RESILIENCE:

THE EXPERIENCE OF IMMIGRANT AND REFUGEE WOMEN

BY

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A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
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Abstract

The purpose of this descriptive study was to explore resilience in the lives of immigrant and refugee women who have come to Canada in the last 5 years. The study focuses on their strengths, the factors that have affected their ability to cope with adversity and maintain their health, and the changes they feel are needed to create an environment that is conducive to their health. The theoretical perspectives underlying the relationship between health promotion and resilience, within a feminist research paradigm, provide the conceptual framework for this study.

The qualitative method used was women-centred interviewing of a purposive sample of 6 immigrant and refugee women living in Winnipeg. Content analysis of the verbatim transcripts revealed the following themes: language barriers, discrimination, social isolation, optimism, adaptability, perseverance, social support and familiarity, reaching out to newcomers, and recognition of existing skills and knowledge. Social isolation was related to language barriers, cultural differences, racism, lack of leisure time, and the harsh winter climate. Social support was identified as a significant factor in the development of their personal strengths, which included optimism, adaptability and perseverance. Participants expressed a need for more opportunities and space for social contact, increased community outreach and acknowledgement of their education and employment skills.

Implications for nursing education and practice, policy development and research are discussed. The study's recommendations incorporate the participants' suggested changes.

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Chapter 1

Significance of the Problem

The purpose of this study was to explore resilience in the lives of immigrant and refugee women. The focus is on factors that enable these women to cope effectively in their new circumstances, and on the barriers that they continue to encounter. Using the principles of feminist scholarship, I interviewed women who had immigrated to Canada within the last 5 years, and who were associated with the Immigrant Women's Association of Manitoba (IWAM).

Feminist inquiry emphasizes collaboration, attempting to see the world from the perspective of the research participants (Hall & Stevens, 1991; Wuest, 1994). Feminist research focuses on gender and the diversity of women's experience (Thompson, 1991). In addition to considering gender relations, "feminist emphasis includes consideration of class and race bias" (Wuest, 1994, p. 578). In this approach, "women are seen as a legitimate source of knowledge, and as experts on their own lives" (Anderson, Blue, Hollbrook, & Ng, 1993, p. 10).

Mangham, Reid, McGrath, and Stewart (1995a) support the use of qualitative research, claiming that such studies "may be particularly valuable [in exploring the concept of resilience] because of their depth of description" (p. 10). Integral to the process of interviewing is the "inter-subjective construction of meaning . . . the process of reciprocity between interviewer and interviewee . . . [and] verification of the interpretation of the data" (Anderson et al., 1993, p. 11).

My commitment to feminist research, and the exploration of resilience in immigrant and refugee women, stems from my interest in community health nursing and women's mental health; and most particularly from a recent elective course on community organizing offered by the Women's Studies Program at the University of Manitoba. Not only did the course content focus on women who had been marginalized, but my class project involved working with several members of IWAM. The exuberance, camaraderie and emotional strength of these women, despite the numerous difficulties they have encountered, left a lasting impression. When I decided to explore the positive and health enhancing concept of resilience, this population seemed a most appropriate choice from which to recruit participants for my study. In my review of selected literature on resilience as well as on immigrant and refugee women, I also discovered a number of researchers who encourage this type of exploration and support its relevance to health promotion.

Statement of the Problem

The term resilience [also referred to as resiliency] is used to describe the ability to cope successfully with adversity (Hunter & Chandler, 1999; Mangham et al., 1995a). The resilient individual has a sense of meaning and purpose in their life and appears to possess a number of qualities including tenacity, flexibility, creativity, a sense of humour, optimism, insight and interdependence (Flach, 1988; Mangham et al., 1995a; Middleton-Moz, 1992; O'Gorman, 1994). These same characteristics are often used to describe mental health, and indeed one group of Canadian researchers considers resilience to be a health enhancing attribute relevant to health promotion (Mangham, Reid, McGrath, & Stewart, 1995b).

The term *immigrant* refers to an individual who has left their homeland voluntarily; while a *refugee* is someone who has been forced to leave their country (Allotey, 1998; Hakim & Angom, 1999; MacKinnon & Howard, 2000). It is often unsafe or impossible for refugees to return to their country of origin. DeSantis (1997) reminds us that "the issues which affect immigrants, refugees, and displaced persons may vary in the degree and intensity with which they affect their resettlement process" (p. 20).

The 1996-97 National Longitudinal Survey of Children and Youth found that a significant number of immigrant children had superior academic performance and better emotional adjustment than their Canadian-born counterparts, despite the fact that the former were more likely to be living in poverty (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). Authors of the survey believed that this was the result of "the immigrant context of hope for a brighter future [which] lessens poverty's blows" and their finding that "poor immigrant families seem particularly able to provide emotional stability to their children" (p. 85). One priority put forward by this Advisory Committee is the need for "enhanced analysis of the effect of gender, culture, age/stage of development and socioeconomic status on measures of health" (p. 177).

One of the main attributes linked to resiliency is the ability to cope with "disruptive life events" and "enabling coping is a key mechanism of health promotion" (Mangham et al., 1995a, p. 3). The connection between resiliency and health promotion is now beginning to be discussed in the resiliency and health promotion literature. Mangham et al. (1995a) maintain that "resiliency has a positive role to play in health status, health

behaviour . . . and in health promotion" (p. 4). Their detailed discussions of the relevance of resiliency to health promotion are a valuable resource to my study.

In their study of immigrant women experiencing chronic illness, Anderson et al. (1993) discovered that "the conditions under which immigrant women live and work can have profound effects on their health" (p. 8). A number of researchers describe the difficulties faced by women who have immigrated to North America from countries whose values and culture differ markedly. Language barriers, multiple identities, role overload, lack of social support, financial problems, marginalization and uncertainty are stressors identified by immigrant women that have tremendous potential to affect their mental and physical health (DeSantis, 1997; Dhruvarajan, 2002; Edwards, 1995; Ghorayshi, 2002; Hattar-Pollara & Meleis, 1995; Wilson, 1995). In addition to attempting to adapt to different values, culture and language, many immigrant women of colour are marginalized because of their racial or ethnic origin and what appears to be society's growing intolerance for diversity (Kozny, 1999; Thompson, 1991). Lack of opportunity to learn English [women face increased barriers] and unrecognized employment skills force many immigrant and refugee women to work in environments that create further marginalization and powerlessness (Allotey, 1998; Ng, 1998).

Certain protective factors, when present in an individual's environment, appear to enhance resiliency. Social support is thought to be of particular importance, especially when accompanied by "respectfulness, recognition, acceptance, empathy [and] a sense of community" (Flach, 1988, p. 213). DeSantis (1997) refers to the "solidarity . . . born out of ethnic identity and the resiliency of survivorship" demonstrated by immigrant women

(p. 25). Coping skills and social support networks are identified as factors that influence "health, well-being and quality of life" (Manitoba Health, 1997, p. 4). As health care providers and policy makers, it is crucial for us to know more about the type of environment that would enable these individuals to cope more effectively with the multitude of problems they too often encounter.

Oxman-Martinez, Abdool, and Loiselle-Leonard (2000) describe immigrant women as "an invisible, isolated population within Canadian health interventions" (p. 394). They point out that although gender and culture are identified by Health Canada as determinants of health, "pre and post migratory experiences remain unexplored as factors of women's health" (p. 394).

DeSantis (1997) identifies a gap in research related to immigrant and refugee women, stating that "their resiliency, survivorship skills, and adaptability have largely gone unrecognized" (p. 26). Mangham et al. (1995b) concur, recommending "studies of resiliency among specific groups" including "recent immigrants to Canada" (p. 15). Abdo (1998) encourages research on the situation of refugee women, claiming that "most conventional research methodology is gender blind, if not gender-biased . . . [which] distorts the history and materiality of their life experiences" (p. 41). In addition, Hall (1999) suggests that "personal narratives elaborate exteriorized life experiences . . . [and provide] a powerful source of resilience for marginalized persons" (pp. 99-100) This insight lends further support to the use of women-centred interviews and a feminist approach in my study.

Research Questions

The following research questions provided direction for the study:

1. How do immigrant and refugee women describe the difficulties they have encountered living in Canada?
2. In what ways do the difficulties encountered by immigrant and refugee women affect their health?
3. What factors do immigrant and refugee women identify that have helped them to survive their immigration and resettlement experiences?

Question #3 explores the personal strengths and supports that have been most helpful to the women, and determines their views on the changes that are needed to create an environment that is conducive to their health.

Summary

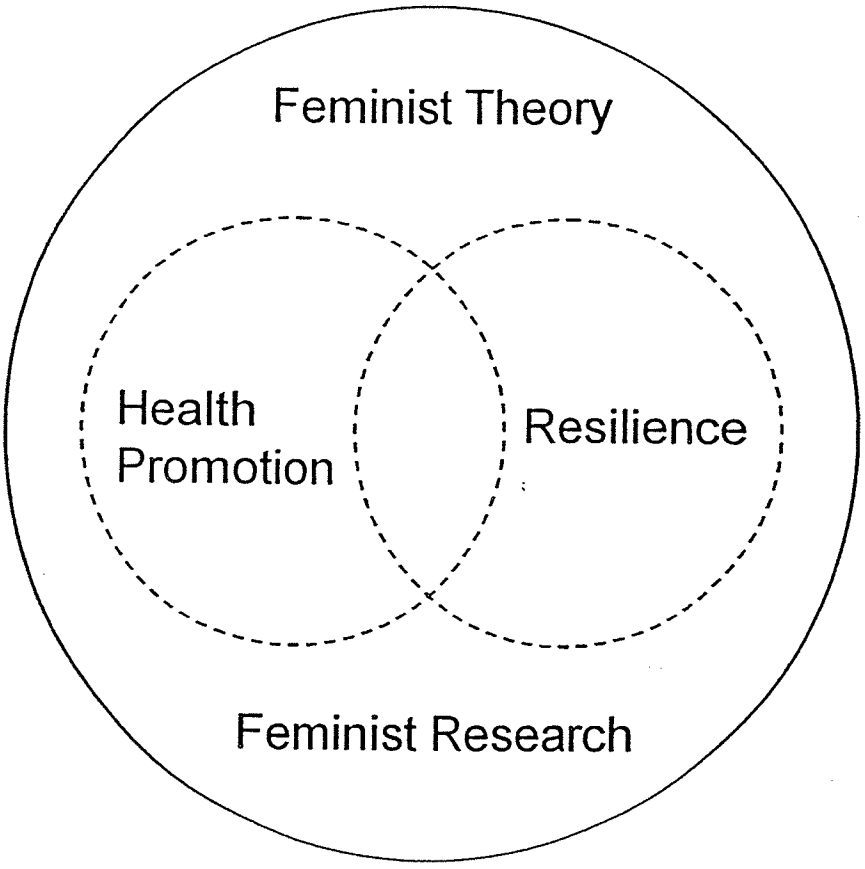
In this first chapter, I have identified the purpose and described the focus of my study and outlined my research questions. I have explored my reasons for choosing the specific topic, participants' perspective and method. The proposed method and population were discussed with support from selected literature on resilience, immigrant and refugee women, feminist research and health promotion. The latter two subjects will be explored in more depth in the following chapter, as they will contribute to the theoretical basis of my study.

Chapter 2

Conceptual Framework

Using a feminist perspective by listening to, reflecting upon, and sharing the experiences of women, I focused on their strengths and the factors that have affected their ability to cope with adversity and maintain their health. As outlined in Figure 1, the theoretical perspectives underlying the relationship between health promotion and resilience within a feminist research paradigm provide the conceptual framework for this study.

Figure 1: Framework of Resilience and Health Promotion within a Feminist Paradigm



Health Promotion

Health has been described as "a resource that enables individuals and communities to meet their needs" (Manitoba Health, 1997, p. 3). This concept of health goes beyond the previous notion of the absence of disease. Health promotion "broadens the conceptualization of health beyond the health care system", emphasizing the "prerequisites needed for health" and requiring "action in the arenas of public policy, supportive environments, and community participation as well as the development of personal skills and a reorientation of health services" (Chalmers & Bramadat, 1996, p. 723). This relates to the protective factors thought to enhance resilience and supports the use of a collaborate approach with the research participants, a core principle of feminist research.

The concept of empowerment, an important element of health promotion and resilience, is frequently discussed in feminist literature. Feminist research "emphasizes empowerment of women along with the transformation of patriarchal social structures" (Clarke, 1992, p. S56). Ryles (1999) emphasizes that in order for empowerment to succeed we need to "understand the complex social, political and economic forces that shape people's lives . . . and conspire to limit their scope" (p. 601). VanderPlaat (1999) uses the term "relational empowerment" to describe a mutual process in which "power is not given or taken . . . but emerges through interaction . . . [and is] oppressive if it is not harnessed to the realities of other people's lives and experiences" (p. 777).

Sheilds and Lindsey (1998) describe the components of the "health promotion practice framework" including "listening and critical reflection . . . participatory dialogue and critical questioning . . . pattern emergence and recognition . . . and movement to

action" (p. 30). The authors' description of health promotion practice is not unlike the qualitative, woman-centred research approach used in this study to explore resilience in the lives of immigrant and refugee women.

Resilience

Mangham et al. (1995a) define resiliency as "the capacity to 'bounce back' in spite of significant stress or adversity" (p. 1). This concept includes the characteristics of perseverance, adaptability, ingenuity, and optimism. Resilience is described as "a balance between stress and adversity on the one hand and the ability to cope and availability of support on the other" (Mangham et al., 1995a, p. 1). The researchers suggest that the key concepts of health promotion "coping, social support, competence, empowerment, self esteem, self efficacy, and self help" (p. 3) are particularly relevant to the discussion of resilience. They stress that resilience "has a positive role to play in health status and health behaviour" (p. 4), referring to resilience as a "*process* of coping" (p. 2) rather than a static characteristic. Their belief that the "unique contribution of resiliency to health promotion lies in its application to situations of unusual stress and adversity" (Mangham et al., 1995b, p. 20) encouraged me in the development of the framework conceptualized for this study.

Sheilds and Lindsey (1998) argue that listening and critically reflecting "exemplify the most fundamental processes within health promotion practice" (p. 30). The researchers' framework includes "participatory dialogue and critical questioning" as well as a "focus on capacities, strengths, and relational experiences" (p. 31). In my reading of their arguments, they appear to be describing resilience.

Feminist Theory

A feminist approach to research is subjective, women-centred, egalitarian and focused on change through activism (Campbell & Bunting, 1991; Miles, 1991; Wine & Ristock, 1991). The experiences and perceptions of women are viewed as valid and legitimate sources of knowledge (Campbell & Bunting, 1991; Hall & Stevens, 1991). Ideally, feminist relationships are based on cooperation and collaboration rather than competition and hierarchy (Christiansen-Ruffman, 1991). Even in the most collaborative research relationship a power differential exists. With the addition of language and economic barriers, many immigrant and refugee women experience an even greater gap between their life circumstances and the privileged position of most researchers.

Gender is an explicit focus of feminist theory (Campbell & Bunting, 1991). According to Oakley (1997), the term gender is used by academic feminists to "gain respectability" and "explain women's position" (p. 30). Traditionally the study of men was the norm. Men did not need to wonder about or explain their gender.

Feminism is "a method of approaching life and politics, rather than a set of political conclusions about the oppression of women" (Hartsock, 1998, p. 35). There is increasing agreement among feminist writers that feminist theory must reflect the diverse nature of human experience (Feldberg, 2001; Wuest, 1994). Recognizing that class and racial bias continue to oppress and further marginalize women is a crucial development in feminist theory (Campbell & Bunting, 1991; Ristock & Pennell, 1996).

Feminist Research

Vissandjee (2001) recommends that as we further our understanding of how gender "interacts with, and structures, other health determinants . . . it is essential that migration experiences be accounted for" (p. 4). In addition to making gender an "explicit focus", feminist research is "openly committed to a diverse range of women's experiences and struggles" (Thompson, 1991, p. 31). It is important to remember that the circumstances of immigrant and refugee women vary greatly and "each is affected differently by the experience of relocation" (Hakim, 2001, p. 6).

Central to feminist research is "the valuing of women and a validation of women's experiences, ideas, and needs" (Hall & Stevens, 1991, p. 17). Gender is considered to be a "key social factor influencing health" (McLaren, 1998, p. iii). Another link between the determinants of health and feminist inquiry is the latter's "focus on the diversity of women's experiences and the effects of the social context within which a woman lives" (Weber, 1998, p. vii).

