2009). In addition, they are highly dependent on social services to assist in their settlement (Grove & Zwi, 2006). These conditions may increase stress and struggles associated with the settlement process (Suárez-Orozco, Suárez-Orozco, & Todorova, 2008).

Also, while voluntary migrants and ones selected by the receiving country for their human capital are seen as contributing to the receiving nation's economy or culture, refugees as well as migrants from lower socioeconomic classes may be viewed as a drain on the receiving country's resources (Steiner, 2009). Migrants who are rejected or discriminated against in the receiving society may have more trouble adapting following migration, resulting in distress (Portes & Rumbaut, 2001; 2006).

**Context of reception**. Studies have found that the attitudes of receiving-society members toward refugees interact with refugees' own acculturation patterns, determining the extent to which they are received favourably or unfavourably (Berry, 2006; Rohmann et al., 2008). An unfavourable context of reception, negatively affecting health, also includes a lack of access to jobs and other social resources, being marginalized and stigmatized and living in unsafe neighbourhoods. Some ethnic minorities, such as

Mexicans and Indochinese, are especially likely to settle in stigmatized and unsafe neighbourhoods, for both social and economic reasons (Portes & Rumbaut, 2006).

Context of reception also includes support that migrants receive from members of their receiving community. Migrants may be best able to integrate into the receiving society when they receive social support, encouragement and helpful resources (Akhtar & Choi, 2004). Such support may help to counter the negative effects of discrimination and feelings of inferiority in the majority culture (Suárez-Orozco et al., 2008). Without such support, migrants struggle and encounter stress.

**Other stressors.** Other factors may also contribute to newly arrived refugees' distress, including the fear that they are only temporarily protected and that they may lose their refugee status (Grove & Zwi, 2006). Also, even after a few years of arrival, refugees experience high levels of anxiety as a result of concern for family who is left back-home (Grove & Zwi, 2006). Moreover, they worry about being safe and secure in their new environment (Grove & Zwi, 2006).

Applying for refugee status can also be straining, as refugees may wait long to be accepted (Grove & Zwi, 2006). Refugees may wait for many years in refugee camps hoping for a visa (Grove & Zwi, 2006). Also, the fact that some applicants will not be accepted creates uncertainty and anxiety (Grove & Zwi, 2006). Even when they do get accepted, they undergo stressors involving integrating into their new communities, employment, financial and health (as mentioned earlier) (Gushulak, & MacPherson, 2006).

Other stressors include accessing health care and the responsiveness of practitioners and the health care system (Gushulak & MacPherson, 2006). Prevention and

promotion services may not be accessed by migrants as such services may not be perceived as needed (McDonald & Kennedy, 2007; Newbold, 2009). Even when these services are accessed, sociocultural dimensions may determine the understanding and management of refugee health issues, which may result in needs being unmet. According to Ekblad's (2004) study, mainstream services are not culturally sensitive. Also, refugees' health concept may not be the same as the Western system. For example, when an Asian refugee believes that an illness is as a result of human curse (DeBellonia et al., 2008), provision of health care for such a client may be challenging for a health care provider who is not familiar with this idea. Unfortunately, instead of responding to refugee health needs, the receiving society is more concerned about refugees negatively affecting the health of the community and their potential to drain the system of its resources (Grove & Zwi, 2006).

According to Grove and Zwi (2006), "care may be inadequately sensitive [even] to the prior experiences of the migrant and may pose the risk of re-traumatising a potentially fragile individual ... failure to provide welcoming, accepting and fine-tuned services may do the opposite of what is required and will instead distance people, contribute to their alienation and undermine their health" (p. 1939). Despite this problem, health care providers are limited in their resources to meet the unique needs of refugees as the concern is often more with costs rather than with ensuring refugee wellbeing (Mares, 2002).

Clearly, refugee health is negatively influenced by both pre-migration and post-migration factors (Gushulak et al., 2011). It is no wonder that migration has been

associated with depression and psychosocial illness, particularly in refugees (Fazel, Wheeler, & Danesh, 2005; Kuo, Chong, & Joseph, 2008).

## Research Questions

Based on the above literature review, this study asks the following research questions:

1. What are the factors that influence *specific* refugee groups' perceived mental health post-migration to Canada?
2. What are the ethnic and individual differences and commonalities (if any) among and between various refugee groups with regards to the factors that influence their perceived mental health?
3. Do refugees perceive that, as a result of their exposure to pre-migration trauma that they are at a high risk for developing mental health problems when they experience post-migration stressors?

## Background of At-Risk Groups

**Afghans.** According to Dupree (2002), over the millennia, Afghanistan has been settled by a rich diversity of people, as it occupies a position in the centre of four countries. Its centrality is what has attracted different peoples and groups including "armies, men of intellect, missionaries, pilgrims, traders, artisans, nomads and political exiles" (p. 1). Many of them stayed and settled in this country.

During the 1970s, conflicts over values erupted. The thousands of Afghans who had studied abroad came back to Afghanistan with their own ideas which clashed with those of the conservatives. The exodus of Afghans from Afghanistan began as a result of the 1978 coup d'état by the communist faction of the Afghan government. The Soviet's invasion of Afghanistan in 1979 followed, and resulted in millions of Afghan civilians

fleeing into exile (Dupree, 2002; Lipson, 1991). For about ten years, the USSR and the pro-Soviet Afghan government maintained power over Afghanistan in the face of the Afghan mujahideen (freedom fighters), who were the resistance group (Lipson, 1991). There was much chaos, leading to "a period of doctrinaire ultra-conservatism under the Taliban, followed by uncertainties in which an interim government struggles for national unity" (Dupree, 2002, p. 7).

Millions fled to Pakistan as refugees because they were either affected by the violence exerted by the resistance group over the communists or because they were endangered politically (Lipson, 1991). Not only were they torn from their homes and country, the mujahideen overpowered these refugees. The mujahideen wanted to maintain a good reputation around the foreigners and so they imposed extremely strict rules on the women, including physical and psychological seclusion. By the end of the year 2000, the Taliban regime was gaining an upper hand (Dupree, 2002).

Afghans have suffered for many years from the traumas of war, inept and unstable governments, as well as a collapsed economy and disruptive society. Settlement issues among Afghans have been studied using mixed methods in Australia (Waxman, 2001), Canada (Simich, 2003) and the Netherlands (Gerritsen et al., 2005). As in other refugee studies, a number of social factors are commonly associated with poor health outcomes and poor integration: lack of social support, lack of proficiency in English, female gender, older age, pre-migration trauma and status as asylum seekers. According to Statistics Canada (2006a), there are a total of 36,165 Afghan immigrants in Canada.