Parker and McFarlane (1991) describe feminist research as being "grounded in women's actual experiences" and emphasizing "professional and public awareness, sensitization, and advocacy for changes in the social, health, and political policies that affect women" (pp. 64-65). Feminist inquiry focuses on "making the invisible visible, bringing the margin to the center . . . [and] putting the spotlight on women as competent actors" (Reinharz, 1992, p. 248). Marginalization is a term frequently used by feminist scholars to describe how race, class and gender have been used "as sources of exclusion"

(Hall, 1999, p. 89). Hall describes marginalization as a "sociopolitical process, producing both vulnerabilities (risks) and strengths (resilience)" (p. 89).

Dynamic Relationship Between Concepts and Theoretical Perspectives

The concepts of health promotion and resilience stress the importance of a supportive environment to enhance the coping process and promote self efficacy. An explicit focus on gender and consideration of the social, economic and political context of women's lives are major aspects of feminist theory that are also found in health promotion literature. Empowerment is another key element in feminist research, health promotion and resilience. Feminist research attempts to validate the diverse experiences and perceptions of women. Recent literature on health promotion practice highlights the need for listening and reflecting on the expressed concerns of individuals, families and communities. This collaborative approach is an integral part of feminist research. Health promotion and feminist research focus on the importance of action and change. With increased awareness of the factors that promote resilience and empower individuals and communities, we are challenged to work together in an effort to change existing policies.

Summary

I have incorporated the ideas of several researchers to create a representation of the interactive relationship that I believe exists between health promotion, resilience, and feminist scholarship. There appear to be particular personal characteristics associated with resiliency and certain protective factors that enhance resilience. Resilient individuals seem able to cope more effectively with adversity. Asking women to assist in identifying factors

that increase personal strengths and create supportive environments is in keeping with the main tenets of health promotion, feminist theory and feminist research.

Although I was unable to discover an existing framework that included all the concepts essential to my research question, some connections are beginning to be identified. In the following chapter, I will review the literature related to these concepts and to the experiences of immigrant and refugee women.

Chapter 3

Literature Review

To provide a context for the exploration of resilience in immigrant and refugee women, I have reviewed selected research literature describing their experiences and literature in the areas of health and health promotion, resiliency, psychological endurance, feminist theory and feminist research. I have discussed what has been written to date, and have attempted to identify existing gaps.

Health and Health Promotion

Health is frequently described as a resource for living (Manitoba Health, 1997; Sheilds & Lindsey, 1998). It is considered to be "both a fundamental human right and a sound social investment" (World Health Organization, 1999, p. 2). Pender (1996) defines health as "the flexibility to adapt and adjust to varying situations" (p.16). She proposes a "positive model of health" that emphasizes "strengths, resiliencies, resources, potentials and capabilities" (p. 21).

Health can be promoted by encouraging individuals to assume responsibility for their own well-being and by ensuring that the physical, social and emotional environment is conducive to health (Braithwaite, Bianchi, & Taylor, 1994; Choudry, 1998; Kozier, Erb, & Blais, 1992). There is an increasing focus on healthy public policy and empowering individuals to participate in identifying health problems and solutions (Camiletti, 1996; Crichton, Robertson, Gordon, & Farrant, 1997; Manitoba Health, 1997; Thompson, 1992). According to the World Health Organization (1999), health promotion is a

"process of enabling people to increase control over and to improve their health" (p. 1). Health promotion goes beyond the "provision and acquisition of the necessities of life" (Clarke, 1992, p. S54). It must also include the "reduction of inequities and enhancement of coping" (Crichton et al., 1997; World Health Organization, 1999). Smith (1991) echoes their sentiment and suggests that our efforts move "into the realm of the power and politics of quality of life and inequities" (p. 18).

Certain factors are considered to be pre-requisites for health. Health Canada (1997) refers to these factors as *determinants of health.* Their recently revised list includes: "income, social status, social support networks, education, employment and working conditions, physical and social environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture" (p. 1). The World Health Organization (1999) provides a broader perspective by adding "peace, shelter . . . food . . . empowerment of women, a stable eco-system, sustainable resource use, social justice, [and] respect for human rights and equity" (p. 1). Issues of equality and empowerment are increasingly being linked with health. Howard (2000) advises that "improving health status means a more equal distribution of power in society and giving people control over their lives" (p. 15).

The Federal, Provincial and Territorial Advisory Committee on Population Health (1999) has identified as a priority the need to increase understanding of how these determinants influence "collective and personal well-being" (p. 177). In addition, the committee recognizes the need for "enhanced analysis of the effect of gender, culture, age/stage of development and socioeconomic status on measures of health" (p. 177).

Despite the fact that gender and culture are increasingly considered to be important determinants of health, the connections between gender and other determinants are only beginning to be made. Kosny (1999) contends that "the compounding and interconnected impacts" of culture, race, gender and social status "influence social support networks, access to education, access to quality employment, risk of violence, and other resources affecting health" (p. 9).

Until recently, a significant gap in the research literature related to health promotion has been the effect of migration experiences on women's health (Oxman-Martinez et al., 2000). In a study commissioned by IWAM that explored barriers to accessing health and social services, the researchers noted a definite lack of research and analysis of policies and programs addressing the needs of their population (Hakim & Angom, 1999; Fox, Cowell, & Johnson, 1995; Matsuoka & Sorenson, 1999). As Vissandjee (2001) points out, "not everyone shares the same concept of health [nor do they] experience health determinants in the same way" (p. 4).

A recent attempt to fill this gap is a study sponsored by the Maritime Centre of Excellence for Women's Health. The researchers "explored immigrant women's experiences and perceptions of the factors that influence their health behaviours and the health services that they use" (MacKinnon & Howard, 2000, p. iii). The women in the study "identified social support, personal health practices and employment as major factors affecting and maintaining their health" (p. 38).

Focus on the determinants of health is becoming more prevalent. Some researchers are beginning to explore the connections among these determinants, particularly gender

and culture. They are pointing out the inequities that continue to exist for women, especially those who face multiple barriers as a result of their diversity. Promoting the health of immigrant women must include efforts to "facilitate a healthy pattern that is congruent with their way of being . . . without cultural imposition" (Choudry, 1998, p. 274). An example of this is to provide nutrition and cooking classes focused on adapting traditional methods of cooking to foods that are presently available and affordable (MacKinnon & Howard, 2000). As the researchers further suggest, this is also an excellent way to increase social contact.

Resilience

Similar attributes were evident among the numerous definitions of resilience. The dynamic nature of the concept was reflected by the recurring descriptions of the ability to adapt or to restore balance, being able to *bounce* or *spring* back from adversity (Cadell, Karabanow, & Sanchez, 2001; Dyer & McGuiness, 1996; Jacelon, 1997; Kadner, 1989). The term is often defined by identifying its characteristics. In addition to being adaptable and flexible, the resilient individual has a balanced perspective and is optimistic, courageous, determined, resourceful, socially responsive and possesses a sense of humour (Dyer & McGuiness, 1996; Felton & Hall, 2001; Jacelon, 1997; Wagnild & Young, 1990). The ability to find meaning and purpose in adverse circumstances and to focus on what can be controlled are also associated with resiliency (Ortberg, 2001). Waring (1996) admires and values humour in women along with their "remarkable resilience in the face of very real obstacles to their rights to equality, visible work and female human rights" (p. ix).

Some researchers view resiliency as an inherent trait. Others argue that it is a process that anyone can develop with the assistance of protective factors which could include personal characteristics or experiences, such as supportive relationships (Cadell et al., 2001; Jacelon, 1997). Resiliency is thought to involve "the element of risk being mitigated by protective factors to produce a positive outcome or adjustment" (Stewart et al., 1999, p. 51). Mandleco (1995) describes resilience as "the ability to respond, endure, develop and master life situations and stressors" (p. 219).

The importance of community was a strong thread in much of the resiliency literature. It is not difficult to see how a supportive community would provide a sense of belonging through the sharing of a common history, identity and experience (Cadell et al., 2001; Stewart et al., 1999). In their study of a group of Chilean political prisoners, Cadell et al. (2001) described the experiences of the men who had been incarcerated. The prisoners spoke of being able to create "a safe, caring, and accepting culture in which [their] humanity could be nurtured" providing them with "camaraderie, hope and a proud identity" (p. 31).

The focus of the majority of literature about immigrant and refugee women is almost exclusively on the very real problems facing them and the isolation and psychological problems that result (Beiser & Hou, 2001; Hakim & Angom, 1999; Le Centre d'excellence pour la sante des femmes-Consortium Université de Montreal, 2000; Mohamed, 1999; Novac, 1999; Hattar-Pollara & Meleis, 1995; Wilson, 1995). In her exploration of the meaning of the experience of refugee women from South East Asia, Davis (2000) discovered "a psychological resilience not extensively explored previously"

(p. 144). The stories of the women in her study "portray an extraordinary resilience of the human spirit, which is fortified through strong family and community affiliations" (p. 159). Armstrong (2002) described the women of Afghanistan as "heroic women . . . filled with hope and energy for the future" (p. xvii). While these women were realistic about the problems they faced, they showed determination and hope as well as "bravery and moxie in facing the future" (p. xvii).

The concept of empowerment, "an important ingredient of health promotion" is frequently mentioned as an outcome of successful community building but tends to be neglected "in the resilience literature which focuses on individuals" (Stewart et al., 1999, pp. 76-77). Cadell et al. (2001) believe that "the intrinsic and inseparable interplay of resilience and empowerment builds sustainable, healthy, evolving individuals and communities" (p. 24). Many immigrant and refugee women are isolated and apprehensive and may need assistance to connect with others (Wason-Ellam, 2001). Enhancing individual empowerment would encourage these women to use their strengths for mutual support. The principles of feminist theory provide further insights into the complex nature of empowerment.

Feminist Theory

Feminism, as does nursing, values "intuitive knowledge, receptivity . . . the ability to experience life as a whole . . . and attempts a fuller understanding of everyday experience" (Parker & McFarlane, 1991, p. 60). Valentine (1997) describes this awareness as an important element of the feminist process, and defines it as "becoming knowledgeable about self and others in a world context" (p. 85). Action and change are

also key words in feminist discourse. Praxis, another crucial component of the feminist process, refers to "values that are enacted" (Valentine, 1997, p. 84). Code (1988) states that "the point of studying the situation of women is to work toward changing it" (p. 18). In their discussion of empowerment, Ristock & Pennell (1996) encourage us to think "consciously about power relations, cultural context, and social action" (p. 2).

Feminist scholars aim to increase awareness of the "ideologic, structural, and interpersonal conditions that oppress women" and attempt to "bring about social change of oppressive constraints through criticism and political action" (Hall & Stevens, 1991, p. 17). One of the "theoretical underpinnings" of feminist theory is "the political nature of the personal experience" (Maharaj, 1999, p. 259). This study focused on experiences of the participants and encouraged them to identify barriers and suggested changes. Their ideas were included in the study recommendations which will be shared with appropriate agencies and individuals.

Wolf (1993) defines feminism simply as "women's willingness to act politically to get what they determine that they need" (p. 59). She goes on to assert that "women have the right to determine their lives", that their "experiences matter" and that they "have the right to tell the truth about [them]" (p. 138). Wolf encourages us to "identify with one another primarily through the shared pleasures and strengths of femaleness, rather than primarily through our vulnerability and pain" (p. 53). O'Leary and Ickovics (1995) also recommend that we "move beyond the vulnerability/deficit model of women" and instead focus on our "strengths and [our] ability to thrive in the face of adversity" (p. 121). The

major emphasis in this study was the strengths of the women and their ability to cope effectively.

hooks (1989), who has written extensively about her experience as a woman of colour, expresses disappointment that "not enough feminist work has focused on documenting and sharing ways individuals confront differences constructively and successfully" (p. 26). Continuing on a positive note, Code (1988) states that the purpose of feminist theory is "to understand the oppressive social practices that disadvantage women and to think innovatively about women's possibilities" (p. 18).

In their research with Eritrean women in Canada, Matsuoka and Sorenson (1999) found that many of the women experienced considerable isolation and loneliness due to the nature of their jobs and their lack of opportunity to improve their fluency in English. Work opportunities for women whose skills and education are not recognized tend to be in environments that further isolate and discourage them. The researchers promoted gender-based analysis because of its emphasis on the recognition of the unique difficulties faced by refugee women.

Neufeld, Harrison, Stewart, Hughes, and Spitzer (2002) studied a group of Chinese and South Asian women who were caring for their ill or disabled relatives. The researchers recommend that "policies affecting immigration require review to examine the adequacy of support for immigrant women in community, employment and family roles" (p. 766).

Chinn (1991) challenges those who would claim to be feminists to "take responsibility for values and acts that move the world more toward a full accounting of the

human experience" (p. ix). My exploration of the strengths of immigrant and refugee women adds to this important narrative by encouraging six more women to share their stories.

Summary

In this chapter I have attempted to highlight the connections between health promotion, resilience, feminist theory and feminist research. Although initially there appeared to be little written about resiliency in immigrant and refugee women, further investigation of the literature revealed a growing number of significant studies. Due to the multi disciplinary nature of my study, it was necessary to explore the literature beyond the discipline of nursing. Health promotion and resilience share a number of common elements. Feminist theory and research also emphasize a number of the same principles and offer further insight into the concept of empowerment and the importance of the consideration of gender.

Chapter 4

Methodology

In their writing on the experiences of immigrant women, health promotion, resilience, and feminist theory, scholars from diverse disciplines have discussed the advantages of using a qualitative approach and a feminist perspective when exploring the lives of marginalized women. Included among the marginalized groups of women in Canada are "women of colour, immigrant women [and] refugee women" (Heaman, 2001, p. 81). Hall (1999) describes personal narratives as a "powerful source of resilience for marginalized persons" because these stories are able to "validate perceptions . . . foster hope and connectedness, and enable them to educate those, such as nurses, who wish to become allies in liberation struggles" (p. 100). Researchers exploring the link between health promotion and resilience recommend qualitative studies of resilient individuals and groups, valuing "the depth of their description", and suggesting that "such studies would be essential to obtain a comprehensive view of the dynamics and process of resiliency" (Mangham et al., 1995a, p. 10).

Feminist Research

Feminist research involves "an intense focus on and legitimization of women's experiences", includes "conscious efforts to break down power hierarchies" and has the "express intention to make women's perspective central and continuous" (Wine & Ristock, 1991, p. 17). Several researchers emphasize the ideal nonhierarchical nature of feminist methodology, pointing out the reality of power differentials that often exist

between researcher and participant and encouraging us to devise ways to lessen this discrepancy (Anderson, 1991; Christiansen-Ruffman, 1991; Glass & Davis, 1998; Hall & Stevens, 1991; Hebert, 1998; Ristock & Pennell, 1996; Thompson, 1991; Vickers, 2002). Silvera (1993) contends that "it is the sharing of information about the self, as much as possible that breaks the dominant/dominated dynamic" (pp. 217-218).

Throughout this study I was aware of my position of privilege as a White, middle-class woman, fluent in English and currently employed. I have the additional advantages of familiarity with Canadian culture, recognized academic credentials and work experience, and an established social network. My efforts to decrease this power differential included dressing casually, encouraging participants to ask me questions and attempting to relate in an open, honest manner without academic jargon. I was genuinely interested in their experiences and suggestions and demonstrated this non-verbally and in the questions chosen for the interview schedule. Collaboration in the research process was encouraged by offering the women a summary of the preliminary findings for their feedback.

Studies that reflect a "feminist perspective in the design and in the interpretation of data" allow for "an examination of the data within the context of race, class, culture and gender" (Meleis, Sawyer, Im, Messias, & Schumacher, 2000, pp. 13-14). Research that is "gender blind [or] gender-biased . . . obstructs true knowledge . . . and distorts the history and materiality of [the participants'] life experiences" (Abdo, 1998, p. 41). Gender sensitive research, on the other hand, "deconstructs the category of the supposedly universal immigrant and /or refugee" (Juteau, 1998, p. 38). Qualitative studies that focus on individual realities can help accomplish this goal. Hall & Stevens (1991) point out that

although feminist inquiry makes use of a variety of different methods, the research questions "reflect the concerns of particular groups of women" and investigate the concerns "in their diversity" (pp.17-18). Participants in this study were asked to describe their unique experiences, perspectives and recommendations.