According to the Afghan participants in this study, Afghanistan is a war-torn country and is neither safe nor secure for them to live there. In addition, education was

not available for their women and children as a result of the war. Many of them did not come directly from Afghanistan to Canada. They sought refuge in Pakistan from Afghanistan and settled there for a few years before migrating to Canada. They could not continue living in Pakistan as they were discriminated against. They lacked opportunities. To elaborate, they mentioned that education is not readily accessible to Afghans and that Afghans do not receive equitable pay when employed. The Pakistani police also mistreat the Afghans due to their status as refugees. The Afghans felt that they did not have a future in Pakistan.

**Colombians.** Colombia "has endured a long-standing, multipolar and mobile armed conflict in which the continual performance of violence in the form of massacres, selective assassinations, threats, disappearances, forced recruitments, rape and forced displacement inscribes terror in local landscapes and everyday life" (Riano-Alcala, 2008, p. 2). Armed groups including left wing guerrillas, right wing paramilitary, and the army and drug traffickers rule Colombia and its civilians.

The over fifty years of internal conflict, the rulings of the armed groups (to establish control over strategic territories- trade/circulation routes, areas rich in natural and mineral resources) and the violation of human rights has resulted in the forced displacement of refugees and in refugees crossing borders. Colombia is the main source of forced migration in the Americas. Millions of Colombians are internally displaced. Also, more than 260,000 Colombians have sought refuge and live in countries such as Ecuador and Canada (Riano-Alcala, 2008).

According to some of Colombian participants in this study, they escaped to the U.S. first from Colombia, lived there for a few years and then migrated to Canada. Their

illegal status in the U.S. compelled them to move to Canada for security. Approximately 50% of the 30,000 Colombians who have arrived in Canada since 1990 were accepted as refugees, but in Toronto, Colombians have tended to distance themselves from one another (Landolt et al., 2009). There are a total of 39,145 Colombian immigrants in Canada (Statistics Canada, 2006a).

**Karen (Burmese).** Burma has been affected by civil war for more than forty years, affecting large minority groups including the Karen, Karenni and Mon. It has been under military control since 1962, and the current military regime is called the State Peace and Development Council (SPDC). The Burma regime is considered among the world's worst human rights violators in terms of murder, arbitrary executions, torture, rape, detention without trial and many other forms of abuse. This has resulted in mass migrations and regional disruptions. The ethnic minorities—40% of the Burma's population—including the Karen (Burmese), are the primary target of abuse. Since 1984, many refugees from Burma have escaped to other countries including Thailand, Bangladesh and India (Kemmer et al., 2003).

The Karen (Burmese) fled their country in 1995 to escape armed aggression and persecution by the SPDC against the Karen National Union. They, along with other Burmese refugees, have been forced to seek protection in Thai refugee camps for over 20 years (Citizenship and Immigration Canada, 2007), and more than 135,000 of them have been living in those camps. Many of them have also been internally displaced (Kemmer et al., 2003).

According to the Karenni Student Development Programme (2009), although the Burmese government denies ethnic cleansing, the Four Cuts policy which has been

implemented since the mid-1960s by the Burmese government acts to "cut the supplies of food, funds, recruits and information to resistance groups...by systematically terrorizing, controlling, and impoverishing the civilian population in resistance areas" (para. 4-5). The SPDC's implementation of this policy has been more brutal than its predecessors, as the SPDC has forced mass relocations by burning villagers' homes and farms. The areas affected the most include the Karen and the Karenni States, which are areas on the eastern border with Thailand (Karenni Student Development Programme, 2009).

Less has been published about the Karen refugees from Burma, who are now living in Toronto, although they have experienced many of the pre-migration stresses noted for other forced migrants. This group was admitted as government-assisted refugees (GARS) to Canada. They received the support of a collaborative initiative between the COSTI refugee reception house and an integrated primary care and social work team at Access Alliance Community Health Centre aimed at promoting refugee health. There are a total of 4,990 Burmese immigrants in Canada (Statistics Canada, 2006b).

According to the Karen (Burmese) participants in this study, Burma is not a democratic country. The Four Cuts policy ensured cutting the Karen leader from its civilians; not allowing Karen armies to get taxes from Karen civilians; forbidding the Karen leader to be in contact with its civilians; and, killing the Karen civilians. As a result, the Karen civilians were oppressed, persecuted and discriminated against in Burma. They had to hide and live in jungles, suffered from extreme poverty and were always on the run. Also, they could not obtain education. These circumstances forced them to enter Thailand's refugee camps for shelter. They were not given the permission

to go outside of the camps, not even to look for employment opportunities. When they attempted to leave, the Thai police would arrest them. Their basic human rights were violated.

Also, while the United Nations (UN) provided them with rice and beans, they did not have the money to spend on other basic needs such as vegetables or meat. In addition, they were not given medical treatment when it was needed. Moreover, they did not feel secure in these camps, as the Democratic Karen Buddhist Army (DKBA) and the Burmese soldiers would infiltrate refugee camps and attack them. The Karen (Burmese) saw themselves as stateless people with no legal recognition. As a result, many Karen (Burmese) refugees decided to come to Canada.

## Method

This qualitative study will be based on a parent study on resilience, acculturation and integration of adult migrants conducted by Simich et al. (2011), which sought to understand the cultural strengths of recent refugees. Qualitative interviews were conducted in the summer of 2010 with adult participants from a range of refugee source countries, with 8 members from each study group (4 men, 4 women) to develop an in-depth understanding of why some forced migrant groups stay healthy in the face of migration and settlement stressors. My study is an offspring of Simich's et al.'s (2011) study. Using the qualitative data collected in Simich et al.'s (2011) research, I will identify the factors that affect the mental health of adult refugees after migrating to Canada. The data for the Afghan, Colombian and Karen (Burmese) refugees will be used. The rationale for using the data for *three* groups is to gain a good understanding of the factors that affect the health of newcomer adult refugees after migrating to Canada, and to find out commonalities, as well as ethnic and individual differences (if any), between and within the two groups. These refugee groups are exemplary cases for investigating refugee health after migration to Canada, as they are priority at-risk populations in terms of policy and public service delivery because of their forced migration experiences and notable exposure to racialization, discrimination and low SES poverty and social exclusion during early resettlement years (Simich et al., 2011).

In depth qualitative research methods are appropriate for investigations that seek to examine perceptions and experiences of various groups in particular social contexts (Simich et al., 2011). Interviews were conducted by trained bi-lingual community and student researchers in both university and community settings, with the assistance of a

research coordinator based at the Centre for Addiction and Mental Health. In this community-based study, researchers acted as cultural brokers who built rapport with participants. The participants were recruited using purposeful sampling, as qualitative studies generally employ such methods, for information rich cases that will illuminate the question under study (Lincoln & Guba, 1985). Particular attention was paid to ensure diversity of the sample by age, gender, occupation, length of residency in Canada and varied experiences with forced migration and settlement. A gender balanced sample helped ensure that the analysis reveals any important differences in migrant women and men's experiences. A sampling framework was created by approaching key service agencies and community leaders, explaining the study and asking for recommendations of appropriate participants (who were informed in their language of choice about the study and gave permission to be contacted by the research team). The criteria that were followed included: All individuals should be between the ages of 18 and 65 and will have lived in Toronto for one or more years. As used in Canada, the term "recent refugee" generally refers to those who have resided in Canada up to ten years; however, the study required participants who have lived in Canada at least one year to ensure enough familiarity with the social environment and time for reflection on the migration and settlement experience to make the interviews productive. English proficiency was desirable, but lack of proficiency did not exclude cases.

Community researchers, settlement and health care organizations assisted with study participant recruitment. Specifically, community and health agencies who are actively working with members of the study communities were approached and interested students (including myself) and professionals who are members of the communities, were

engaged as research advisors and research assistants. Afghani students (including myself) were employed as Research Assistants at Ryerson University under the direction of Dr. Pickren, to outreach for recruitment to Afghan community associations; Colombian interview participants were recruited by collaborating with an experienced Colombian settlement worker, who was based at the Mennonite Centre for New Canadians; and a key Karen (Burmese) settlement worker, Ms. Wah Paw Lah, a Peer Health Education Outreach Worker at Access Alliance Community Health Centre, was approached to help with the recruitment of the Karen (Burmese) participants.

**Interview Structure**

Patton (2002) maintains that the primary purpose of qualitative interviewing is to provide a framework within which respondents can express their own understanding about a particular topic in their own terms. In essence, the process of interviewing allows individuals to share stories and perceptions regarding acculturation experiences (Simich et al., 2011). The interviewing technique was guided and interactive, in order to produce narrative texts from subjective perspectives (Corbin & Morse, 2003; Dossa, 2002). Narratives have long been a part of lay and professional traditions of understanding meanings of health and wellbeing and serve to illuminate both personal and social resources (Mattingly & Garro, 2000).

Interview topics were partially adapted from the work of Mollica (2006), who found work, altruism and spirituality as qualities grounded in cultural values and as factors that ease the process of acculturation. Some basic interview themes were as follows: Migration and adaptation challenges (i.e. difficulties--events or ongoing struggles--before and after migration); responses to challenges and an exploration of

resiliency factors (i.e. ways of overcoming these difficulties, followed by probes into various aspects of resiliency) and sense of identity, values, social relations or cultural practices perceived to help or provide strength; lessons and prospects (i.e. reflection on what has been learned and what is needed from society to achieve health and equity).

Interviews averaged 1.5 hours and were conducted in comfortable, confidential settings. Study participants received a $30 honorarium. All interviews were digitally recorded with permission, translated into English when necessary by bilingual research assistants and transcribed for coding and analysis. The parent study protocol was approved by the Research Ethics Review Board of the Centre for Addiction and Mental Health and Ryerson University.

**Interview Process**

At the beginning of the interview an attempt was made to develop rapport with the participants by letting them know a little bit about the researchers' backgrounds and the purpose of the study. Each Afghan participant was interviewed by two Afghan interviewers (including myself) at the same time. Each Colombian participant was also interviewed by two interviewers (one from Chile; one from Spain) at the same time. The Karen (Burmese) participants were interviewed by one interviewer (from Burma). An attempt was made to keep the interview conversational and informal. The participants were reminded that if they wished to share something additional at any point, they were free to do so. The order of the questions varied depending on the lead taken by the participants. Many times the initial questions were followed by additional probes to clarify or explore the experiences shared by participants. The style of interviewing was facilitative, thus allowing the participants to share whatever they wanted while being

respectful of the emotional and deeply personal nature of the experiences being shared by them.

Interviewers were conscious of the fact that they are not neutral or objective participants in the interview process. Being an Afghan might have influenced the participants and the interview process; yet, at the same time, interviewers were able to utilise their knowledge and personal experience of having lived in other countries to enhance their sensitivity to the experiences of the refugees. Hence, the style of interviewing was not interrogative but flexible in order to encourage ideas to emerge freely during the interview. Interviewers also withheld comments except to paraphrase or probe what was being shared.

After the interview, the participants were invited to ask any questions or make comments. Some of the participants asked if it would okay for them to contact us (the interviewers) if they needed guidance or information regarding practical matters. We provided them with our contact information and assured them that we would be more than willing to be of assistance.

**Data Organization**

The data in the form of audio recordings and transcripts were coded using a number system. Each participant was identified with a number and an alphabet. All files were closely protected, that is, saved within a password protected folder on the computer that also included the identifying information of the participants assigned to a numbering system. In order to further protect the identity of the participants, when family members and or relatives were mentioned in the interviews, they were identified with letters and numbers.

## Data Coding

The critical analyst contextualizes data by considering beliefs, norms and structural and situational constraints that shape experiences and behaviours (Lock & Scheper-Hughes, 1996). The process of coding and analysis typically combines 'directed' content analysis based on interview topics for systematic comparison across cases; 'open' or *in vivo* coding to identify insider's perspectives (Ryan & Bernard, 2000); and a higher, more abstract level of analysis to link common ideas to larger conceptual or contextual issues. Meaningful themes and patterns that emerge from the data and related to individual and group characteristics, culture and social resources and contextual factors can be identified.

Thematic analysis is a widely used method within qualitative analysis. The method entails certain core skills which are common to many other types of approaches. One of the key features of thematic analysis is its flexibility and its independence from any theory and epistemology (Braun & Clarke, 2006). The method involves a process of identifying, analyzing and seeking patterns or themes within the data. The data collected in Simich et al.'s (2011) study are analyzed using the guidelines suggested by Braun and Clarke (2006).

**Getting familiar with the data.** This phase has been completed by the research assistants in Simich et al.'s (2011) study. After conducting the interviews, they were transcribed verbatim in order to begin the analysis. While the process of transcription can be very time-consuming and trying at times, transcripts can be used to get familiar with the interview data and to take notes and mark ideas for coding. Portions of the interview which were not audible were marked by brackets [….]. The transcripts were then checked

against the original audio recordings for any errors or omissions. The repetitive close reading of the transcripts helped facilitate a meaningful understanding of the different issues explored within each of the interviews. The current study involved the phases below.

**Phase 1: Generating initial codes.** This stage of the analysis began after reading and becoming familiar with the written transcripts and having generated an initial set of ideas about interesting things in the data. This phase involved the application of codes to the textual data to organise it into meaningful and manageable data fragments. Familiarization with the data allowed recognition of recurring ideas across transcripts. Afterwards, the process of coding was initiated.

Codes refer to any meaningful semantic feature of the data that are salient to the research and appear to re-occur across the transcripts. The entire data was given full and equal attention. After an initial set of codes were developed, the printed transcripts were coded manually by writing on the texts and using highlighters to identity the segment of data extract that match the code. Additional codes that emerged during this process were added to the original list. The coding for each group's transcripts was done separately in order to be able to compare the groups. It was ensured that the text is coded for as many relevant codes as seemed important.