Goals of feminist methodology include "professional and public awareness, sensitization, and advocacy for changes in the social, health and political policies that affect women" (Parker & McFarlane, 1991, p. 65). It is not enough for feminist research "to describe and interpret the phenomena of women's lives", it must also "raise consciousness and bring about changes in the interest of the women studied" (Hall & Stevens, 1991, p. 17). Feminist researchers are challenged to "work to link personal narratives with knowledge of how we must act politically to change and transform the world" (hooks, 1989, p. 111). The recommendations of this study will be shared with the individuals and agencies who could work toward the realization of the suggested changes. Hartsock (1998) suggests that "the power of a feminist method grows out of the fact that it enables us to connect everyday life with an analysis of the social institutions which shape that life" (p. 36). The implied goal of empowerment for women "can only be achieved by recognizing those forces that conspire to limit the scope of [their] lives" (Ryles, 1999, p. 603).

Qualitative Research

The aim of qualitative research is "to generate knowledge concerned with meaning and discovery" (Burns & Grove, 1995, p. 395). A descriptive, exploratory approach is especially useful when "there is little reported research on the topic under study"

(Choudry, 2001, p. 380). In their study, *Affirming Immigrant Women's Health*, MacKinnon and Howard (2000) used this methodology "to listen to, to hear and to include the voices of women not typically heard in health research" (p. iii).

Qualitative research is "based on the premise that gaining knowledge about humans is impossible without describing human experience as it is lived and as it is defined by the actors themselves" (Polit & Hungler, 1995, p. 517). In the "naturalistic/ interpretative paradigm, reality is assumed to be multiple and constructed rather than singular and tangible" (Sandelowski, 1993, p. 3). This type of inquiry fits well with recent feminist thinking and research which has "shifted . . . in the direction of more particularized knowledge and away from any sense of the universal" (Olesen, 2000, p. 223).

Reflexivity is an important aspect of qualitative research. Through "*reflexive thought*" and "a conscious awareness of self" the researcher "explores personal feelings and experiences that may influence the study and integrates this understanding into the study" (Burns & Grove, 1995, p. 398). Koch (1998) refers to reflexivity as "the critical gaze turned toward the self" (p. 1184). Keeping a journal to record thoughts and feelings related to the research process is often recommended (Koch, 1998; Rose & Webb, 1998; Sword, 1999). I used field notes to record my observations and perceptions related to recruitment, data collection and analysis. These reflections are incorporated both directly and indirectly throughout the study.

Sword (1999) describes reflexivity stating that "by revealing how I dealt with feelings, role and interpretation of data, I have underscored self as part of the process of

discovery" (p. 277). In feminist research it is particularly important to reflect on "our own perceptions and decisions, on the aims and impact of our research, [and] on the ways in which that research is and is not empowering" (Ristock & Pennell, 1996, p. 48).

Sample

Purposive sampling was used in this study. This is a "non probability" method which involves selecting participants "on the basis of personal judgment about which ones will be most representative or productive" (Polit & Hungler, 1995, p. 652). The 6 immigrant and refugee women who volunteered to participate, ranged in age from 28 to 35 years, and were from six different countries. This diversity of experience and background was important to elicit a variety of responses.

Participation Criteria

In addition to membership in IWAM, the participants needed to be able to communicate in English and have lived in Canada for 7 years or less. Other researchers have chosen to interview immigrant women who have been in Canada for several years, but I believed it was important that the immigration experience was relatively recent in order for participants to have a clear memory of their experiences. Respondents were of varying ages, educational backgrounds, and lengths of stay (5 years or less). Hakim and Angom (1999) suggest that "collecting data from a wide range of respondents offers more inclusive perspectives" (p. 3).

Recruitment Strategies

My initial intent was to interview 6 to 10 immigrant and refugee women who were members of IWAM. I had met several members and staff of this organization whose

mandate is "to facilitate the settlement and integration of immigrant [and refugee] women . . . by providing information, referrals, volunteer training, counselling, language training, advocacy and public education" (Immigrant Women's Association of Manitoba, 2001, p. 1). This proved somewhat challenging, since in 2001 IWAM lost its funding and office space. Their resource centre is currently located in a small space in the University of Winnipeg library. Their counsellors continue to work out of the original office, but are now administered by a separate government agency. IWAM is carrying on with their mandate and hosting activities in a room provided by the University (Immigrant Women's Association of Manitoba, 2001).

Women were invited to participate in my study by means of a letter (Appendix A) that briefly explained the intent and asked interested individuals to call me for more information. The president of IWAM reviewed my plans and encouraged my efforts, suggesting that I contact specific members of the association to assist in recruitment. She also welcomed me to speak about the study at IWAM's meetings and events. Over a period of 8 months, after speaking with several IWAM members and attending a number of the associations meetings and workshops, I was able to recruit 6 women who were either directly or indirectly involved with the association.

Data Collection

After obtaining informed consent (Appendix B), data were collected by means of individual face-to-face interviews of 1 to 2 hours in length. The intent had been to interview each woman twice to allow time to build trust and rapport. This was possible with 2 of the participants, but time constraints for the other 4 allowed for only one

meeting. Part 1 of the interview schedule (Appendix C) was used to elicit demographic information. These factual, closed ended questions and the semi-structured interview questions in Part 2 and Part 3 of the interview schedule have been guided by the literature review and adapted from recent studies (Hakim & Angom, 1999; MacKinnon & Howard, 2000; Meleis & Lindgren, 2001; Polit & Hungler, 1995). To check for clarity and cultural sensitivity, the interview questions were pre-tested with a woman who came to Canada as an immigrant 5 years ago.

Interviews were audio taped and the majority were transcribed verbatim by an experienced transcriptionist. The researcher transcribed two of the interviews. The location for the interviews was decided in collaboration with the research participants. Four of the women chose to be interviewed in their home while 2 suggested a private location in their workplace. Considerations in choosing the site should include safety, convenience, comfort, accessibility, privacy and lack of distraction (Heaman, 2001). Privacy was ensured during all of the interviews, but some degree of noise and distraction was part of the reality of most of the women's lives. In one particular interview, I was reminded of Fadiman's (1997) description of trying to listen to her participants "against a background of babies crying, children playing, doors slamming, dishes clattering, a television yammering and an air conditioner wheezing" (p. vii).

Rigor

In qualitative research, data are considered credible if the participants are able to recognize "their own reality in researchers' accounts of their lives" (Sandelowski, 1993, p. 5). It is important to ensure that "the information we gather . . . will resonate with the

experiences of participants . . . and that we are accountable to them and to the broader communities that may be affected by our research" (Ristock & Pennell, 1996, p. 50). Recommendations from this study will be shared with relevant community agencies and individuals. Participants in this study were sent a summary of the findings and they were asked for their feedback as to how accurately the findings reflect their experience. The woman who responded to this request indicated that her experiences were reflected in the summary.

Rigor is associated with "openness, scrupulous adherence to a philosophical perspective, thoroughness in collecting data, and consideration of all the data in the subjective theory development phase" (Burns & Grove, 1995, p. 397). From a feminist perspective, rigor "includes the degree to which research reflects the complexity of reality" (Hall & Stevens, 1991, p. 23). In this study excerpts from interview transcripts were specifically chosen to demonstrate the complexities and diversity of the participants' reality.

Auditability is achieved by "leaving a decision trail" in the form of notes or journals "discussing explicitly decisions taken about the theoretical, methodological and analytic choices throughout the study" (Koch, 1998, p. 1188). My initial thoughts and ongoing perceptions/reflections were documented in journal accounts and field notes and were included in the findings. The interview guide was pre-tested with one immigrant women who has research expertise. She felt that the questions were relevant and pertinent. This increased the likelihood that the issues were of relevance to respondents. The questions "should reflect knowledge of the culture and norms of the population group, including

sensitivity to age, social class, language, reading levels, and religious customs as well as race/ethnicity" (Heaman, 2001, p. 84). Participants in this study varied considerably in their racial and ethnic background, social class and English language fluency. The interview schedule was open-ended and did not include complex terminology.

Data Analysis

The researcher began by listening carefully to the audio tapes. The participants' words often contained emotional significance. This was emphasized by the use of italics. In addition to words, the tapes also "contain feeling, emphasis, and nonverbal communication, which are at least as important to communication as words" (Burns & Grove, 1995, p. 400). Sandelowski (1995) recommends "getting a sense of each interview before attempting any comparisons across interviews" (p. 373).

After the audio taped interviews were transcribed verbatim, the researcher read and reviewed the transcripts and notes to determine emerging patterns and categories (Li & Browne, 2000; MacKinnon & Howard, 2000; Stewart et al., 1999). Analyzing the "content of narrative data to identify prominent themes and patterns among the themes" (Polit & Hungler, 1995, p. 532) is known as *content analysis*. Content analysis can be used to describe the "characteristics of the content of the message" (Polit & Hungler, 1995, p. 509).

Data are initially coded "according to the topical areas or broad categories elicited by the interview questions" then later given "specific descriptive subcodes" (Aroian, Khatutsky, Tran, & Balsam, 2001, p. 267). Sandelowski (1995) also suggests using the interview guide as "an initial organizing framework" but cautions the researcher not to

allow this framework to "prematurely close off recognition of other ways of organizing the data that are truer to them and more illuminating" (p. 375). In addition to the "scientific dimensions" of qualitative research which include the use of a "disciplined and systematic approach" and the ability to be "reliably communicated to others" this form of analysis also has "artistic dimensions . . . involving playfulness, imaginativeness and creativity" (Sandelowski, 1995, p. 375).

Ethical Considerations

Prior to pre-testing the interview guide and recruiting participants, a description of the proposed research project and interview guide were submitted for approval to the Education/Nursing Research Ethics Board (ENREB) of the University of Manitoba. The ethics protocol submission form included detailed information about the study to ensure that participants would not be subjected to undue physical or emotional risk. At the time of the submission, the researcher had applied for funding to provide participants with a small monetary compensation. This information was included in the Consent Form (Appendix B). There was a clear explanation of the nature and benefits of the study, as well as evidence that the participants had voluntarily agreed to be interviewed and had been informed of their rights. Consent forms were included with the application. Measures to protect confidentiality were outlined as well. In addition to describing how the anonymity of participants would be assured in the final report, the researcher indicated where the taped recordings, transcripts, and field notes/journal recordings would be stored.

The vulnerability of immigrant and refugee women was acknowledged and addressed during the planning and implementation of this study (Heaman, 2001). The researcher recognized that cultural differences, language barriers and participants' experiences prior to and during resettlement could influence their ability to develop trust, to understand their rights and to cope effectively with their emotional responses.

Trust was enhanced by recruiting through women from IWAM who were acquainted with the researcher and the participants. Two interviews were planned to allow more opportunity to establish rapport. The participants chose the location for the interview and were asked permission to tape record the sessions. Prior to the interview, they were shown the interview schedule (Appendix C), asked if they wished to discuss it and informed that they could refuse to answer any questions or stop the recorder at any time.

The interview schedule was pretested for clarity and cultural sensitivity with a woman who met the inclusion criteria for the study. Although she did not suggest changes to the questions, she did recommend that time be allotted for more thorough explanation and discussion with women who are not fluent in English. Complex terminology had been avoided in the interview schedule, but sections of the consent form contained required terminology that could be difficult to comprehend. Adequate time was made available to ensure that participants understood the form and its intent. Several words in the consent form and interview schedule were particularly challenging to one of the women. After questions were rephrased and words defined, she was able to comprehend their meaning.

Aware that some of the participants may have had particularly traumatic experiences, the researcher, who has a background in mental health nursing, was attentive to any emotional responses that might necessitate stopping or discontinuing the interview, or require referral to appropriate counselling services. The women in the study did speak candidly of the difficulties they have experienced and the struggles that continue. The telling of their stories appeared to be cathartic, rather than disturbing for them.

After receiving initial approval from ENREB and beginning recruitment, the researcher discovered the limitations of the participation criteria. Permission was granted from ENREB to expand the criteria related to length of stay in Canada from 5 to 7 years, and to recruit participants through the International Centre and other immigrant and refugee associations. Further permission was granted to include the data from the pre-test interview.

Chapter 5

Findings

The results of this study were determined through the following process. After each of the interviews, which ranged from 60 to 90 minutes, the researcher reviewed the tape and wrote field notes to record observations and impressions. Demographic data were managed using descriptive analysis and content analysis was used to elicit themes from the responses to the open-ended questions. To ensure accuracy of transcription, the interview transcripts were proofread by the researcher while listening to the tapes. The written transcripts were reviewed several times to identify significant elements. The following themes emerged from the responses: *language barriers*, *discrimination, social isolation*, *optimism*, *adaptability*, *perseverance, the value of social support and familiarity, reaching out to newcomers,* and *recognition of existing skills and knowledge*. The researcher has added comments throughout the excerpts (enclosed in brackets) to ensure clarity and add context. Participants were offered a summary of these findings and were asked how accurately the interpretations reflected their experience and if they wished to make any further comments.

Characteristics of the Sample

Countries of origin of the 6 participants included Argentina, Peru, Iran, Malaysia, Sierra Leone and South Korea. Two women came directly to Canada; one had visited her husband's family in Winnipeg prior to her immigration, and the other had been in Canada on a Student Visa several years ago. The increased familiarity with their new environment helped ease the transition for these women. Four women spent time in another country

prior to coming to Canada. One woman worked for a year in a country where she was able to become more fluent in English and experience other cultures. The three women, who were refugees in neighbouring countries, experienced uncertainty related to their situation but were in a safe environment.

Length of time in Canada varied from 7 months to 5 years; with an average time of approximately 2 years. For these women, the presence of social support appeared to have more influence on adaptation than length of stay. Three of the women arrived as landed immigrants; one continues to have this status, one is now a permanent resident, and one has become a Canadian Citizen. The two women who were refugees on arrival have applied to become Permanent Residents. The woman who came to Canada on a Student/Work Visa has applied for Immigrant status. In addition to the concrete benefits of permanent residency and citizenship, some of the women expressed that this change of status increased their feelings of belonging.

On arrival, three of the women spoke only a few words of English, although one was fluent in French. The other participants indicated that they studied English in their country of origin. Comprehension, especially "slang" remained a problem for some and others found that at times they were not understood. Fluency in English was a major influencing factor for successful adaptation.

Four of the women studied at university prior to their arrival; two of them having completed a Bachelor of Arts degree, and one a Bachelor of Science degree in Nursing. Prior to completing a degree in Sociology, one of the four had to flee her country. While in Canada on a Student Visa, one woman completed a Bachelor of Science degree. One

woman trained as a medical secretary. Four of the women are currently employed; one as a Home Care Assistant, one as a Registered Nurse, one as a researcher, and one is a business owner. Their insightful and articulate responses reflect their education and interest in research. The frustration that most of the women experienced because their academic credentials were not fully recognized is also evident in the findings.

The participants ranged in age from 28 to 35, with an average age of 30 years. Two of the women are single, three are married and one became separated and divorced since her arrival in Canada. She is the single parent of a pre-school child and has the least amount of social support. One of the married women is the mother of two young children, one in pre-school and the other in Grade 1. None of the women have other dependents, though some indicated that they were trying to be of financial assistance to their family who still live in their country of origin. The two single women are in frequent contact with their families back home but have struggled to develop new friendships. The married women appeared to be in supportive relationships with their spouses and extended family.

Themes

The first three themes, language barriers, discrimination and social isolation, emerged from the data related to obstacles and barriers faced by the women in this study; and optimism, adaptability, and perseverance from data focussing on their strengths. The last three themes are related to social support and familiarity, outreach, and recognizing existing skills and knowledge. Problems encountered by the participants primarily related to language barriers, racism, cultural differences, and lack of recognition of their previous employment and education. One woman also struggled to cope with very limited finances

after becoming a single parent. Her story illustrates the complex and dynamic relationships among these difficulties.

> I am a single mom. I am a woman. And I can't speak English very well. I don't [have] enough education. And also I don't have a job. You think so many problems, you know, without clear future, that . . . sometimes, I am confused. You can't save money, because everything just . . . go for the apartment, for the food or for everything. So it takes a long time to save that. It really, really was hard for me. . . . It was really, really hard [to learn] English. When I came to Canada, my English . . . maybe I know just some word, a few grammars. It's very difficult for me, because I am a single mom. So many responsibility, my life, my child's life and without anything, for example, car or . . . money. I have to arrange everything with just a little money. And it's difficult for my life because I don't have money. . . . [It] makes me confused and makes me disappointed.

She described her own initial sadness and depression as well as that of her young child who was having difficulty at Daycare.

> We had very, very bad days. I'm thinking about the future, about the now, about time and also I'm sad for my daughter because my daughter always she cry and she nervous and she had a bad time.

Language barriers. Although three of the women spoke English on arrival in Canada, one was caught off guard by the frequent use of unfamiliar slang which sounded to her like a foreign language. Another when asked about barriers and obstacles she experiences as an immigrant woman, replied "The first thing is English. Second is English!" She described English comprehension as a major stress both in her personal life and at work.