**Phase 2: Searching for themes.** At this point, a long list of codes was identified across the data set. This phase of analysis consisted of sorting the different codes into potential themes. While the codes constituted the basic semantic units of analysis, the themes were much broader in focus and required a more interpretative analysis. Writing the codes on a separate piece of paper was visually helpful in organising the different

themes piles. At this stage, I also began to think about the relationship between the codes and the themes. Themes were then checked for emerging patterns of variability and consistency. The interpretation of the themes was conducted by a process of re-reading the transcripts and relevant literature.

**Phase 3: Reviewing and naming the themes**. The themes were then closely examined to check whether all the coded data extracted fit the theme and whether the individual themes were representative of the data set as a whole. The themes were then examined separately and in relation to the others. Different levels of themes were helpful in demonstrating the significance of each one within the text.

## Results

The analysis of the transcripts resulted in 3 interrelated higher order themes and 7 subthemes. Table 1 lists the themes generated.

Table 1. Higher Order Themes and Subthemes

| | |
|---|---|
| Contextual Factors | Receiving Community |
| | Context of Migration |
| Discrimination | Deskilling |
| Lack of Resources and Support | Guidance |
| | Language Skills |
| | Social Support |
| | Instrumental Support |

### Contextual Factors

There were two subthemes which emerged within this theme. The first highlighted factors pertaining to the receiving community. Within this subtheme, the first important issue that came up was the refugee's experience based on where they first resided- whether a shelter, relative/friend's residence, a rented place, etc. For Afghan and Colombian refugees, settling first in a shelter meant residential support, at least some guidance and information and direction and orientation, however, it was seen as temporary support. Also, spending time in the shelter was seen as a waste of time, especially by Colombians, resulting in distress. One Colombian man stated:

> The worst were those three months, dead, in a shelter. Wow, that was…I think that is the best way to kill time. Wow, that is deceiving to have to wake up and you only wait for the time to pass to go back

> to bed because there is nothing else to do. It's extremely frustrating, tremendously.

Settling first in a relative or a friend's place meant initial support and comfort, but also temporary and stressful due to limited available space and the need to become independent. The Karen (Burmese) did not mention living in either a shelter or a friend/relative's home upon arrival; they discussed issues experienced in the apartments that they lived in independently with their families. For all three groups, a rented place meant financial difficulties, at least the first few years, and loneliness if living alone, leading to depression. The Karen (Burmese) especially suffered from poor housing conditions, but did not have the financial capacity to move to a better place, negatively affecting their mental wellbeing. One Karen (Burmese) man said:

> Housing remains a big issue for me. My landlord and I cannot communicate well. I cannot speak his language. As you entered into my room, you should notice what damages or repairs that need to be made. My bathroom has been broken and in need of repairing for more than one year.

Thus, while participants preferred renting their own place to have more space and privacy, they had to work overtime to be able to pay their rent and were often faced with financial difficulties. Working overtime also resulted in having no time for leisure or for family gatherings.

Close proximity to community organizations, community centres and religious institutions and employment and volunteer opportunities are perceived as important by the participants. These enhanced participants' experiences socially, as they helped them make social circles and networks; physically and mentally, as participants were guided with practical matters and were assisted to and from places such as hospitals; occupationally, as they were assisted with finding jobs and writing resumes, and thereby

financially. Lack of these facilities and opportunities, negatively affected their social, financial, intellectual and mental wellbeing.

While the Karen (Burmese) wished to live around their own group, as in their country of origin their group members helped one another, for some Afghan refugees, living around people with a similar background and SES meant losing the opportunity to be around people from different ethnic, occupational and educational backgrounds, therefore disadvantaged in acquiring diverse perspectives and information. They perceived this as a barrier to moving forward. Some Colombians also wished to avoid living in close proximity with their group as they perceived Hispanics to be selfish and so unwilling to share any information or be of any assistance. A Colombian woman stated:

> The Hispanics, unfortunately there is a lot of envy, like we are jealous if someone else gets a job, so we hold back giving information, even if we know it we won't tell it, we won't share it.

At the same time, for Afghans and Colombians, access to an institution or an individual who is culturally sensitive meant one's personal and cultural needs will be met. This was especially true for the Karen (Burmese) participants. However, all three groups felt that this was lacking, negatively affecting their mental wellbeing. One Afghan woman said:

> I feel that the problems Afghans experience can only be best understood by Afghans. Many Afghans suffer from psychological problems due to their horrific experiences during the war, the struggles to make a living in Canada and lack of assimilation into the Canadian society. I truly believe that these experiences and struggles could not be comprehensible to a non-Afghan health professional. The non-Afghan professionals hear stories as stories and help to the extent they can. I am not saying that everyone should seek help from people of their own ethnicity but sensitive experiences of Afghans and many other refugees can be best understood by people who have also experienced these events and are sensitive to the cultural protocols that come along with such experiences.

(As a result of their collective orientation to life [Waxman, 2001], most of the Afghan participants speak about their personal experiences and needs collectively rather than individually).

A Colombian woman also stated:

> For example, the difference in our health care system that today you have to pay to enter a hospital, we are very passionate in that sense, so when we receive a patient in Colombia we are very helpful with the patient – they attend you, what's wrong with you, where does it hurt, be very careful and all that. Here, there is not so much. And the other thing is at the mental level for me they prescribe medicines very quickly, so it's like a very quick diagnosis. The doctor right away gave me sleeping pills and antidepressants and I said no, I'm not buying that.

Other contextual factors which played an important role in the experiences of participants were preconceived notions about the receiving community and the levels of mental and physical preparation for the changes that will be experienced in Canadian society. The groups expressed that they knew they would experience changes and difficulties upon arrival and in the adaptation process; however, they stated that the level of difficulty and challenges faced were much greater than anticipated. Also, the groups thought that they would do much better here than they did in the multiple countries they lived in before migrating to Canada. They expected to be safe and financially secure. However, while the participants' lives did improve in Canada, specifically with regards to safety and being granted rights, in other ways, their socioeconomic status, specifically of Afghans and Colombians, worsened here in Canada. As most of the Afghans and Colombians were professionals back home, they stated that while they did not expect to be given the opportunity *right away* to practice in their own fields, they were shocked their qualifications and experiences were not recognized and that even for sweeping the

floors they needed "Canadian experience." The groups became financially insecure, resulting in at least symptoms of depression, especially during the early settlement years.

The Afghans were especially disheartened by this situation. They reasoned that in Afghanistan it was extremely difficult to obtain education and qualifications and that as they nevertheless obtained them in those circumstances; it was difficult for them to accept that their credentials count for nothing in Canada. For example, an Afghan woman remarked:

> What bothers me most about Canada is that they do not recognize our diplomas and or degrees. Not only do they not recognize our abilities and education, they also do not recognize the circumstances under which we completed our education. It is so easy for them to just overlook all our hard work and achievements just because it was completed in another country. This is not fair. I am not saying that they should just allow us to have the exact careers that we had in our countries of origin but they should allow us to enter somewhere in our fields for experience, practice and better understanding of the Canadian system, after which they can test us, and if we pass, we should be entitled to our original careers. This is bothersome! We want to go back to our own fields. No matter where we apply, we get rejected because we do not have Canadian experience. They deny us any right to gain experience and at the same time they demand Canadian experience.