> I have to communicate in English all day at work. Once I experience my function of communication, then I really get stressed out. [I] don't want to talk any more. And I believe it is important for us to communicate, so it makes me more nervous. Understanding is definitely harder than speak, cause if people can understand even though I don't speak properly, but people can understand what I'm saying. But if I don't understand what

> they're saying, there is no initiation of communication. Because I cannot, I *cannot* understand!

The next statement was made by a woman who was fluent in French and Spanish but was about to begin a program of study at a university, where the classes would be conducted in English. Although her husband spoke Spanish, she would need to become fluent in English in order to communicate with his family and friends as well as neighbours and merchants.

> I knew English some, because at the university [in her country of origin] I had to read some things that were not translated, so I was exposed to written English. When I came . . . my spoken English was terrible! I had to learn that.

Two of the women, arriving as refugees, knew very little English. One of them who spoke just a few words on arrival, recalled, "I couldn't speak even *one* sentence". Another participant, who is fluent in English, discussed the following language and cultural barriers faced by the newcomers she has assisted in her role as a volunteer.

> They were scared of even picking up the phone. Somebody calls, they don't pick up the phone because they don't know how to speak English. They don't know where to go, what to wear . . . what bus to take . . . what is the currency. . . . What happens if they get sick? Who can go to the doctor with them, if they can't speak English?

Discrimination. Participants spoke of experiencing discrimination related to their lack of fluency in English. One woman who spoke English well was sensitive to how her less fluent friends were treated, noting "There seems to be a standard that if you are able to speak English, we accept you". Another related this incident that occurred shortly after her arrival in Winnipeg:

> A horrible thing! One day I had a phone call from [one of the utility companies] to check on something, some information. I don't know if it was because of my English . . . but the person was *so* rude! I didn't get her question, what she wanted to know. I think it was something to do with when we moved from our house, some transfer of services. She was so rude because she couldn't understand me. I don't know, maybe I should have just hung up, but then I never had terrible experiences. I guess, because I am White, if I don't speak, they don't know that I am not Canadian, whatever *that* is! I guess it would be different for a Black person.

One of the women and her family escaped a country in the midst of civil war. This trauma made them especially sensitive to noise. She described their experiences in their first apartment in Winnipeg.

> We've been having lots of problems like noise because we are from war. So any little bit of noise can affect us, especially the kids. Like *boom*! Noise like that. Whenever the noise increase, if we tell them, they say "This is normal noise." Normal noise? In the middle of the night?!? Sometimes we just jump out of bed! The kids are afraid to even lie down in their own bedrooms. So, all of us just can be squeezing together because we're all afraid. There is no way we can get help. But it was terrible at first, yeah, really terrible! I went through lots of bad experience back home. So any little boom can make me emotionally sick. And even make me become so stressful. Every day I was crying. I wanted to go back home. We had to give up the apartment.

She then experienced this disturbing situation when attempting to move with her husband and young children into a new apartment.

> We had hired a truck and we had loaded our stuff and we cannot find the caretaker. For forty five minutes we waited, and we waited! She cannot come so that we can get access to the apartment. We decided to come back again [to her sister's house] and unpack. We called the office and tried to explain. They cannot listen to us. The caretaker had a different version. And when we tried to explain, they cannot give us a listening ear. They just think what the caretaker says is the truth. If this is the case, then why are we here [in Canada], if justice cannot be given to someone who has rights? Shouldn't they say "Sorry!" and then try to find out, to make amends, so that things can be better? But they cannot listen to my own version and

> they listen to somebody else's version because my colour is not like her. That's how I'm thinking, that it is because I am Black.

Although the misunderstanding was never really clarified, a housing counsellor from the International Centre was able to intervene and discover that the suite was being renovated and would be available for occupancy in a week. At the time of our interview, the respondent was feeling better, but described having felt so discouraged and depressed about the incident that for days she had been unable to eat, sleep, attend classes or even play with her young children.

Another participant, also a woman of colour, recounted the following mix of reactions:

> Because I'm [Asian] and look like the natives, the Aboriginal people here, some people perceived that I am a native. They treated me with less respect. When they found out that I wasn't native, they treated me a lot different. I was able to see that change.

Social isolation. When participants were asked what it was like for them when they first arrived in Canada, most spoke of being isolated. Even after being here for a number of years, some of the women are still experiencing isolation, because of language barriers, cultural differences, and discrimination. The women also mentioned lack of time for social interaction, and two factors associated with Winnipeg, the established social networks and harsh winters. They related feelings of loneliness, anxiety and depression. Initially, many of them felt disconnected, as though they did not belong, and could not identify with their new homeland. One of the women, who spoke very little English on arrival, depicted her experience as follows:

> Everything was really different. Because I did not speak so much English, it was very frustrating. I could not express myself. I was all the time feeling that I don't belong here, that I don't want to live here. I have no family here, no friends. I got into a very deep depression.

Describing her emotional health at the time she became a single parent shortly after arriving in Canada, one woman stated "I was really sad. All the time I was really sad." She expressed concern for her young daughter who was also having difficulty.

> She always scream, yell and crying. She doesn't like Daycare because she can't make friends, because she didn't speak English. For more than one year, she very sensitive and she very sad . . . because she has a bad situation.

One woman studied English in her country of origin and worked in an English speaking country for a year. In Winnipeg, she took an intensive ESL course. Despite this, communicating in English was a major stressor for her.

> I seclude myself. I don't go out often. I just watch TV. Always stress in English, always! I'm not that shy in my country, but here I became really shy. People think that I am shy, because I avoid the difficult conversations. And it's hard to make friends. It is not that hard, but I mean, it's easy to get to know people, but it's hard to get to know people more deeply. I think that's because my English, the level of language, it's difficult to talk about . . . how can I say, deep conversation? English is major, major reason, I think. If I can speak or communicate freely, I think I would have many friends, cause there are many good people here. Yeah, that's sad!

Isolation was often the result of cultural differences in emotional expression and social interaction. Two of the women offered the following descriptions of the disparity they felt:

> The way that you approach people is very different. Our custom is to give everyone a kiss on the cheek. When we meet we are like . . . OK! Big hug to you!

> It's the closeness, the space to allow yourself to be silly . . . to be daring . . . to forget about politeness . . . to allow those gut reactions, to loosen up and to just laugh! It is not the same connection here. You can joke about certain things, and I know people who are open minded, but sometimes . . . I wonder. Maybe people don't do that here, goof around and just laugh. Tell jokes and just don't care about what the other person thinks, because after all , you are friends! You have that space to allow yourself to be whatever. I haven't experienced that here very much.

Similar sentiments as well as concern about being able to "reinvent" herself to fit Canadian norms was evident in this participant's statement:

> Relationships [here] are different. How to connect to the network? How to connect, to be part of . . . and learn whatever cultural codes to do that properly. To talk to people, the biggest thing was to learn that. Kissing and hugging, a small thing like that. Someone introduces someone else and you discover a difference. You know, we always kiss, and that wasn't the case here. So you get sort of, you know, hanging there, in mid air!

Despite having a number of acquaintances in Winnipeg, one woman spoke of missing the frequency and spontaneity of the social interaction she had enjoyed before coming to Canada. Her ongoing feelings of isolation, a number of years later, were evident in this account:

> Being at home and nobody rings the bell. Something that is so common, so part of your daily life. When in your country . . . people come. Your door is open and you spend a lot of time with people, just talking and hanging out. I like silence, but not *that* quiet! I saw people just going to English classes. My husband wanted to reconnect with his friends, so we were going out. But on a daily basis, most of the time it was quiet, sort of isolated.

Shortly after her arrival, one of the women contacted the International Centre because of her loneliness.

> I want to have contact and communication with Canadian people because I am very alone. And they introduced me to two ladies. We are friends, but

> one of them is a high school student and doesn't [have] enough time. Sometimes, she comes to my house and we have tea or just talk together.

Lack of time for social interaction was expressed by other participants as well. It wasn't so much their own lack of time. Despite their numerous obligations and responsibilities, socialization seemed a priority to all of the women in the study. Sometimes, their friends had chosen to devote almost all of their time to work, school, and family. One woman noted this change in her own priorities since arriving in Canada.

> Here, I seem to be working all the time. I wonder if I am working so much to avoid what I was talking about . . . the lack of spontaneous social contact. My preference would be to spend more time with others, to have that connection. Maybe I'm working more because I can't find people, on a daily basis, just to hang out. That has been the most difficult, a daily thing. And I know people here, yet it's difficult for me to find enough friends. I talk about them as friends. It depends on which definition you use, but sometimes, I don't see them for weeks.

Another problem getting to know people in Winnipeg was the numerous well established social networks that exist among those who are not newcomers.

> All the people that I know have grown up here, have spent all their lives here. They have their own circle. They know each other and it is difficult to break into those networks. You don't know the code. You don't know how to relate. You are always sort of an outsider to that. These are long term relationships. Probably in other places, where people move in and out, the relationships are more fluid and they tend to be more open to new people. But here, especially with established people, people who have lived here for a long time, it's hard to get into that.

The challenge of coping with Winnipeg's long and severe winters was identified by all of the women in the study. This is how one described the effect of the weather on her health:

> We are so much isolated by the cold. You don't go outside much and then you feel disconnected. Then time goes by and you don't have energy. I used my bike all the time, everyday, going back and forth everywhere.

Particularly for the two participants who did not know anyone in Winnipeg when they arrived, their isolation had a profound effect on their emotional health. When asked what it was like for her when she first arrived, one woman recalled, "I was very, very sad. You can't imagine!" Another described her initial experience in these words:

> It was hard, really hard! I couldn't identify with anything here. It was *so* different. Nobody knows you. I missed my family and my friends. I didn't have people to talk to about my feelings. All the time I was depressed and crying.

A change in status, the kindness of strangers, making new friends, and keeping in touch with family and friends back home have helped these women to cope with feelings of isolation. One woman who had arrived as a refugee 2 years ago explained how her situation has improved.

> [Becoming] a landed immigrant helped me in a way, to feel that I was able to integrate into the community. Emotionally, it is taking me a while to adjust myself to my new home. I am happier now. I feel the streets around here are *my* streets. I have good friends here. It is nice because I feel part of life around here. It takes time. I am becoming more like I used to be. I am a friendly person, very sociable. It helped to stay in communication with my family and friends. Because you are more aware of what is going on, what is happening with them. Information keeps you straight.

Another woman spoke positively about her experience when she first arrived in Canada as a student.

> I would consider myself very fortunate because the types of people that I met when I first came here, they were very kind to me. They helped me cope with the homesickness, missing the food, missing all the things that I'm so familiar, so used to back home.

One participant, whose husband originated in Winnipeg, explained how this connection, as well as beginning employment, eased her transition.

> Through him I learned about the culture, and through his family. I learned about the city. And we connected with other people, because he already had friends here. I met people through work. That facilitated a lot of contact. A lot of support comes from that, having people, having that tie.

All of the women maintained contact with family and friends via telephone or the Internet. This was especially important for those women whose country of origin was engaged in political or economic upheaval.

> I try to maintain the communication open and honest, as fluid as possible, to really know, especially with friends and family, what it is like for them. The Internet helps. I use a lot of e-mail. Even if you communicate a lot of trivia, if you do it on a constant basis, there is spontaneity in the communication and it helps you to go into deeper things. I have to keep the channels open. It's not easy. The reality is so different and you change so much when you are in a different country. People change so much as well, because life changes so much. It is very important not to make any assumptions.

Optimism. One of the personal strengths identified by all of the women in the study was optimism. This characteristic was manifested by a positive attitude, belief in self, faith in a higher power, the search for meaning in life, and a sense of humour. The latter was often evident nonverbally during the interviews. The women were able to discover and share the humour evoked in retrospect from at least some of their experiences.

The respondent who had felt so angry and frustrated when the apartment that she and her family expected to move into was not available, was able to see another side to this encounter.

> You have to face something to make you strong. As we have come to know different types of strategies, how people are, how they feel, I think

> we have learned to be strong, and try not to let that situation make us discouraged. We try to be . . . positive.

After relating how she missed communicating spontaneously with friends, one of the women went on to make this hopeful statement: "I haven't experienced that [open and spontaneous communication] here much, but I'm sure there are some people here like that and I just haven't met them yet."

One of the participants, who related in a very positive manner during the interviews, depicted her optimistic view in this way:

> The personal quality that I have in myself is desire. I have a desire to come to Canada to build a good life. We all want to do something significant with our lives. When it comes to doing something great in life, I always believe it has to do with how I look at life. I have a very positive way of looking at life. There is a lot of negativity around us so sometimes I just say "Well, you know what? There is positive in this direction, whatever it is, and I can move forward".

The most vivid example of belief in self is from this excerpt of an interview with a woman who continues to experience numerous obstacles and barriers:

> I didn't ever give up. I [didn't] give up because I wanted victory from problems, and I hope I can. But I'm sure I can. But I also told myself "You believe [in] yourself! You *can* do it." I am sure that [is] very difficult, but I hope! In my opinion, it is not important [to] win or fail. It's important to [not] give up. Sometimes I really [was] feeling bad. I was crying so much because I can't stop it. All the time I was talking with myself, and I believe [in] myself. I think idea and [belief] is very important [in] life. Maybe you believe *one* thought. Maybe you believe [in] God . . . the sky. In my opinion, if I believe [in] myself and I believe in [humanity], I believe something, but more than everything, I believe [in] myself. I think just that, that topic helped me [in] life. That belief wake me up! And so, I don't give up, just for that belief.

Of all the participants in the study, one woman spoke most directly and openly about her faith and how it had helped her cope since her recent arrival as a refugee.

> Just believe that God is always by your side and, you know He will always help to get you by. Even though it may be hard, it may be tough, but that's faith. And it makes you be alright! Yeah! Yeah, even during the war. We lost everything, even food to eat, but having faith always makes us get something for the kids to eat. So, you know there is something in me that keeps me alive, or that strengthens me to always look to the future.

The search for meaning and significance was often mentioned in the interviews. One woman explained how she continually tried to go forward:

> My focus has always been . . . trying to find a way . . . so that our settlement here, with my husband is much more meaningful, more significant.

Finding meaningful employment was a goal for all of the women. One woman felt that she had achieved that goal, at least for the short term.

> In the job that I have I meet different kinds of people. It is easy to meet people in work relationships. My job is . . . I take care of sick people. They always say that they are happy that I am there. The families love me! They see that you care and you develop relationships. It's beautiful! I really like it. I may not do this my whole life, but so far, for now, I feel that it is what I want to do.

Another woman related how she was able to find meaning in her present circumstances.

> I see myself doing something that is meaningful. And I guess that is the attitude that gets you through a lot of frustration with learning English. And I just love going to the movies! I had to keep going to the movies . . . and at the end of the night you might get some stories out of that. Maybe not the same story that a lot of people got, but I try to communicate with people and not be too isolated. Anyway, I think that is what basically helped me.

The support and encouragement of friends and family and counselors helped the women develop and maintain their optimistic outlook.

> I grew up in a very supportive family. My parents were teachers and they tell me "You can do anything! If you want it, you can get it. It's up to you! You have the ability to get whatever you want".

One of the women described her gratitude to her sister who helped her survive emotionally with the barriers and obstacles related to her settlement.

> If my own sister was not in Canada, maybe . . . I don't know, maybe I would just have lie down and never get up, because I'll just be thinking and thinking, slowly not eating. Everyday thinking [about] back home, and stress finally take over. . . . So, I really appreciate what my sister is doing for us. Yeah, my sister here, she is a great help to us, really! Because in Africa we suffer war, but there is one thing we call love. If you have your problems, you are able to discuss them. Discussion will find a way. That this person will know about it, there'll be a solution.

In response to the question about supports that have been helpful in coping with the challenges of resettlement, one woman replied:

> The encouragement of my family. I have been making friends here since I came and that has been helpful. Before I came, because my dad knows me, that I am emotive. . . . I think you say emotional, he arranged with a colleague to get me a counsellor here. Since I have been meeting with her, she is a kind of point of reference, all the time there. Because when you are in the ocean there is a little island there. You know it is there all the time. That is what she is for me. Our relationship has grown, I will get in touch with her and it is mutual. She wants to talk too, and it is nice. She knows lots about me. Here in Canada, she is the person who knows more about me than anybody. All the time she is sending me e-mails about things that she thinks I would be interested in. Yeah, it is a beautiful feeling! She can help me to get through things. She has been the best support for me here.