An Afghan man added:

> It is unfair to compare Afghans with other people who have come from Europe and established or developing countries. Afghans have had a war for 30 years. They have not seen anything else but continuous war and killing. For this reason, most Afghans are not mentally stable. When they come here, the smallest things can set them off to depression and other mental disabilities.

It is not simply the lack of understanding which participants note, but the stress at being an adult who has had to "restart their life from zero" in the new country. The system includes macro-level institutions one interacts with, such as health care, the government, children's schooling, to day-to-day pragmatics such as banking, buying

groceries and taking transit. Inaccessibility and unfamiliarity with the health care system was especially problematic as these refugees came here already suffering from mental health issues as a result of undergoing traumatizing events in their counties of origin, worsening their health. The Karen (Burmese) especially suffered from unfamiliarity as they had difficulty carrying out even basic chores including cooking, cleaning and doing the laundry, resulting in stress. One Karen (Burmese) man elaborates:

> We want to have our body checked and blood tested. We had lived in jungles for a long time and thus we were worried that some diseases may occur and make us sick.

A Burmese woman adds:

> The fact that I could not come home on my own was a sad reality that made me feel bad about myself. I never grew up in a city or a town. Because of this, it was so challenging for us to live in a city. Sometimes, we feel very down as we think about our situation.

Their new environment--the Canadian climate, living in a city and the use of cars--was completely foreign situation to the Karen (Burmese). This is because in Burma, they lived in villages, jungles, or camps. A Karen (Burmese) woman further adds:

> We see snow though we had never seen it before. Then, we see cars and buses whereas back-home we never saw them. We lived here and there in jungles.

Another Karen (Burmese) woman related:

> In my first job, I worked six hours per day. I completed my hours and I should come home. However, I did not know my way back to home. I had to help my colleagues out until they finish their shifts. My friend worked eight hours per day whereas I earned only six hours a day. Because I could not come home by myself, I had to wait for my friend until she completed her hours. I was told to just rest and wait for her, but I did not. I just helped her out until she finished. Then, I came home together with my friend. Once I got home, my husband told me that you officially worked for six hours. Since you did not earn more hours, you should come home when you finished the work. It would be a disadvantage for you if you did extra hours without getting paid. I

> told him that it was fine because I could not come home alone. I had to travel through busy train intersection which was always crowded. I did not have a sense of where I was going, and thus I felt really bad and hopeless about myself when I was a newcomer.

A Karen (Burmese) man also stated:

> But, as we arrived, we did not know how to cook nor did our laundry. We did not know how and where to buy foods. Life was really hard.

While the Afghan participants were well prepared for Canada's cold climate, stating that the climate is very similar back home, the Colombians and the Karen (Burmese) were neither prepared mentally nor physically for the cold. Moreover, all three groups expressed undergoing a cultural shock. An Afghan man said:

> In Canada, it was challenging because of the…cultural differences. Overall, it is very difficult to adjust to life in Canada.

A Colombian woman also remarked:

> It was very different to live in the adaptation process of the family because of the cultural shock.

A Karen (Burmese) man adds:

> At first, we could not live [in this culture]. It was so shocking. We dared not to look at how inappropriate people dressed up. We were not used to seeing it.

Clearly multiple intersecting contextual factors including the context of reception, refugee status, work environment, employment and volunteer opportunities and proximity to community organizations and other facilities influence the experiences of these refugees.

**Discrimination**

All three groups expressed experiencing discrimination in the workplace and with respect to occupational opportunities as a result of lacking "Canadian experience." This

was problematic for these groups. Participants questioned how they can obtain Canadian experience when they are not given the opportunity to work in Canada. It was difficult even to find volunteer positions where they can gain this so-called Canadian experience. This situation resulted in distress. A Colombian woman complained:

> When one goes to a new place you don't have the Canadian experience, but how in God's name will you have the Canadian experience if they don't give you the opportunity to work.

Colombians and the Karen (Burmese) mentioned additional experiences of discrimination. They felt they were discriminated against because they were perceived "illiterate" and "mute" as they were unable to communicate in English. A Colombian woman said:

> When I left, I left like that, I left with that great illusion, I didn't leave thinking that I would crash with a language that I did not understand neither forward nor backward.

The Karen (Burmese) reported that they were especially treated badly by coworkers. One Karen (Burmese) woman related:

> The only concern I have is regarding language barrier. Our supervisors and monitors are nice and considerate, but our fellow workers are frustrated and yell at us frequently.

Another Karen (Burmese) woman remarked:

> We do not want to be looked down upon all the time as we have been. We have been a group that was oppressed, persecuted and discriminated against.

Colombians experienced discrimination in their daily interactions outside of work as well. They felt that they were looked down upon and perceived as "retarded" because of their inability to communicate in English. This experience contrasts to how they were

perceived in Colombia which was feeling valued and negatively affected their sense of integration in Canada, resulting in distress.

Other barriers that Afghan and Colombian participants experienced and that they perceived as discrimination are lack of recognition of foreign credentials, education or training and employment experience. The lack of recognition of refugees' qualifications, past education and past employment inhibited the refugees' ability to find meaningful employment. They attempted to overcome these barriers through school, volunteer work, or re-training, but in several instances, updating skills was not enough and participants simply had to change fields or work in a considerably lower position in their field. They were disheartened, frustrated and even angry that their qualifications were not recognized in Canada. They felt as if their employment and educational history had been wiped clean, resulting in depression. A Colombian woman remarked:

> When I first arrived especially toward the end of my one year sponsorship from the government, I was so worried and did not know what to do. I applied for many jobs, but got none. I complained and groaned. I thought about myself in comparison to my younger siblings. I am an oldest child, but I am useless. My younger brother has a good job. These kinds of thoughts came into my mind and I became so depressed.

Colombians mentioned that unemployment put them in close proximity, at home, with their spouses and children for longer hours during the day. This negatively affected their family dynamics and eventually resulted in separation.

> The family break-up…So, one decides *the gypsy curse*, no I mean it more seriously, what happens is that in Colombia one didn't live with their partner 24 hours and here in the adaptation process of immigrants one has to live with their partner 24 hours. So they form all the dilemmas. And you start to see all the defects. So it was all the economic dilemmas, all the dilemmas to overcome things. When I first arrived especially toward the end of my on-year sponsorship from the government, I was so worried and did not know what to do. I

> applied for many jobs, but got none. I complained and groaned. I thought about myself in comparison to my younger siblings. I am an oldest child, but I am useless. My younger brother has a good job. These kinds of thoughts came into my mind and I became so depressed.