Despite having experienced major obstacles in their lives, all of the women displayed a positive outlook toward the future. With the support and encouragement of friends and family, they were able to find meaning in their lives. Faith in a higher power and the personal characteristics of humour and hopefulness helped them to cope with numerous stressors and avoid despair.

Adaptability. The ability to adapt to new circumstances was another personal strength identified by all of the participants. This characteristic was manifested by open-mindedness, flexibility, valuing of diversity, thirst for knowledge, and the use of effective coping strategies. Adaptability was influenced by personality, past experiences, as well as the encouragement and support of family, friends, teachers, the International Centre and the Immigrant Women's Association of Manitoba.

After sharing her experiences of living and working in another country, one woman spoke about what influenced her decision to come to Canada.

> Then I got home and I think . . . that was a really good experience, so I want to do more. And then I get a chance to come here. I'm not so closed minded. I don't have a narrow mind. I can accept that people are different. I think to live in Canada. . . . Canada is a diverse, big country, multi cultural. So, people should have that kind of mind if people choose to live here. I'm not afraid to learn or experience other people's culture.

The woman who came to Canada from the Middle East expressed her open-mindedness and appreciation for diversity in this way:

> I am not related to one culture. I choose everything, as everyone's culture is good. Which one is better for life? Which one [will] help me to be more human? So I don't have any problem with culture, because I'm not related to any culture, any special culture.

Another participant also conveyed the importance of "understanding that things can be done in different ways, many different ways". She stressed that, "You always have to be very open-minded about what you can do . . . how you can translate, do different things. I was very open to that".

One of the women felt that the majority of people in her country of origin were not open to diversity and she described why she was.

> They don't know much about other culture, other values, and other situations. It is easy to simply think that mine is better. But I didn't think . . . I never ever thought that, because you know people can be different. I am very interested in learning that kind of value. I got interested in seeing American culture. In America there are many ethnic groups but they get along well. I think that was the initiation of my interest in other cultures. So I chose to learn and chose to experience.

The woman who identified Winnipeg's harsh winter weather as her greatest challenge, described how she coped with this obstacle.

> The weather, the changes and all that, those challenges, it was good that I was able to face them and move forward from that. Not just [be] stagnant and can't do anything. No, no I was having a lot of fun. We went cross country skiing, tobogganing. Those first exposure to adapting myself. That word is good. I was able to adapt myself, yeah!

Being adaptable helped in the adjustment to the cultural differences that were discovered in everyday life.

> I guess being open and flexible helps you to . . . to navigate. I try to find some familiarity with certain things, a certain pattern or logic. Then I can say "That makes sense. I can live with that". What I was used to doing was to eat late. Sometimes I have trouble with that. Especially in the summer here, when I have to meet people, when we arrange to do things together with people who are used to eating early. You just have to kind of compromise. There has been nothing that I couldn't do related to my culture. I don't think I would have had any problems anywhere. I'm very flexible.

While discussing the difficulties experienced in attempting to continue her academic pursuits, one woman described how she was able to succeed.

> I couldn't lose that momentum. It would have been terrible if I would have done that! It would have been horrible. Coming from my country, having done all the stuff that I've done there . . . the study, being involved with the university, going to conferences. I didn't have a lot of money, but I was able to do a lot. It would have been horrible to come here and not be able to reinvent myself in a way that would allow myself to continue to do something that was meaningful.

While describing a backpacking experience she had when traveling and waiting for permission to come to Canada, one of the women spoke of her interest in the people of the country that neighboured her own. She recalled "I was observing . . . and I thought 'Oh, I'll learn from this too!'" This enthusiasm and openness to learning were evident throughout the interview.

Willingness to learn and adapt was evident in those women whose academic credentials were not accepted in Canada. One of them spoke about what this process was like for her.

> My first employment here was a summer job. The work wasn't as meaningful, but I was around books in the library, so I learned something. And from then on, I've had work that more or less related. I can see a lot of relationship with my studies. It has been great. But I have to say that it's because I decided to go for my masters and because of my thesis . . . what I chose to do. I decided that I wouldn't do something that was just with books in the library. And so I said "O.K., maybe this is the opportunity to learn more about Canada". It was my excuse to learn more about the system. And that worked very well, because that opened the door. People got to know me, got to know my interests, because I was focused on research. I got involved on committees. And from there I can draw the line from that to getting a job. It was a lot of conscious decision. I knew when I came that if I wanted to do something in my field, I needed to be able to communicate in English.

It was not always practical for the women to continue previous academic interests. The woman whose studies were interrupted by her need to flee her country, described her love of sociology and her realization that right now she must pursue a more practical path.

> If I get a job, maybe I continue that [studying sociology]. Work situation is very important for life. If I have a good situation, for sure I'm looking for my interest and I continue my interest in sociology. I think it doesn't need, it's not very, very necessary to [go to] the university, because lots of books I can study by myself. Because it's my interest and also I think I know

> basic sociology. I like university for discuss with professor and the students. I hope [to get] this chance and getting to the university. I like fighting with my professor [laughs] and I really . . . sometimes I think I am really thirsty for education. Accounting is not my interest, but I don't hate it. In my opinion, when you want to do something you can love that. You can like that. And you can live with that. But if I choose, I choose sociology, for sure! But for now, for this time, I choose computer accounting just for getting job and life.

Coping in their new environment did not always involve adopting the ways of their new country. One of the women who had spoken of missing the spontaneous and physical way of greeting others found a solution. She explained, "I am teaching my friends to do that [hug and kiss when they meet]. . . . And they think it is just great! It is kind of strange to readapt myself."

The value of family support and assistance was again identified:

> The important thing is that I have a lot of supports. I had this job before I came because my husband has connections here. He introduced me to different things. And when I came here it was great. I didn't need to go by myself everywhere. A lot of things he already knew. We had to go for the social insurance. He knew where to go and that helped. I had to do all the university stuff and that was tough.

One of the women wasn't sure why she was open to diversity, but offered this explanation:

> I really don't know why I have an open mind. I just have interest in people, people in different cultures. I think . . . ah! I think [it's] the movies! You don't have foreigners in [her country]. The only exposure to other cultures is only through movies. So, while I watch a movie, I think . . . I thought then, why do they do certain thing in certain ways. So that made me interested.

Perhaps the traits of open-mindedness and eagerness to learn motivated the women to participate in the study. Certainly these characteristics, along with flexibility and an

appreciation of diversity, enhanced their ability to cope with their experience of immigration and resettlement.

Perseverance. The ability to persevere despite all odds was evident in all of the women who participated in the study. They expressed determination, the ability to identify and focus on present and future goals, and courageousness. Past experience, personality factors and the support of family, friends and agencies were again identified as important factors in the development of this strength.

One woman described her determination as a "don't give up attitude". She spoke of her husband and herself, stating, "I think we want to persevere". Another participant, when asked what personal qualities and strengths helped her to survive, replied "Sometimes I think I am a strong woman. And I didn't *ever* give up!"

Keeping focused on their long term goals helped one woman and her husband to establish their own business and become financially independent.

> We are trying to improve our lives on a daily basis, and what we do is we'll just reflect back. Where were we a year ago? O.K. What do we have this year? And what are we going to do for next year? So we're always trying to move forward and our qualities are in unison. Even the good times, especially the bad times, you just . . . just focus where you want to be.

Two other participants described how setting goals led to their ability to achieve academic success and career development.

> I think I am pretty much goal minded. I set up the goal. I want to reach that level so I don't plan for the long term, but I plan for the short term. When I came here, O.K., let's finish English first. Then I don't think about later things. Once I finished that, then I started to set up a goal to finish the nursing refresher and pass the exam. When I passed, then I needed to get a job. So at the moment I kind of planned it, to stay where I am now, at the

> unit, for one year. And then I want to move on to [specialty] course. That's the plan. I don't think other things too much, just what I have to do.
>
> I think it was my recognition that I needed to communicate somehow, and that I needed to learn. . . . I knew that English was what I needed, that I needed to 'go for it'. I needed to push myself. I knew that going to the university would help me to make some connection. I already had a focus for my career. I had a vision of what I wanted to do. That helped. And having short term goals.

Courage and bravery were frequently cited as qualities that helped the women to deal with difficulties in their lives before and after immigration. When asked what helped them to develop these and other strengths, their responses were somewhat varied. One woman replied "I just be brave". She seemed to think it was part of one's character, suggesting that "maybe just certain people brave, and certain people *chicken* ".

Past experiences and the support of friends helped this woman to persevere and to be strong.

> It's related to where do you live, when do you live. When I was a child, revolution in my country happened. That make me very strong. Because I saw so many things when I was young. Sometimes I think . . . it's not fair, because I didn't [have] childhood. [On the] other hand, maybe that was very helpful for me. That time push me to be free, push me to love people. I forgot to tell you what personal qualities make me strong. Belief and friends. Some of my friends, thinking the same as me, had the same ideas as me. For example, the goal of human rights, child rights, woman rights. They have the same idea. It's very helpful for me. It makes me relax. Because when, sometimes when very, very disappointed, just I think, oh, I have one friend. It's far to me [the geographical distance from her friend], but all the time she helps me because I am sure when I [don't have anyone] they . . . take my hand! It's good for life. It's the best thing [friendship] to continue life and be happy. It makes me happy.

As expressed in the following two accounts, family was often credited with assisting the women to develop the characteristics needed to persevere despite difficulties.

> My sister says "You have to cope. You have to learn to cope with big problems. Small problems, big problems, you have to cope with it. If you learn to cope, then there's nothing. . . . Anything that comes your way, you just have to think that it is a washing breeze! Just a breeze! Like if you are feeling hot, and then a breeze, just a beautiful air just come by like this. Shhhhh! And then pass by. So that's how you look at problems, just allow it to pass by". All the way, she talked to us, encouraged us.

> Even though I am here by myself, they [her parents] don't worry too much because they know that I am not going to do some wrong things. The belief they have about me is really, really helpful. Some characteristics I have is from my parents. So I think even if we have different thought and different thinking about life, certain strengths, say . . . not to plan too much, cause it's like, not so smart to plan long term, because I never know what's going to happen! I think I learned from my mom that kind of thing. My mom used to say to me "You don't know what is going to happen. So always be . . . do your best." Yeah, so all these qualities I learned from my parents and my culture.

One woman found that involvement with the Immigrant Women's Association of Manitoba was helpful. She was also grateful for the ongoing support of her teachers.

> I got involved there [IWAM] when I was in Canada for about one month, because basically I needed to get out more. Because if I am by myself, that's not gonna help, and that's not what I want. So at that moment, it's like right now, I was concerned about my English. So I wanted to expose myself and I have a chance to know that there is that kind of organization. So I joined there and I met [the president and a volunteer] there and they have been really helpful. Even though while I'm studying I have little time to join and to participate in activities. I just very hardly participate, but I still keep in touch with [the volunteer] and she is like my best friend here. I think they helped me. And the teachers who I met doing my course, an English teacher and nursing teacher, especially the teacher in English class. She taught us for 6 months. Now, she's like our friend. Whatever happened to us, we used to call her and say "I got a job! I passed English!" Yeah, she has a special feeling about us and we also do. It's like, you know *Grandma*! She was the first Canadian that we met here. I think it would probably be the same for the other immigrants. The first Canadian they meet is in school, because they have to learn English. So, if that experience was good, then that feeling goes with you forever. So because she's so nice, we got to know her and we got together a few times after the class. So, yeah, she's like *big mommy*!

In addition to the influence of family and friends, one woman spoke of the importance of self development.

> How I developed those strengths [determination and goal mindedness] are from my upbringing and the people that I am spending time with, the friends that think the same way as I do. And a lot of times, I develop these qualities by reading. I read a lot. I think it's important for us to learn that from reading, rather than actual experience. You can't experience everything, so I do a lot of reading.

Courage, determination, and the ability to set and focus on goals were seen as valuable traits that helped the women to persevere in their struggle to overcome the barriers and obstacles resulting from immigration and resettlement. Once again, personality factors, past experiences, significant others and certain agencies were identified as important influences.

The value of social support and familiarity. Two of the participants were somewhat familiar with Winnipeg from visiting the city prior to their immigration. Both of these women are married to men who were born in Canada. Each of the men had lived in the homeland of their respective spouse and developed an appreciation for the country's culture.

Despite numerous cultural differences between their homeland and Canada, all of the women found consolation in the fact that they were able, for the most part, to carry on their cultural traditions. They found or created opportunities to share their dress, music, and dance. One spoke of being able to find familiar foods, even though at times these items were costly.

> I drink a sort of . . . tea. It's called *maté*. I am able to get that here. The foods that I used to get in my country, I can get it but it's not very cheap.

> Because it's imported, it costs more. And when you think how much it costs in your country. . . . I say, "Forget it!" I was very happy that we were coming here because of all the vegetarian options.

Another woman was able to find all of her favourite foods once she knew where to shop for them.

> I found that there were Oriental or Asian markets. You could find certain food items in Superstore and there was a small store. I could find certain things like noodles and spices and all the type of seasonings that I used in my cooking.

The delight was evident in this woman's description of discovering a downtown market that sold a variety of international foods:

> There we can get all our African food. Everything we need! Everything! *Everything!* And like, we eat hot sauce. So when I came I thought, oh if there is no papaya, if there is no hot sauce, I would not like to stay here! My sister took me and said "Come, let me show you!" Then I say "Yes! You have *it* [hot sauce]!" Yeah, I can have *everything* I want.

One woman described the value of social contact, her own experiences, and her ideas for change.

> It is important to know that there are people around that welcome you, that care about you. It is really important to help those people that are newcomers. I was lucky. I was by myself when I moved here and needed a roommate and I got a volunteer from the International Centre. So for both of us it was very good. Friendships are the most important. There are people volunteering at the Centre picking you up and taking you places on the weekend. You need that. Oh huge one, yeah! And they are taking their time to spend with you. They don't know anything about you, but they say "Hey, you wanna come over for supper or lunch, or let's go for a walk". Just *that*. For me at least, I think it's very important, those connections with the people here. Organizations are like . . . 9 a.m. to 4 p.m. That's *it!* You are part of their work and that's it, "Bye". No, you need friends! An organization could get volunteer programs to make friendships with newcomers. That would be great! The informal environment. They [newcomers] are living here and they need help to enjoy all the things in the city. For example, the International Centre has a little program, which is a

> kind of social club, and they do different activities every month. They send you a calendar of all the things that they are doing and you can come to whatever you want and participate in those things. Like, you could be going to the beach, or to the zoo, or to the cinema, or having a conversation night, or watching a video together. And you start meeting people there. It's nice! Yes, I think those things are very important.

Another woman wasn't as enthusiastic about the number of possibilities for meeting people. She felt that space was needed to provide these opportunities.

> I guess there is some stuff out there. I don't know if you can artificially develop something that can help with that. I don't know if support groups would be the right thing, or coming together around certain things. I guess providing certain spaces for people to gather. I don't know, maybe around an activity. A place you can go and just . . . I'm an immigrant, but I worry about getting just clustered with your own people, because I don't think it is very helpful either. It is difficult to facilitate something that can bring everybody together. I don't know if there would be something like that. I have been troubled with that myself, to connect, to have that space. I don't know if people are too busy, maybe I should just get some people and do that.

One of the women talked about the value of socializing in order to improve her English.

> Oh, making friends, go out! When I got here, I said "I need to speak more!" I definitely feel that listening isn't so much problem, but speaking is the problem That's the thinking at the moment, so that's why I go out. I want to go out and I want to participate in activities [at] the International Centre or IWAM. They were great organizations to meet people.

Reaching out to newcomers. Participants felt there was a definite need for agencies to develop community liaisons and provide more accessible services.

> I believe there are a lot of agencies that are getting government funding to support immigrants and refugees. However, these centres, or these agencies are not reaching out to the immigrants, because they are expecting the immigrants to reach them. If they [immigrants and refugees] were going to take courses, they would want to speak to someone they are familiar with. Who do they speak to? They speak to another immigrant or refugee.

> What happened is these agencies are mostly non-immigrant agencies. You need to have someone that could relate to these people, maybe from their community, a representative from their community. I've connected with some people that are able to translate. And there are a lot of people like that who are not working for the organizations that would support immigrants and refugees. And they are out there helping out. They're the key people that should be working for the agencies. Some of the agencies out there, the immigrant agencies, like the International Centre, and *Welcome Place* have immigrants that work in the programs to help support immigrants and refugees. And I think that's really great! It's also attitude. Either you wait, or you go out and help them because they [newcomers] don't even know where to go. Go to the building, the community residence. Organize, create an environment so that you can organize an event to reach out to all those people. That's what IWAM is doing. We want to set up classes in the building so that they don't have to take a bus.

One woman did find organizations that were helpful to her in her search for work. It was a change from her country of origin.

> The organizations here are supportive and helpful. There is a lot of opportunities to find jobs. If you need papers, they are . . . how do you say . . . efficient? People are very straight up, very clear, very honest. That encouragement really helps you to trust and understand and keep going, knowing that you are able to reach whatever you want. I came from a country where the crisis is so huge that whoever finds a job is privileged. It doesn't matter what conditions you are working, like twelve hours and getting paid little. You don't have much rights, but the situation is so difficult, you don't complain. So here, with human rights, there is unemployment and health insurance. Those things help you to have a good solid environment.

The participant who arrived as a refugee from the Middle East had these suggestions:

> I think the government or international organization has to be more patient to women and immigrant people. Almost all immigrant people from another country have a bad situation. And when they come to Canada, I think it is unfair to continue that situation. If we have some program for that woman, because some women have a child and [don't] have education. Maybe just learn English, just for conversation, not really study writing or reading, without education, just speaking. It's not helpful because it's just,

> no education. They have to help them more [with getting] jobs. That money to immigrant people is for 1 year. It's not at all enough, because when I wanted to buy clothes, we can't. That money just enough for food and rent. That's it! I think if government can't give the immigrant more money, give that money and also part time job. Part time job makes experience. It's difficult to get a job [with no experience]. But if you have a part time job, it's helpful for the income and [on the] other hand, it is helpful for being in contact, in direct contact with people, Canadian people. And also getting experience, and more than everything it's good for income.

Recognition of existing skills and knowledge. Three of the women have been able to find work that is meaningful to them. One of these women had chosen to come to Canada because the working conditions and opportunities for nurses were better here. Another, able to work as a researcher, after obtaining her master's degree here, felt that the academic credentials she obtained from her country of origin were not recognized. The third woman has found fulfilment in the business she has established with her husband.

One of the women, unable to find satisfying work outside her home since her recent arrival, expressed anger about the fact that despite having completed high school and a technical school certificate prior to coming to Canada, every employment counsellor she spoke with urged her to return to school and repeat Grades 10 through 12. Despite several years experience in her chosen profession, she continually met with the suggestion to take a Health Care Aide course. She described her frustration and discouragement as follows:

> I'm a [medical] secretary for a long time. But since I came, they tell me "You have to do some Grade 10". You know it was really discouraging, yeah it was discouraging! Oh I cannot stand it! What, me go back to Grade 10? You come here, you go back to zero and start to climb the ladder. You start from down and then you can't even go to the middle. I cannot practice my own career here. I love my career, so I want to continue. I

> don't want to divert from my own career. I've learned it, it is in me, it is part of me. If I don't like a career and then I went into it, then it's meaningless. Not everyone can do Health Care Aide. No. All immigrants do Health Care Aide? No, no! It's really disheartening! You deserve to get what you work for in life.

Later in the interview, she spoke very candidly about what needs to be changed.

> Not every woman that comes to Canada must go and do Health Care Aide. Some are qualified women. Some are housewives. You can encourage them to do something to help the community. But imagine someone who has a career back home. Why can't the Canadian Government help that person to resume her career instead of telling that person to demolish her career and then pick up another career which she had never ever dreamed of? You think she can practice that with love? Never! So help them remain in whatever career they have practiced. So if they can concentrate on women to develop whatever they have already *got*, I think that would be better, really. It's not to find money to survive but to build Canada because you want to become part of Canada, so you have to [use] what you already have. You have to use it so that you build the country up. You have to value it [existing skills and education].

The majority of the participants had been able to find some assistance and support in their attempts to resettle. They all perceived gaps in the present system, identifying the need for more opportunities for social contact, improved community outreach, and recognition of existing knowledge and skills. These changes could lessen the isolation and emotional distress experienced by immigrant and refugee women and enhance their optimism, adaptability, and perseverance.

Summary of Findings

The characteristics of the sample varied according to country of origin, length of time in Canada, immigration status, English language proficiency, relationship status, academic achievement, and economic security. Participants were similar in age, which

ranged from 28 to 35 years. Their relative youthfulness and early stage of career development may have enhanced their resilience.

All of the women in the study expressed some degree of emotional distress, including anxiety, apprehension, uncertainty, frustration and depression. The severity of these emotions seemed to depend on fluency in English, financial security and social support. Social isolation was also identified as a major concern and related to language barriers, cultural differences, time constraints, discrimination, and harsh climate. The result of their isolation was feelings of loneliness, alienation, anxiety, and depression. Keeping in touch with family and establishing new friendships helped the women to feel less isolated.

Personal strengths identified by the respondents included optimism, adaptability, and perseverance. Some thought that these traits were an inherent part of their personality, while most agreed that the support of family, friends, and specific agencies was crucial to the development of these qualities. Participants expressed a need for more opportunities for social contact, increased community outreach and acknowledgment of their education and employment skills.

Barriers and obstacles continued to create difficulties for the women. They spoke candidly about past and present concerns. Despite the severity of their problems, all of the women were able to identify their own resilience and the positive influences in their lives.

Chapter 6

Discussion

Participants in this study varied considerably in background and experience. The 6 women were similar in age and revealed some similarities in their responses to questions about the barriers and obstacles they had experienced as immigrant and refugee women; their strengths and supports, as well as their suggestions for change.

In this chapter I will discuss the findings of the study in relation to the conceptual framework, research questions, factors that influenced data collection and analysis, and previous research. A discussion of the implications for nursing education and practice, policy development, and future research are followed by a list of recommendations.

Conceptual Framework

The conceptual framework developed by the researcher for this study depicts the interactive relationship between health promotion and resilience within a feminist research paradigm. *Coping* is one of the key concepts of health promotion (Manitoba Health, 1997). Resilience has been described as a process of coping (Mangham et al., 1995a). The literature on resilience, health promotion, and feminist theory focuses on the capacities and strengths of individuals, families and communities (Davis, 2000; Dyer & McGuiness, 1996; Pender, 1996). Social support, a prerequisite for health, is also considered to be a protective factor in resiliency (MacKinnon & Howard, 2000). Feminist writers also stress the importance of the social context of women's lives. The stories of the women in this study echo this crucial emphasis. Empowerment, emphasized in feminist research, is

considered a vital element in health promotion practice. Listening, critical reflection and the validation of the experiences and perceptions of respondents are fundamental to women-centred interviewing. These principles were a constant reminder to me to make the best use of my personal and professional skills as an active and attentive listener, to validate participants' responses verbally and non-verbally and to take time for thoughtful reflection.

The qualities and strengths that helped the participants to cope with resettlement parallel the characteristics associated with resiliency: optimism, courage, resourcefulness, adaptability, determination, perseverance and a sense of humour. Social support, a factor thought to promote health and enhance resilience, was identified by all respondents as a critical influence on their adjustment. In keeping with the tenets of feminist research, this study focused on gender, diversity, and the social context of the women's actual experience. This framework guided the researcher in designing an open-ended interview schedule and woman-centred method that encouraged the women to share their individual experiences, identify their strengths and supports and offer their recommendations for change. The framework was a helpful reminder throughout the research process of the dynamic relationship between the concepts.

Research Questions

The immigrant and refugee women who participated described a number of difficulties that they encountered living in Canada. Many of the women identified language barriers as the greatest obstacle to their adjustment. Cultural differences and the lack of recognition of their education and employment skills also presented major problems for

most of the respondents. Some of the women experienced discrimination related to their racial background, skin colour and lack of English language proficiency. All of the women identified that the harsh winter weather in this part of the country had a negative influence on their health.

The difficulties experienced by the women affected their health in varying degrees. They spoke of feeling anxious, fearful, and uncertain. They were frustrated and discouraged in their attempts to find meaningful employment and often reported feeling depressed as a result. Their experience of isolation, loneliness, and alienation compounded their distress.

The women identified personal strengths and supports that have helped them to survive their migration and resettlement experiences. A universal quality they displayed was optimism, evidenced by humour and positive attitudes and beliefs. Another strength they all described was adaptability. This was characterized by flexibility, effective coping strategies, open-mindedness, and an appreciation of diversity. Perseverance was the third trait that was common to all of the respondents. They demonstrated courage, determination, and an ability to identify and focus on present and future goals.

Participants freely shared their views about the changes that they felt were needed to create an environment more conducive to their health. These suggestions related to the need for more opportunities for social interaction, improved community outreach by government agencies and increased recognition of education and skills.

Factors Influencing Data Collection and Analysis

Three of the participants had no direct knowledge about the researcher prior to the first interview. They were referred by women who met me and became familiar with my study through the Immigrant Women's Association of Manitoba (IWAM). I had spoken briefly with one of the women at an event sponsored by IWAM. Time constraints of 4 of the women permitted only one interview, while 2 of them were able to meet with me on two separate occasions.

Familiarity with the investigator and length or number of interviews did not appear to have a major influence on the level of trust expressed by the participants. All of the women responded with warmth and candour, openly sharing their thoughts, feelings, and experiences. Some of the more personal revelations were made by the women who had not met me before.

When the initial contact was made, most of the women expressed interest in "helping" me with my study. This may have been due to their own academic backgrounds and appreciation of the value of research. It may also have been because they felt that the study would add to a growing body of knowledge about the experiences and needs of immigrant and refugee women. Perhaps the study's positive focus on their strengths was a motivating factor. Certainly they welcomed the chance to give their views on changes that were needed in the system.

Throughout the interviews it was evident that the women appreciated the opportunity to express their feelings and to describe their experiences. One of the women, who had not been able until now to find "a listening ear", indicated that participating in the

study was particularly cathartic. Despite having recently arrived as a refugee from a war torn country, being in the process of moving and attending school, as well as caring for two young children, she was determined in her efforts to be part of this research.

I was not in a direct position of power in relation to any of the participants. Many efforts were made to increase control for the women in the interview situation. They were asked to choose a time and location that was most convenient and comfortable for them. The consent form explained the purpose and process, assuring them that they were free to withdraw from the study at any time, to refuse to answer any questions, and to stop the tape recorder if they wished. Prior to the beginning of the interview they were given a copy of the questions to review. The questions were semi-structured to allow for individual expression.

I am a second generation Canadian and when asked about my background I shared the fact that my parents were immigrants from Eastern Europe. On hearing that I was single and had no family in Winnipeg, one respondent said, "You are the same as me". On further reflection she decided that this was not the case because I had a degree, a job and was familiar with the city. Financial security and language proficiency were other barriers we did not share.

Throughout the development of this thesis I have experienced growth both personally and professionally. Part of this change is a result of the knowledge gained from the academic literature on resilience, health promotion, feminist scholarship and research on the experiences of immigrant and refugee women. Equally valuable in increasing my sensitivity and insight were my encounters with the study participants, my involvement

with IWAM through meetings and workshops, and awareness of other women's stories through their writing and film. Their courage, wisdom and articulate expression have inspired my efforts in this and future projects.

Previous Research

The findings of this study are compared with selected literature from the past 15 years related to the concept of resilience, feminist scholarship and the experiences of immigrant and refugee women. This section is organized according to the themes which emerged from a content analysis of the data.

Language barriers. Anxiety, fear, uncertainty, frustration and depression related to language barriers, cultural differences, and unemployment are well documented in the literature on immigrant and refugee women. In their study on the health of immigrant women in Canada, Oxman-Martinez et al. (2000) noted that the unemployment encountered by many of the women, due to a "lack of professional accreditation, education or language barriers" (p. 395), led to increased stress, depression and decreased self-esteem.

The uncertainty and frustration related to language and financial problems were also reported by a number of researchers (DeSantis, 1997; Edwards, 1995; Hattar-Pollara & Meleis, 1995; Wilson, 1995). MacKinnon and Howard (2000) identified the lack of language proficiency as a major factor influencing the health of immigrant and refugee women in Prince Edward Island. Hutton (1993) found that of all predictors of adaptation in refugees, language proficiency was the most influential. In their study on the barriers to accessing health and social services by immigrant and refugee women in Winnipeg, Hakim

and Angom (1999) also discovered that the women experienced "enormous personal discouragement and stress" (p. 1).

Discrimination. The literature on immigrant and refugee women includes numerous references to racism (DeSantis, 1997; Dhruvarajan, 2002; Hakim & Angom, 1999; Hattar-Pollara & Meleis, 1995). At times blatant, but most often subtle, discrimination continues to exist toward individuals whose racial or ethnic origin differs from what is perceived to be the majority.

According to some researchers, there appears to be a growing intolerance for diversity in North America (Kosny, 1999; Thompson, 1991). One of the forms of subtle discrimination is the ignoring or exclusion of people who are referred to as *visible minorities*. Immigrants and refugee women from this population actually often become invisible and isolated (Oxman-Martinez et al., 2000).

Three of the women who participated in this study spoke of experiencing blatant discrimination based on racial or ethnic background or on their ability to speak fluent English. Feminist scholars continue to encourage researchers to focus on those who have been excluded because of their race, class or gender (Hall, 1999; Wuest, 1994). It is hoped that as more voices begin to articulate the reality of discrimination, awareness will increase and change will follow.

Social isolation. Loneliness and alienation resulting from social isolation were frequently cited as main concerns. Women from South East Asia spoke of their despair and feelings of isolation (Davis, 2000). In the video, *I Am Not a Stranger,* a refugee woman from Africa, now living in Winnipeg, identified loneliness as one of the most

difficult obstacles in her resettlement (Mennonite Central Committee of Canada, 2000). Migliardi (2001) identified isolation as a "common thread" in the experience of the 25 immigrant and refugee women she interviewed.

Isolation often resulted from language barriers, unfamiliar customs, lifestyles and relationships (Hakim & Angom, 1999). Discrimination also adds to the feelings of alienation and loneliness. All respondents to a study by Beiser, Noh, Hou, Kaspar and Rummens (2001) had experienced subtle discrimination. A recent Canadian study by Neufeld et al. (2002) revealed that although "the immigrant woman's ability to participate effectively in social and work life required facility in English" (p. 761), the programs that were available to newcomers were often inadequate.

Immigrant and refugee women consistently reported that social support is an important influence on their health (Aroian, Spitzer & Bell, 1996; Cadell et al., 2001; Israelite et al., 1999; Jacelon, 1997; MacKinnon & Howard, 2000). In their study on healthy transitions, Meleis et al. (2000) found that immigrant women "utilized social and kinship networks as important sources of information, housing, transport, employment and social support" (p. 24).

Optimism. Studies are beginning to focus more on the positive attributes and strengths of immigrant and refugee women. Authors of a survey by the Federal, Provincial and Territorial Advisory Committee on Population Health (1999) expressed their belief that the "immigrant context of hope for a brighter future" (p. 85) helped them to deal with the difficulties they countered. In her study exploring the meaning of the experiences of

refugee women from South East Asia, Davis (2000) discovered "a psychological resilience" (p. 144) not previously explored.

Optimism, a sense of humour and a sense of meaning and purpose were frequently identified as traits related to resilience (Flach, 1988; Mangham et al., 1995a; Middleton-Moz, 1992; O'Gorman, 1994). In their research with Somali refugees, Israelite et al. (1999) found that although the women reported feeling hopeless and disillusioned, their spirits were lifted by a strong religious faith. A group of refugee women from El Salvador also identified their faith in God as crucial to their "survival, strength and health" (Bowen, 1999, p. 142).

Adaptability. Studies on immigrant and refugee women have tended to focus on barriers and obstacles. Despite this, most researchers report that the women do manage to adapt and cope fairly effectively with their resettlement. Flexibility, adaptability and resourcefulness have been identified in the literature as characteristics of resiliency (Dyer & McGuiness, 1996; Felton & Hall, 2001; Jacelon, 1997; Wagnild & Young, 1990). Bowen (1999) concluded that "pragmatism directed individuals to focus on doing what was necessary to meet the demands of any situation" (p. 243). Neufeld et al. (2002) found that although all of the immigrant women in their study had experienced considerable barriers, "some possessed strategies and resources that enabled them to address these issues, while others remained isolated and unconnected" (pp. 757-8).

Perseverance. The qualities of courage and determination demonstrated by the women in this study were mostly found in the literature on resilience (Felton & Hall, 2001; Jacelon, 1997; Wagnild & Young, 1990). Although not identified specifically as

perseverance, evidence of this trait was present in descriptions of how immigrant and refugee women adapted to their new environment (Cadell et al., 2001; Davis, 2000; DeSantis, 1997).