Lack of employment also meant the need to receive assistance from welfare. Afghan and Colombian participants were especially upset that they were in need of social assistance as being on welfare was against their values of being independent. For example, one Colombian woman said:

> The other thing that I didn't mention was that I was on welfare for about 6 months, I have never liked to have social assistance and that I think is something innate, Colombian.

Those who had dependents in their countries of origin, specifically the Afghan participants, especially suffered from discrimination. As discrimination results in unemployment, and lacking employment means financial difficulties, it made it really difficult for the Afghan participants to make a comfortable living and at the same time ensure one's relatives' wellbeing back-home, resulting in depression.

Under the discrimination theme, an important subtheme that came up is deskilling. Often because individuals' past experiences and education are not recognized in Canada, participants, specifically Afghans and Colombians including the highly educated professionals, were unable to find employment in their fields and ended up volunteering in very low positions in their areas of interest and/or working menial jobs. Other participants had to switch careers altogether. This was especially true during the early years of settlement, negatively affecting the participants' health. An Afghan man stated:

> Afghans come here from a war-torn country, they have lost everything they have owned and when they arrive here, they are pressured by

> numerous responsibilities. The work that is available for them is usually degrading, unstable and the pay is at minimum, all adding to deteriorate these individuals' physical and mental health.

A Colombian woman also said:

> And there is a great contradiction at the government level when they say that they need professionals in Canada and they bring us to sweep the floor so it is a little unfair.

The lack of recognition of their qualifications, past education and past employment inhibited their ability to improve their future situation. Professional and/or linguistic skills that these refugees came with were diminished as they were not given the opportunity to use them. An Afghan man related:

> The first year that I came here, I had night shifts because I couldn't find a job in the day. Everywhere that I submitted my resume, they would tell me that the first problem is that I don't have Canadian experience. This hurt a lot because when you really do have so much experience ... when I came here, I didn't have a problem speaking English. I was able to at least communicate; my English is probably worse now.

All three groups felt that they were a "nobody" here in Canada, resulting in stress and or depression. Even though the Karen (Burmese) participants were not professionals in their country of origin and their levels of education were minimal, their work conditions here in Canada were so new and different that the work-related skills they had obtained in the past were not useful. Participants in all three groups were disappointed that they could not apply any of the skills that they brought with them.

**Lack of Resources and Support**

The two important subthemes within the theme "lack of resources" are guidance and skills. It is important to note that participants required guidance in order to receive suitable support including, instrumental and social support and to have access to various

facilities and services. As a result, resources and support work together. Social support includes family and community as well as government policies and programs. Social support entails coping in a variety of ways: sharing information with others; seeking reassurance, advice, help and social interaction; and becoming involved in the community. Instrumental support entails helping in practical ways, such as providing temporary housing, transportation to a doctor, a loan, or a tip about finding work or where to shop (Simich et al., 2011).

**Guidance**. Lacking proper guidance made even simple daily tasks difficult to carry out and placed most participants "on the wrong path" towards their education and careers, making it difficult to adjust to Canadian life, affecting their wellbeing. As a result, participants repeatedly stated a desire for guidance, mentoring and receiving information that is specific to their needs, across multiple areas: life skills, education, seeking employment and career development, amongst others.

Some participants complained that because they were not given the right advice for credential recognition in Canada, they lost their chances of becoming what they qualify for. One Afghan man said:

> Unfortunately there wasn't anyone to give me the right direction, right at the beginning. The opportunity that I had, to become a doctor here is not there anymore.

In addition, most Afghan participants also came with some language proficiency. Lack of guidance has detrimental effects. For instance, an Afghan man who was fluent in English was forced into a job much below his standards (working double-shifts at a convenience store) for *seven* years, and so not surprisingly, he lost his fluency in English, negatively affecting his self-esteem and sense of self-worth.

Every participant expressed the importance of proper guidance and information. While all three groups were aware of the existence of either individuals or community organizations that served their ethnic groups, some of the Afghan and Colombian participants did not find out about these organizations until a few months after arrival. Many Afghan participants expressed that knowing about community organizations earlier would have made life easier in regards to practical matters and direction. An Afghan woman said:

> I wasn't aware that there are communities and organizations that help refugees. I had no idea, that there are sources/organizations, like the Afghan Women's Organization, that help refugees settle, when they first arrive here. I had no idea.

Afghan and Colombian participants complained that while they may have been informed about facilities and services for refugees, they had poor recall of the information, since it is offered at the very beginning of their settlement, when a great deal of new information is being disseminated quickly.

While the Karen (Burmese) seemed to be aware of volunteers and informal organizations that can guide them, they complained, along with some Afghan and Colombians participants, that they still need non-voluntary, government provided sources--ones that they can actually depend on and not worry that they may quit volunteering-- to assist them with practical matters, employment and volunteering, education, food banks, etc. An Afghan woman elaborates:

> Yes, the problem that I personally faced was that, I didn't have enough information about where I should go or how I should deal with my needs and problems. When someone comes newly to Canada, he/she definitely needs guidance and instructions. Later, I found some organizations, to help me find a job, and help me with courses. Everywhere I went, people gave me their own opinion. There is no organization that specifically helps those who newly arrive here; with

> guidance, with the way to deal with things in every situation. I was completely lost!

A first source of guidance for many of the refugees was their family or ethnic community. However, while intending to be helpful, this small network of people who may be newcomers themselves often offer inaccurate or conflicting advice. For instance, some of the participants felt that some of the courses, in which they enrolled based on the suggestions by acquaintances, were a waste of time, and that it therefore took them much longer to reach their goals. In addition, information on more technical or strategic matters, such as career development and career pathways was sometimes provided by individuals within supportive organizations who are not qualified to give accurate information. The guidance and mentorship of qualified professionals were highly desired but were lacking, making the process of acculturation difficult, resulting in distress.

**Language skills.** Particularly in the earliest stages of post-migration, formal guidance in the migrant's native language is very important. Some participants expressed concern about not being able to speak with their doctor in their native language which has lead to health problems, reasoning that illness or the aggravation of illness have been a result of their inability to communicate their problems and receive the right treatment.

The importance of the ability to communicate in English is noted by all participants; however, most also stress the importance of having assistance in their native language, at least in their first year of settlement. Particularly for health care, participants seek out practitioners who speak their language when possible and continue to rely on interpretation within medical settings long after they cease doing so for other services. Those participants who have had need for acute medical care express frustration, confusion and, at times, fear over the lack of access to interpretation within medical

settings. While most Afghans were able to communicate in English in their early (and later) settlement years, Colombians and the Karen (Burmese) were not able to speak English. As a result, acculturating socially was especially difficult and stressful for the Colombians and the Karen (Burmese).

The Colombians and Karen (Burmese) also had difficulty reading traffic signs and making small talk, as a result of English language barriers. A Colombian woman adds:

> I think that it was very difficult because here the language barrier is very tough. But here, you go to some place and you want something but you can't ask for it because you can't talk or anything – that is so so so frustrating.

An interesting finding was that while the Afghans and Karen (Burmese) hoped that their children would become proficient in English, the Colombians expressed frustration that their children were able to learn the language faster than them. This situation meant that their children had more power and that they needed to become dependent on them for translation. This was problematic, as it meant a shift in parent-child power relations. A Colombian woman remarked:

> Another challenge is at the level of family- so, to start to overcome the contradictions with the young people who learn English like this [snaps finger to demonstrate 'quickly']. Since the start I didn't accept translations from my children.

In addition, many of the services provided to refugees, including brochures, were in English. Given that many of the refugees who came to Canada could not speak English, and in this case, Colombians and the Karen (Burmese), these services were inaccessible. Not surprisingly, language barriers negatively affect health.

**Social support.** Participants' cultural expectations about social support were sometimes challenged in Canada which was disappointing because of the traumatic events experienced in their countries of origin. A Colombian woman stated:

> I'm saying there is a big difference between Colombia and here. Here everyone lives a busy life. And when you have strong emotional problems you need to talk to someone, who listens to you … people in Colombia are always available to listen, here no. Here you have to ask for an appointment or first say 'hi, how are you? Are you okay? Are you busy? Oh yes? Okay, I'll call you later.' But here I have a network of friends who also take care of me. I am very spoiled, perhaps because of all the tragedies that I have faced.

In the following case, the type of social support that was really needed was denied because of insensitive institutional rules that purported to support the rights of shelter inhabitants. A Colombian woman complained:

> I didn't have anyone to talk to. In the shelter there were other people that were also alone, and with those people we made a 'prayer group'. We would meet in an office for which we asked permission, but they would tell us 'no, you can't have that, like religious meeting here, because here everyone has rights.' We said, 'well then, tell us at what time all the other religions have their meetings and the time that is available; we will come from the Catholic religion to do our rosary.' I could not enter their rooms – it is prohibited—nor could they enter my room either.

As a result of lack of social support, social isolation remains a serious problem for some. This man describes how he tries to cope, but still longs for the social supports available in Colombia:

> Everything changed. My birthday goes on being my birthday. All my life I have celebrated it with cake. Here, I have been alone and I bought cake, and I sing happy birthday and I cut the cake alone. That I have been trying to maintain because if I lose it…. For when I have kids, so I try to maintain it. And that hurts me...Christmases, very alone! I have spent them with very special people but one feels alone, one feels a very big empty space and one is not able to fill it, you can't fill it. It's been four years of Christmases where I always cry; there are always tears, always, always, always. I don't know until

> when, but each time I cry less. But I will always cry, because I always miss my family.

Several participants also noted with exasperation that they were unable to update their training and education to Canadian standards because they had to work to survive and to take care of dependents. This challenge was seen by many as a result of limited support available and as a roadblock to working toward a better future.

One of the resources that participants found integral to their present and future success in Canada were government supported English classes. However, they felt that the Language Instruction for Newcomers to Canada (LINC) was not enough to allow one to become fluent. This was especially true for professionals who had to return to school or gain employment in their fields, where high English proficiency is necessary. A Colombian man remarked:

> Yes, I am talking about the LINC; it wasn't very useful. You have to start all over again in another location. Besides that the things that they teach you in LINC, no one certifies you.

Participants were also underwhelmed by the lack of instrumental support- refugee specific services available to help them adjust, including programs to help them adapt psychologically to Canadian life which is vastly different than their country of origin. There were also other barriers to improving one's situation. Some participants described more barriers to improving one's situation in Canada than there were opportunities, resources, or helpful organizations. For example, obtaining refugee status was considered by many Afghans and Colombians to be a confusing and slow process that was riddled with misinformation. During the refugee status process, these participants felt stuck and unable to move forward because they lacked necessary permits. As these participants had left everything behind before migrating to Canada, the thought of having their refugee

claims denied was distressful. Going back was not an option for either group. The Afghans could not go back to a war-torn country, and the Colombians were here as their political ideals clashed with that of those governing Colombia, and so members of neither group could go back. As a result, the slow process made them anxious and uncertain about their wellbeing in the future.

## Discussion

This study sought to understand the factors that influence specific refugee groups' perceived mental health post-migration to Canada. The groups included Afghans, Colombians and the Karen (Burmese). It also examined whether these groups perceived that as a result of their exposure to pre-migration-trauma that they are at a high risk for developing mental health problems when they experience post-migration stressors. Moreover, it explored the ethnic and individual differences and commonalities among and between the groups with regards to the factors that influence their perceived mental health post-migration to Canada. This section will address this study's research questions. In addition, it will discuss the similarities and differences between this study's findings and the existing literature. Also, it will reveal how the findings relate to current theories.

The factors that this study found to affect refugee groups' (in particular, Afghans, Colombians and the Karen (Burmese)) perceived mental health post-migration to Canada are contextual factors (the receiving community and context of migration), discrimination and lack of resources (guidance and skills) and support (social and instrumental).

In many ways, the findings in this study validate previous research. However, some social aspects of the refugee migration and settlement experience reveal under-recognized factors that may help guide social policy and enhance refugees' experiences and their health. In addition, this study found that the literature overemphasizes certain factors and does not give much attention to others.

### Contextual Factors

Like previous literature, this study found that multiple contextual factors

including the context of reception, refugee status, work environment, employment and volunteer opportunities influence the perceived health of refugees.

An interesting finding was that as it was really difficult for Afghans to obtain education and practice in their areas of expertise in Afghanistan, those who risked their lives to gain education and employment in those circumstances reported that their level of depression is higher than others in Canada, as not gaining employment in Canada put all their past efforts and the risk they took, to waste. While there is literature on the mental health consequences of status discrepancy, literature does not take it one step farther to say that the greater the effort they put into getting an education, the greater the amount of disappointment with status discrepancy. This constitutes a new contribution to the field of refugee health.

This study also found other under-recognized factors that affect the wellbeing of refugees including, proximity to community organizations, community centres, libraries and other facilities. Moreover, while literature does not emphasize on the influence of a refugees' initial place of residence on their health, this was found to be a significant factor in this study.

In concurrence with literature, participants expressed the significance of being in close proximity with family, and this was as a result of their groups' inherent emphasis on collectivism.

It is also important to note that literature emphasizes that individuals that have light skin and look westernized in terms of the way they dress, experience less discrimination. However, while many Colombian participants do look white and dress like westerners, they experienced more discrimination. The Karen (Burmese) and

Colombians experienced discrimination to the same extent and thought that it was (or is, in some cases) as a result of their inability to speak even a word in English. The Afghans were somewhat proficient in English even upon arrival to Canada. This points to the significance of language proficiency rather than to be westernized. This also undermines literature that overemphasizes the importance of biculturalism, as it claims that best outcomes including health are the results of integrating both the culture of origin and of the receiving culture, while in reality, inability to communicate in English, lack of Canadian experience and unfamiliarity with the environment has detrimental outcomes even if one has fully acquired mainstream values.