The value of social support and familiarity. Participants in this study identified the need for more opportunities for social interaction, improved community outreach, and recognition of their knowledge and skills. The importance of social support networks for immigrant and refugee women has been discussed by many authors. Bowen (1999), in her study of Salvadoran women in Winnipeg, reported that "social support was perceived to be a critical factor in health, if not the most critical factor" (p. 220). MacKinnon and Howard (2000) expressed the belief that social support protects health by "cushioning the impact of stressors" (p. 11). The importance of a supportive community in enhancing resilience was identified frequently in the literature (Cadell et al., 2001; Stewart et al., 1999).

Reaching out to newcomers. The need for community outreach programs has been discussed in the literature on immigrant and refugee women. MacKinnon and Howard (2000) suggest that such programs would help women "continue with their customary social and leisure activities . . . help them to learn about their new location and to discover the kinds of social and leisure activities available to them" (p. iv). It is difficult for many of the women to explore these options on their own because of language, geographic and financial barriers (DeSantis, 1997; Edwards, 1995; Hattar-Pollara & Meleis, 1995).

Recognition of existing skills and knowledge. The problem of unrecognized academic credentials and employment skills is frequently mentioned by researchers who

have interviewed immigrant and refugee women (Allotey, 1998; Bowen, 1999; Migliardi, 2001; Ng, 1998). At times discrimination based on race, colour, and gender is a factor in employers' decisions. Another factor affecting the women's ability to find meaningful employment is their difficulty in finding opportunities to become fluent in English.

Summary. The results of this study have many similarities to those reported by authors who have explored the experiences of immigrant and refugee women in North America. The difficulties resulting from language barriers and social isolation are well documented in this literature. The strengths of the women, including optimism, adaptability and perseverance, are beginning to be identified. The necessary changes indicated by participants in this study are comparable to those described by other researchers.

It is important to note how the findings of this study compare to the responses of a group of women who attended a recent general meeting of IWAM. Members and non-members had been invited to come and share their vision for IWAM's future. In a format of small group discussion, the 30 participants were asked to identify their needs and challenges and to recommend solutions to these. When the groups reported on their discussion, they too spoke of loneliness, depression, culture shock, and unemployment as their main concerns. Their suggested solutions similarly included finding a place to meet others socially, organizing support groups, providing assistance to access existing resources, and helping women to deal with new roles such as working outside the home. In regards to employment, they asked for guidance in preparing for job interviews and transferring existing skills. They saw IWAM's role as educators of the general public and

the government about the issues faced by immigrant and refugee women in Manitoba. A follow up to the meeting was presented at IWAM's Annual General Meeting on May 10, 2003. Committees were formed to find another accessible location for the association and to create a speakers' bureau to educate other community organizations about the issues facing immigrant and refugee women.

Limitations of this Study

Sample size was one of the main limitations in this study. Despite the richness of the responses from the 6 women who participated, this data provides only a beginning exploration of resilience in immigrant and refugee women. Participants in this study were relatively young, well educated and could communicate in English. The experiences and recommendations of older, less educated women, or those lacking in English language fluency would likely be quite different.

Only 2 of the women in this study had time for a second interview. The subsequent session did help to develop trust and allow participants to reflect and elaborate on their responses. The 4 women who were interviewed once, even those not previously acquainted with the researcher, did demonstrate a considerable level of trust by their openness and warmth.

Implications for Nursing Education and Practice

Depending on their own life experiences, living and work environments, and their social relationships, nurses may have only superficial knowledge about the particular difficulties faced by immigrant and refugee women. It is well known that cultural differences and language barriers create stress during initial adjustment, and that there are

programs and services in place to assist this population. Participants in this and other recent studies (Bowen, 1999; Hakim & Angom, 1999; Migliardi, 2001; Neufeld et al., 2002) report that for many women fluency in English may take a very long time to develop. Their ongoing lack of English language proficiency reduces their ability to access existing services, to find meaningful employment, and to integrate socially into their new environment. The result is often continued isolation, loneliness and despair.

Apprehension, grief and sadness might be expected during the initial resettlement period. The level of depression experienced by some of the women in this study affected their productivity and physical health. In order to accurately assess the health care needs of immigrant and refugee women, nurses need to become increasingly aware of the extent and nature of the social stressors in this population.

One of the ways this knowledge might be gained is by providing more opportunities for clinical practice in communities which include immigrant and refugee families and individuals. Another possibility would be to access the Mentorship Program organized by the Immigrant Women's Association of Manitoba. Through this program, young women and men from first and second generation immigrant families speak with student groups about their own experiences and adjustments. IWAM is hoping to expand this program to include speakers of all ages who would help to educate community organizations about the issues facing immigrant and refugee women (IWAM, 2003).

Increased awareness of these issues is important, but finding solutions is even more crucial. Although the women often demonstrate a remarkable degree of resilience, care providers must learn how to collaborate with them in finding ways to survive and adapt

that do not exhaust their emotional and physical resources. Nurses must encourage and advocate for programs that enhance social support networks. Initiatives such as community gardens and community theatre can be accomplished with limited resources and would provide numerous benefits. Rana Bose, poet, playwright and founding Director of Montreal's Serai Theatre Company, spoke at a workshop sponsored by IWAM about "the power of performance" (personal communication, May 3, 2003) to convey feelings and ideas. The aim of Serai, Bose explained, was to "bring the margins to the centre" and to "undermine and subvert barriers and stereotypes".

Implications for Policy Development

Study participants have indicated that Winnipeg has unique problems which increase social isolation, especially during the winter months. The narratives of immigrant and refugee women, in this and other local studies, indicate that existing programs are not always accessible, adequate or flexible enough to meet their needs. Political rhetoric regarding the values of diversity and inclusion does not benefit women with limited proficiency in English or those with high levels of emotional distress.

One of the key policy recommendations identified in an overview of Canadian research on immigrant and refugee women's health was "reducing social isolation through initiatives such as Immigrant Women's Centres, networking and mentoring, language, employment and retraining programs" (Mulvihill, Mailloux & Atkin, 2001, p. 6). Ironically, these recommendations were made in the same year that IWAM lost their major funding. Since that time the association has shown remarkable resilience. Although the organization still does not have its own location, the University of Winnipeg generously

continues to provide space for meetings and workshops and for a small office area. IWAM is in the process of locating a suitable space of their own where women can meet informally and where they can re-establish programs and provide information.

Last fall IWAM was able to secure funding for 1 year for their Mentorship Program from the Provincial Department of Labour and Immigration. Through this initiative, thirty-two presentations were made to 800 high school students. Teachers and students were very positive in their evaluations of these presentations. This project requires ongoing support to expand and include post secondary education, particularly nursing students.

Many authors have recommended outreach programs for immigrant and refugee women who are isolated and unable to access existing services. These programs would be particularly useful for women with limited English language skills and those with young children or other dependents. To ensure that these projects are relevant and realistic, immigrant and refugee women must be involved in their development and implementation.

Suggestions for Future Research

Studies on immigrant and refugee women have mainly focused on their health problems resulting from trauma in their country of origin and the numerous barriers that they face during resettlement. Researchers are beginning to identify the factors that influence successful adaptation, including language proficiency, meaningful employment, and social support. Despite our increasing knowledge of the problems and the seemingly obvious solutions, the reality is that many immigrant and refugee women are isolated and

continue to struggle with inadequate English language skills and underemployment. More research is needed to discover how this gap can be bridged.

The use of qualitative methods to explore the experiences of immigrant and refugee women can be an empowering experience for participants. This is particularly true when women are involved in identifying the research questions and sharing their views in focus groups. Some women may prefer individual interviews and the opportunity they offer for more private disclosures and development of trust.

Recruitment of immigrant and refugee women to participate in research can be a challenging endeavour. Even if the researcher is known and trusted, other factors may prevent the women from volunteering as respondents. They may be embarrassed about their English language skills, or simply do not have the time and energy to be involved. Many of the women I spoke with had more than one job, family responsibilities, and were taking language classes or upgrading their academic credentials. They would have liked to participate in this study, but realistically could not.

Recommendations

Based on the conclusions of this study, the following specific recommendations are offered.

1. That educational programs for health care professionals include more opportunity for clinical practice in communities with immigrant and refugee families and individuals.
2. That nurse educators invite speakers from the Mentorship Program organized by the Immigrant Women's Association of Manitoba (IWAM) to share their

experiences with students and health care professionals in hospitals and community agencies.

3. That the Provincial Department of Labour and Immigration continue to provide funding to IWAM for the continuation and expansion of their Mentorship program.
4. That community agencies that provide programs and services for immigrant and refugee women consider obstacles such as cultural differences, discrimination and language barriers.
5. That all levels of government increase the proportion of immigrant and women involved in planning programs and services for this population.
6. That programs for immigrant and refugee women include the development of informal social networks.
7. That sufficient funding be allocated for language training programs that would provide immigrant and refugee women with adequate levels of English language proficiency.
8. That researchers engaging in qualitative research with immigrant and refugee women include members of this population in identifying the research questions and reviewing the interview schedule.

Conclusion

The purpose of this descriptive study was to explore resilience in the lives of immigrant and refugee women. It focused on their strengths, factors influencing their

ability to overcome adversity and maintain their health, and the changes they felt were needed to create an environment more conducive to their health.

The average age of the six participants was 30 years. Their country of origin was varied. They described barriers and obstacles similar to those identified in the literature. The emotional distress and social isolation they experienced were a result of language barriers, cultural differences, discrimination and a lack of recognition of their skills and education.

Despite the limitations of sample size and respondents' time constraints, interview data revealed thoughtful, candid and in-depth answers to the research questions. The women who volunteered to participate in this study were well educated and, for the most part, had sufficient time, energy, and some degree of English language proficiency. Their experiences and suggestions cannot be generalized to include those of immigrant and refugee women without these resources.

During the process of this research, I have come to understand that while specific individual traits are important in the development of resilience, social support is a key element. A supportive environment not only enhances resiliency, it may well be instrumental in the creation of some of the personal characteristics the participants identified.

References

Abdo, N. (1998). "Gender" is not a "dummy": Research methods in immigration and refugee studies. In *Gendering immigration /integration: Policy research workshop proceedings & a select review of policy research literature: 1987-1996* (pp. 41-49). Ottawa: Status of Women Canada.

Allotey, P. (1998). Travelling with "excess baggage": Health problems of refugee women in Western Australia. *Women and Health, 28*(1), 63-81.

Anderson, J. M. (1991). Reflexivity in fieldwork: Toward a feminist epistemology. *IMAGE: Journal of Nursing Scholarship, 23*(2), 115-118.

Anderson, J., Blue, C., Holbrook, A., & Ng, M. (1993). On chronic illness: Immigrant women in Canada's work force - A feminist perspective. *Canadian Journal of Nursing Research, 25*(2), 7-22.

Armstrong, S. (2002). *Veiled threat: The hidden power of the women in Afghanistan.* Toronto: Penguin Books Canada.

Aroian, K., Khatutsky, G., Tran, T., & Balsam, L. (2001). Health and social service utilization among elderly immigrants from the former Soviet Union. *Journal of Nursing Scholarship, 33*(3), 265-271.

Aroian, K., Spitzer, A., & Bell, M. (1996). Family stress and support among former Soviet immigrants. *Western Journal of Nursing Research, 18*(6), 655-674.

Beiser, M., & Hou, F. (2001). Language acquisition, unemployment and depressive disorder among Southeast Asian refugees: A 10 year study. *Social Science & Medicine, 53*(10), 1321-1334.

Beiser, M., Noh, S., Hou, F., Kaspar, V., & Rummens, J. (2001). Southeast Asian refugees' perceptions of racial discrimination in Canada. *Canadian Ethnic Studies, 33*(1), 46-69.

Bowen, S. (1998). Resilience and health: Savadoran women in Manitoba [M.A. Thesis]. Winnipeg: University of Manitoba.

Braithwaite, R., Bianchi, C., & Taylor, S. (1994). Ethnographic approach to community organization and health empowerment. *Health Education Quarterly, 21*(3), 407-416.

Burns, N., & Grove, S. (1995). *Understanding nursing research.* Toronto: W.B. Saunders.

Cadell, S., Karabanow, J., & Sanchez, M. (2001). Community, empowerment, and resilience: Paths to wellness. *Canadian Journal of Community Mental Health, 20*(1), 21-35.

Camiletti, Y. (1996). A simplified guide to practicing community based/community development initiatives. *Canadian Journal of Public Health, 87*(4), 244-247.

Campbell, J., & Bunting, S. (1991). Voices and paradigms: Perspectives on critical and feminist theory in nursing. *Advances in Nursing Science, 13*(3), 1-5.

Chalmers, K., & Bramadat, I. (1996). Community development: Theoretical and practical issues for community health nursing in Canada. *Journal of Advanced Nursing, 24*(4), 719-726.

Chinn, P. (1991). From the editor. *Advances in Nursing Science, 13*(3), ix.

Choudry, U. (1998). Health promotion among immigrant women from India living in Canada. *IMAGE: Journal of Nursing Scholarship, 30*(3), 269-274.

Choudry, U. (2001). Uprooting and resettlement experiences of South Asian immigrant women. *Western Journal of Nursing Research, 23*(4), 376-393.

Christiansen-Ruffman, L. (1991). Bridging the gap between feminist activism and academe. In J. Wine & J. Ristock (Eds.), *Women and social change: Feminist activism in Canada* (pp. 258-282). Toronto: James Lorimer.

Clarke, J. (1992). Feminist methods in health promotion research. *Canadian Journal of Public Health, 83* (Supplement 1), S54-S57.

Code, L. (1988). Feminist theory. In S. Burt, L. Code & L. Dorney (Eds.), *Changing patterns: Women in Canada* (pp. 18-49). Toronto: McClelland & Stewart.

Crichton, A., Robertson, A., Gordon, C., & Farrant, W. (1997). *Health care: A community concern? Developments in the organization of Canadian health services.* Calgary: University of Calgary Press.

Davis, R. (2000). Refugee experiences and Southeast Asian women's mental health. *Western Journal of Nursing, 22*(2), 144-168.

DeSantis, L. (1997). Building healthy communities with immigrants and refugees. *Journal of Transcultural Nursing, 9*(1), 20-31.

Dhruvarajan, V. (2002). Women of colour in Canada. In V. Dhruvarajan & J. Vickers (Eds.), *Gender, race and nation* (pp.99-122). Toronto: University of Toronto Press.

Dyer, J., & McGuiness, T. (1996). Resilience: Analysis of the concept. *Archives of Psychiatric Nursing, 10*(5), 276-282.

Edwards, N. (1995). The enigma of ethnicity: What does it mean for clinical practice? *Canadian Family Physician, 41*(10), 1645-48.

Fadiman, A. (1997). *The spirit catches you and you fall down.* New York: Farrar, Straus & Giroux.

Federal, Provincial & Territorial Advisory Committee on Population Health. (1999). *Toward a healthy future: Second report on the health of Canadians.* Ottawa: Health Canada.

Feldberg, G. (2001). The power of citizen engagement to influence research and policy. *Centres of Excellence for Women's Health Research Bulletin, 2*(1), 4-7.

Felton, B., & Hall, J. (2001). Conceptualizing resilience in women older than 85. *Journal of Gerontological Nursing, 27*(11), 46-53.

Flach, F. (1988). *Resilience: Discovering a new strength at times of stress.* New York: Fawcett Columbine.

Fox, P., Cowell, J., & Johnson, M. (1995). Effects of family disruption on Southeast Asian refugee women. *International Nursing Review, 42*(1), 27-30.

Ghorayshi, P. (2002). Working Canadian women: Continuity despite change. In . Dhruvarajan & J. Vickers (Eds.), *Gender, race and nation* (pp. 123-146). Toronto: University of Toronto Press.

Glass, N., & Davis, K. (1998). An emancipatory impulse: A feminist postmodern integrated turning point in nursing research. *Advances in Nursing Science, 21*(1), 43-52.

Hakim, C. (2001). I landed running. *Canadian Women's Health Network, 4*(2), 4-7.

Hakim, C., & Angom, G. (1999). *An analysis of barriers facing immigrant women and their families in accessing health and social services.* Winnipeg: The Immigrant Women's Association of Manitoba.

Hall, J. (1999). Marginalization revisited: Critical, postmodern, and liberation perspectives. *Advances in Nursing Science, 22*(2), 88-102.

Hall, J., & Stevens, P. (1991). Rigor in feminist research. *Advances in Nursing Science, 13*(3), 16-29.

Hartsock, N. (1998). *The feminist standpoint revisited and other essays.* Boulder, CO: Westview.