**Discrimination**

With regards to discrimination, as found in literature, inability to find employment, as a result of discrimination, jeopardizes mental health. As Rudmin (2009) states, the idea that the settlement process is distressful may occur from failure to control for the negative effects of discrimination. Beiser (2005) also states that "discrimination in the labour market as well as in other social settings is probably another part of the explanation for unemployment and poverty" (p. 39). While unemployment and poverty are "universal health risks, [migration] increases the likelihood of exposure to them (Beiser, 2005, p 36). Beiser argues that this negatively affects the health of migrants. Discrimination also results in deskilling when an individual's human capital is not used. The process of deskilling negatively impacts refugees' socioeconomic status, sense of self-worth and their self-esteem.

**Lack of Resources and Support**

In terms of resources, client-centred services models have been found in literature

(e.g. George, 2002) to be what settlement clients desired, and it is still a tangible need. This suggests a strong need for programs that place clients at the centre and meet their unique needs. The availability and accessibility of such services are questionable.

Support, in concurrence with existing literature was found to be a critical factor in promoting successful adaptation and integration of newcomers. Studies of support have examined structural (quantity of relationships) and functional aspects (e.g. emotional, instrumental or informational) (House, Umberson, & Landi, 1988). This suggests that it is important to understand and promote having multilevel supports: spousal, immediate family, extended family, ethnic community, new contacts and the Canadian society in general. In social and health science research, social support is typically examined on an interpersonal level (for example, in marital relations) and seldom defined broadly enough to include community or socio-political levels of analysis, which limits its potential contribution to practice and policy (Simich et al., 2005).

Social support helps in overcoming adversity. Most study participants talked about the importance of a variety of social supports as enabling at key moments of their adaptation experiences. A large body of stress process research, which investigates how various environmental stressors and resources (personal and social) interact to determine health and wellbeing, identifies social support as a key resource that helps people cope with adversity. Social support plays a particularly important role during major life transitions by moderating the impact of stressors (Brown & Harris, 1978; Cohen & Wills, 1985), enhancing coping skills, promoting health and enabling help-seeking. For newcomers, the support of family and friends who have migrated earlier already know how to navigate the Canadian society and so they are invaluable for overcoming

settlement and integration hurdles. Refugees arrive in Canada with fewer of these social resources.

**Pre-Migration Stressors**

The struggles that these refugees experienced post-migration to Canada, especially during the early settlement years, underscore the challenges of other immigrants and Canadians. Several of the challenges that participants discussed are similar to ones other immigrants and Canadian-born citizens face every day: poverty, lack of access to employment with liveable wages, lack of access to housing, balancing the income from Welfare with the high costs of living in Toronto, lack of access to mental health services, inability to find meaningful work, lack of resources to return to school, etc. Refugees are not immune to broader social and economic forces, including inequities. They also experience discrimination, threatening their wellbeing. However, what is unique to refugees is that they have suffered from pre-migration stresses. While literature shows that there is a relationship between pre-migration stressors and PTSD, only a few of the Karen (Burmese) participants and none of the Afghan and Colombian participants revealed signs of PTSD. An example of story reported by a Karen (Burmese) participant that reveals signs of PTSD is when a male Karen (Burmese) participant was asked if his fear of Thai police created mental challenges for him to deal with the police here in Canada, he replied 'yes.' He reported that one time he was beaten by so badly by the Thai police that he had to be hospitalized.

According to Beiser (2009), memories get suppressed in the early settlement years and becoming more pressing in the passage of time. This may be one reason to why most of the participants did not have stories where they experienced PTSD.

A model that takes into account migrant characteristics as well as pre- and post-migration stressors, including socio-environmental factors, is the interaction model. It provides the most comprehensive framework for this finding. According to Beiser (2005), "the interaction framework proposes that health is the outcome of interacting processes including predisposition – which may be genetic, or based on pre-migration exposures and experience – as well as post-migration stressors and individual and social resources. Such a model [also takes] take into consideration that immigrants differ by country of origin, entry class (e.g., immigrant versus refugee), previous exposure to illness and prior experience with the western healthcare system…each of which can affect health" (p. 36).

**Similarities and Differences**

This study found greater between-group similarity than is claimed in literature. The similarities among and between the groups are with regards to the factors that they perceive affect their mental health post-migration to Canada. The minor difference found is with regards to the *degree* that the groups perceived the factors affected their mental health. This reveals that at the macro level, opportunities and lack of are the same for migrants.

## Conclusion

The shortcomings in resettlement programs and services are resulting in mental health issues. This is problematic as refugees cannot achieve their full potential—economic and social—when their health is compromised.

Settlement agencies should initially guide newcomers to a shelter in order to ensure a roof over their clients' heads and avoid overcrowded situations in refugees' relatives' residences. This will also give refugees some time to get familiar with their new environment including, facilities and services that can meet their basic needs. In addition, every three months or so, social workers should visit their clients and refer them to available services and resources, including community organizations, to ensure their clients are knowledgeable of and are receiving the assistance they need. Moreover, community organizations should repeatedly encourage the learning of English, as well as guide refugees to suitable alternative courses.

Clients should also be directed to educational institutions so that they may pursue their studies in their areas of interest and thereby increase their chances of employment in their own fields. Pursuing their education will help keep them away from working double shifts in petty jobs and from becoming depressed. In addition, they will not need to worry about supporting their family financially while obtaining their education as they can receive financial assistance from the government (e.g. OSAP) while studying.

Those who lack support—whether personal or social—during the early settlement years are at an even higher risk for developing mental health problems. The survival and use of social support sources are dependent upon the constraints of a community's resources and social interactions in Canada. Social supports may be ameliorated by

appropriate policies and programs (Simich et al., 2011). Perhaps recruiting volunteers or hiring those who have undergone the settlement process to share their experiences and knowledge will help refugees in psychosocial ways that perhaps only they can, because only they can really understand where newcomers are "coming from."

Other facilities including, community centers and libraries are also important and should be available in all communities, especially in areas concentrated by newcomers who cannot afford other services.

Understanding the experiences and needs of refugees is crucial in responding to their health needs. It is hoped that the information presented in this paper will be used to inform policies and programs that are designed to protect refugee health.

**Limitations**

The main strength of qualitative methods is in describing the complexity of social experiences and perceptions of phenomena in a selected context. The limitation of this method is that the determining of the scale of the phenomena on a population level is not possible. Nevertheless, the groups studied for this study does raise interesting questions about the generalizability of findings to other refugee groups in Canada, as they are from completely different regions yet there were many similarities between them.

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