Hattar-Pollara, M., & Meleis, A. (1995). The stress of immigration and the daily lived experiences of Jordanian immigrant women in the United States. *Western Journal of Nursing Research, 17*(5), 521-539.

Health Canada. (1997). *Population health fund: Interim guidelines 1997-1998.* Ottawa: Author.

Heaman, M. (2001). Conducting health research with vulnerable women: Issues and strategies. *Canadian Journal of Nursing Research, 33*(3), 81-86.

Hebert, M. (1998). Methodological issues in generating immigration research: Generations and regeneration. In *Gendering immigration /integration: Policy research workshop proceedings and a selective review of policy research literature 1987-1996* (pp. 23-30). Ottawa: Status of Women Canada.

hooks, b. (1989). *Talking back: Thinking feminist, thinking Black.* Boston: South End Press.

Howard, J. (2000). Gender sensitive health planning - Why is it important? *The Canadian Women's Health Network, 3*(½), 14-15.

Hunter, A., & Chandler, G. (1999). Adolescent resilience. *IMAGE: Journal of Nursing Scholarship, 31*(3), 243-247.

Hutton, D. (1993). *Patterns and predictors of refugee adjustment: Ethiopians, Laotians, Vietnamese, Salvadoreans and Chileans in Winnipeg.* [M. Ed. Thesis]. Winnipeg: University of Manitoba.

Immigrant Women's Association of Manitoba (2000). *IWAM Newsletter, 2*(5),1-3. Winnipeg: Author.

Immigrant Women's Association of Manitoba (2003). *IWAM Newsletter, 2*(8),1-2. Winnipeg: Author.

Israelite, N., Herman, A., Alim, F., Mohamed, Y., Khan, A., & Caruso, L. (1999). Waiting for "Sharciga": Resettlement and the roles of Somali refugee women. *Canadian Woman Studies, 19*(3), 80-86.

Jacelon, C. (1997). The trait and process of resilience. *Journal of Advanced Nursing, 25*(1), 123-129.

Juteau, D. (1998). Gendering immigration/integration policy research: Research gaps. In *Gendering immigration /integration policy research workshop proceedings and a selective review of policy research literature 1987-96* (pp.31-39). Ottawa: Status of Women Canada.

Kadner, K. (1989). Resilience: Responding to adversity. *Journal of Psychosocial Nursing 27*(7), 20-25.

Koch, T. (1998). Story telling: Is it really research? *Journal of Advanced Nursing, 28*(6), 1182-1190.

Kosny, A. (1999). The social determinants of health: Equity across the lifespan. In *Synthesis papers: Executive summaries* (pp. 9-11). Halifax: Maritime Centre of Excellence for Women's Health.

Kozier, B., Erb, G., & Blais, K. (1992). *Concepts and issues in nursing practice.* Redwood City, CA: Addison-Wesley.

Le Centre d' excellence pour la sante des femmes - Consortium Université de Montreal (2000). Experiences of immigrant and refugee women in Quebec with the health care system. *Centres of Excellence for Women's Health Research Bulletin, 1*(1), 16-17.

Li, H., & Browne, A. (2000). Defining mental illness and accessing mental health services: Perspectives of Asian Canadians. *Canadian Journal of Community Health, 19*(1), 143-159.

MacKinnon, M., & Howard, L. (2000). *Affirming immigrant women's health: Building inclusive health policy.* Halifax: Maritime Centre of Excellence for Women's Health.

Maharaj, R. (1999). The role of women's advocacy groups in shaping Canadian health care policy. *Women's Health Issues, 9*(5), 259-263.

Mangham, C., Reid, G., McGrath, P., & Stewart, M. (1995a). *Resiliency: Relevance to health promotion: Discussion paper.* Ottawa: Health Canada.

Mangham, C., Reid, G., McGrath, P., & Stewart, M. (1995b). *Resiliency: Relevance to health promotion: Detailed analysis.* Ottawa: Health Canada.

Manitoba Health.(1997). *A planning framework to promote, preserve and protect the health of Manitobans.* Winnipeg: Author.

Mandleco, B. (1995). The relationship between resilience, coping, gender and social competence. *Communicating Nursing Research, 28*, 219.

Matsuoka, A., & Sorenson, J. (1999). Eritrean women in Canada: Negotiating new lives. *Canadian Woman Studies, 19*(3), 104-109.

McLaren, J. (1998). *Evaluating programs for women: A gender-specific framework.* Winnipeg: Prairie Women's Health Centre of Excellence.

Meleis, A., Sawyer, L., Im, E., Messias, D., & Schumacher, K. (2000). Experiencing transitions: An emerging middle-range theory. *Advances in Nursing Science, 23*(1), 12-28.

Meleis, A. & Lindgren, T. (2001). Show me a woman who does not work! *Journal of Nursing Scholarship, 33*(3), 209-210.

Mennonite Central Committee. (2000). *I am not a stranger* [video]. Winnipeg: Author.

Middleton-Moz, J. (1992). *Will to survive: Affirming the positive power of the human spirit.* Deerfield Beach, FL: Health Communications, Inc.

Migliardi, P. (2001). *Immigrant women, social service and advocacy: The role of an organization of immigrant women in Manitoba.* [M.A. Thesis]. Winnipeg: University of Manitoba.

Miles, A. (1991). Reflections on integrative feminism and rural women. In J. Wine & J. Ristock (Eds.), *Women and social change: Feminist activism in Canada* (pp. 56-74). Toronto: James Lorimer.

Mohamed, H. (1999). Resistance strategies: Somali women's struggles to reconstruct their lives in Canada. *Canadian Woman Studies, 19*(3), 52-57.

Mulvihill, M., Mailloux, L., & Atkin, W. (2001). *Advancing policy and research responses to immigrant and refugee women's health in Canada.* Winnipeg: Centres of Excellence for Women's Health.

Neufeld, A., Harrison, M., Stewart, M., Hughes, K., & Spitzer, D. (2002). Immigrant women making connections to community resources for support in family care giving. *Qualitative Health Research, 12*(6), 751-768.

Ng, R. (1998). Gendering policy research on immigration. In *Gendering immigration/ integration: Policy research workshop proceedings & a selective review of policy research literature 1987-96* (pp.13-21). Ottawa: Status of Women Canada.

Novac, S. (1999). Immigrant enclaves and residential segregation: Voices of racialized refugee and immigrant women. *Canadian Woman Studies, 19*(3), 88-92.

Oakley, A. (1997). A brief history of gender. In A. Oakley & J. Mitchell (Eds.), *Who's afraid of feminism? Seeing through the backlash* (pp. 29-55). London: Hamish Hamilton.

O'Gorman, P. (1994). *Dancing backwards in high heels: How women master the art of resilience.* Center City, MN: Hazelden Educational Materials.

O'Leary, V. & Ickovics, J. (1995) Resilience and thriving in response to challenge: An opportunity for a paradigm shift in women's health. *Women's Health: Research on Gender, Behavior and Policy, 1*(2), 121-142.

Olesen, V. (2000). Feminism and qualitative research at and into the millennium. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 215-243). Thousand Oaks, CA: Sage Publications.

Ortberg, J. (2001). *If you want to walk on water, you've got to get out of the boat.* Grand Rapids, MI: Zondervan.

Oxman-Martinez, J., Abdool, S., & Loiselle-Leonard, M. (2000). Immigration, women and health in Canada. *The Canadian Journal of Public Health, 91*(5), 394-395.

Parker, B., & McFarlane, J. (1991). Feminist theory and nursing: An empowerment model for research. *Advances in Nursing Science, 13*(3), 59-67.

Pender, N. (1996). *Health promotion in nursing practice.* Stamford: Appleton & Lange.

Polit, D., & Hungler, B. (1995). *Nursing research: Principles and methods.* Philadelphia: J.B. Lippincott.

Reinharz, S. (1992). *Feminist methods in social research.* New York: Oxford University Press.

Ristock, J., & Pennell, J. (1996). *Community research as empowerment: Feminist links, postmodern interruptions.* Toronto: Oxford Press.

Rose, K., & Webb, C. (1998). Analyzing data: Maintaining rigor in a qualitative study. *Qualitative Health Research, 8*(4), 556-562.

Ryles, S. (1999). A concept analysis of empowerment: Its relation to mental health nursing. *Journal of Advanced Nursing, 29*(3), 600-607.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science, 16*(2), 1-8.

Sandelowski, M. (1995) Qualitative analysis: What it is and how to begin. *Research in Nursing & Health, 18*(4), 371-375.

Sheilds, L., & Lindsey, A. E. (1998). Community health promotion nursing practice. *Advances in Nursing Science, 20*(4), 23-36.

Silvera, M. (1993). Speaking of women's lives and imperialist economics: Two introductions from the *Silenced.* In H. Bannerji (Ed.), *Returning the gaze: Essays on racism, feminism and politics* (pp. 197-219). Toronto: Sister Vision Press.

Smith, S. (1991). "Why no egg?" Building competency and self-reliance: A primary health care principle. *Canadian Journal of Public Health, 82*(3), 16-18.

Stewart, M., Reid, G., Buckles, L., Edgar, W., Mangham, C., Tilley, B., et al. (1999). *A study of resiliency in communities.* Ottawa: Health Canada.

Sword, W. (1999). Pearls, pith and provocation: Accounting for presence of self: Reflections on doing qualitative research. *Qualitative Health Research, 9*(2), 270-278.

Thompson, J. (1991). Exploring gender and culture with Kmer refugee women: Reflections on participatory feminist research. *Advances in Nursing Science, 13*(3), 30-48.

Thompson, J. (1992). Program evaluation within a health promotion framework. *Canadian Journal of Public Health, 83* (Supplement 1), S67-71.

Valentine, P. (1997). Teaching trends and issues in women's health using a feminist perspective. *Women's Health Issues, 7*(2), 84-88.

VanderPlaat, M. (1999). Locating the feminist scholar: Relational empowerment and social activism. *Qualitative Health Research, 9*(6), 773-785.

Vickers, J. (2002). Methodologies for scholarship about women. In V. Dhruvarajan & J. Vickers (Eds.), *Gender, race and nation* (pp. 64-90). Toronto: University of Toronto Press.

Vissandjee, B. (2001). The consequences of cultural diversity. *Canadian Women's Health Network, 4*(2), 3-4.

Wagnild, G., & Young, H. (1990). Resilience among older women. *IMAGE: Journal of Nursing Scholarship, 22*(4), 252-255.

Waring, M. (1996). *Three masquerades: Essays on equality, work and hu(man) rights.* Toronto: University of Toronto Press.

Wason-Ellam, L. (2001). Living against the wind: Pathways chosen by Chinese immigrants. *Canadian Ethnic Studies, 33*(1), 71-101.

Weber, M. (1998). *She stands alone: A review of the recent literature on women and social support.* Winnipeg: Prairie Women's Health Centre of Excellence.

Wilson, D. (1995). Women's roles and women's health: The effect of immigration on Latina women. *Women's Health Issues, 5*(1), 8-14.

Wine, J., & Ristock, J. (1991). Introduction: Feminist activism in Canada. In J. Wine & J. Ristock (Eds.), *Women and social change: Feminist activism in Canada* (pp. 1-18). Toronto: James Lorimer.

Wolf, N. (1993). *Fire with fire: The new female power and how it will change the 21st Century.* Toronto: Random House of Canada.

World Health Organization. (1999). *The Adelaide recommendations - Health promotion.* Retrieved July 28, 2003 from http://www.who.int/hpr/archive/docs/adelaide.html

Wuest, J. (1994). A feminist approach to concept analysis. *Western Journal of Nursing Research, 16*(5), 577-586.

Appendix A

Letter of Invitation

My name is Judy Toth. I am a graduate student in the Faculty of Nursing at the University of Manitoba. After meeting and working with women from the Immigrant Women's Association of Manitoba, I have become interested in learning more about resilience in immigrant and refugee women.

I am looking for six to ten women who have come to Canada in the last seven years, who would be willing to talk with me about their experience. I would like to know about the difficulties that you face and what has helped you to survive. I will be asking you questions about the barriers or obstacles that you face as an immigrant or refugee woman and the personal strengths and resources that have helped you with resettlement. Also, I will ask you basic questions about yourself, including your country of origin, immigration status, education, language skills and employment. The interviews (two separate sessions with each person) will be tape recorded and last from one to two hours. The interviews can be held in a location that is convenient and comfortable for you.

The information that you share will be kept confidential. Your identity will not be associated with any written or verbal reports. Your participation will be voluntary and you will be free to decide not to answer any of the questions. You are also free to choose to withdraw from the study at any time.

If you are interested in speaking with me, please call me at home or work. My advisor, Dr. Lynn Scruby (Faculty of Nursing, University of Manitoba) can be contacted to answer any questions or concerns you might have. Dr. David Gregory (Faculty of Nursing, University of Manitoba) and Dr. Janice Ristock (Women's Studies, University of Manitoba) are members of my thesis committee.

Appendix B

Consent Form

Research project: Resilience: The Experience of Immigrant and Refugee Women

Researcher: July Toth

This consent form, a copy of which will be left for you for your records and reference, is only a part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand the accompanying information.

The purpose of this Master's thesis research that you are being invited to participate in is to explore resilience in the lives of immigrant and refugee women. The researcher is a Registered Nurse in the Master of Nursing Program at the University of Manitoba. You may contact her at home or work.

You are being invited to share your experience as a woman who has recently come to live in Canada. There will be six to ten women taking part in this study. Your participation in this study is voluntary. If you agree to participate, you will be asked to give from one to two hours of your time, on two separate occasions. The first interview will be an opportunity to become acquainted and to discuss the consent form. You will be asked basic questions about yourself, including country of origin, immigration status, education, language skills and employment. In the second interview you will be asked

about the barriers or obstacles that you experience and the personal strengths and supports that have helped you to survive.

You will be interviewed by the researcher in a location that is convenient and comfortable to you. The interviews will be tape recorded. At any time during the interviews you can stop the recorder. You can ask questions at any time before or during the interview.

The study procedures have no risks or financial costs to you. It is hoped that the research findings may lead to a better appreciation of the strengths and needs of immigrant and refugee women. Prior to the completion of the final report, the researcher will mail a summary of the study findings to you for you feedback. You will also receive a summary of the final report and a small gift (for example, a candle). If this project is funded, you will be provided with a small monetary compensation (not exceeding twenty dollars). If you choose to withdraw from the study, you will still receive these gifts of appreciation for your time and efforts.

The information that you share will be kept confidential. A code number will be used to identify the tapes, transcripts and notes. This data and the signed consent forms will be kept in a locked filing cabinet in the researcher's office at the Grace Hospital. Your name will not be associated with any of the data. There will not be any direct reference to you or your specific situation in any verbal or written reports or any publications. The information will be shared only with Dr. Lynn Scruby (Advisor), Faculty of Nursing, University of Manitoba; Dr. David Gregory, Faculty of Nursing, University of Manitoba; Dr. Janice Ristock, Women's Studies, University of Manitoba; and a transcriber who is yet

to be named. This research has been approved by the Education/Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

_____

Participants Signature Date

_____

Mailing Address

_____

Researcher and/or Delegate's Signature Date

APPENDIX C

Interview Schedule

1. Personal Data:
   1) In what country were you born?
   2) Where did you live just before coming to Canada?
   3) When did you first arrive in Canada?
   4) What was your immigration status when you arrived in Canada?
   5) What is your status now?
   6) When you arrived in Canada were you able to speak English or French?
   7) What level of educational have you achieved?
   8) Are you employed outside of your home?
   9) What is your age?
   10) What is your relationship status? [single /married /widowed /separated /divorced]
   11) Do you have any children /dependents?
2. Barriers /Obstacles:
   1) What was it like for you when you first arrived in Canada?
   2) Tell me about the difficulties that you face as an immigrant or refugee woman living in your community.
      a) Have you experienced any form of discrimination?
      b) Have you been able to find meaningful employment?
      c) Have you been able to carry on your cultural traditions?
   3) What do you find most difficult about life in Canada?
   4) How have these difficulties affected your health?[physical /emotional /spiritual]
3. Personal Strengths /Supports:
   1) What personal qualities /strengths have helped you to survive your immigration and resettlement experience?
   2) What do you think has helped you to develop these qualities /strengths?
   3) What support has been most helpful to you? [family /friends /community]
   4) What changes do you believe are needed to create an environment that would best support immigrant and refugee women in Canada?

Appendix D

ENREB Approval Certificate

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APPROVAL CERTIFICATE

07 May 2002

TO: **Judith Toth**
Principal Investigator

FROM: **Lorna Guse, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2002:034**
"Resilience: The Experience of Immigrant and Refugee Women"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.