Impacts of a Support Intervention for Zimbabwean and Sudanese Refugee Parents: "I Am Not Alone"

**Miriam Stewart, Edward Makwarimba,
Nicole L. Letourneau, Kaysi Eastlick Kushner,
Denise L. Spitzer, Cindy-Lee Dennis, Edward Shizha**

Knowledge about the beneficial effects of social support has not been used to systematically develop and evaluate interventions to help refugee new parents cope. The purpose of this study was to design and evaluate a social support intervention for refugee new parents. A multi-method research design was used and participatory research strategies were employed. Qualitative and quantitative measures were used to understand experiences of participants and to assess the perceived psychosocial and health-related outcomes of the intervention. Mentored support groups, matched by gender and ethnicity, met biweekly over 7 months. The participants were 48 Sudanese and 37 Zimbabwean refugee parents in 2 Canadian provinces. Increases were found in informational support, spousal support, community engagement, coping, and support-seeking. Decreases were found in parenting stress, loneliness, and isolation. The authors conclude that there is a need for culturally appropriate nursing practices and programs for refugee new parents from diverse cultures.

Keywords: Canada, intervention effects, parenting, social support, stress and coping

Résumé

Impacts d'une intervention de soutien pour les réfugiés nouveaux parents zimbabwéens et soudanais : « Je ne suis pas seul »

**Miriam Stewart, Edward Makwarimba,
Nicole L. Letourneau, Kaysi Eastlick Kushner,
Denise L. Spitzer, Cindy-Lee Dennis, Edward Shizha**

Les connaissances concernant les effets bénéfiques du soutien social n'ont pas été utilisées de manière systématique pour élaborer et évaluer les interventions visant à aider les réfugiés nouveaux parents à s'adapter à leur situation. L'objectif de cette étude est de concevoir et d'évaluer une intervention pour venir en aide aux réfugiés nouveaux parents. Diverses méthodes de recherche et différentes stratégies de recherche participative ont été utilisées pour la réalisation de l'étude. Des mesures quantitatives et qualitatives ont été effectuées pour comprendre l'expérience vécue par les participants et pour évaluer les résultats perçus de l'intervention sur les plans psychologique et de la santé. Des groupes de soutien encadrés et formés en fonction du sexe et de l'ethnie se sont réunis toutes les deux semaines pendant sept mois. L'ensemble des nouveaux parents participants comprenait 48 réfugiés soudanais et 37 réfugiés zimbabwéens établis dans deux provinces canadiennes. Ces groupes ont donné lieu à un accroissement du soutien informationnel, du soutien conjugal, de la participation communautaire, de l'adaptation et des demandes d'aide, ainsi qu'à une diminution du stress, de la solitude et de l'isolement des parents. En conclusion de leur étude, les auteurs signalent la nécessité d'adopter des programmes et des pratiques de soins infirmiers adaptés sur le plan culturel aux besoins des réfugiés nouveaux parents appartenant à diverses cultures.

Mots-clés : soutien social, intervention de soutien, réfugiés, nouveaux parents, recherche participative, soins adaptés sur le plan culturel

Each year Canada receives approximately 20,000 refugees (Citizenship & Immigration Canada, 2012). Refugees report a high prevalence of emotional disorders (Bronstein & Montgomery, 2011; Fazel, Reed, Panter-Brick, & Stein, 2012; Kirmayer et al., 2011). Social support mitigates negative health impacts during refugees' early years of resettlement (Anderson et al., 2010). However, intergenerational conflicts, financial constraints, struggle for employment, inadequate knowledge about resources, language difficulties, and lack of transportation significantly impede refugees' ability to mobilize or use resources and may contribute to poor physical and mental health outcomes (Gottlieb & Bergen, 2010; Wu & Hart, 2002). The loss of social support following migration has a detrimental impact since resources and support-seeking can reduce refugees' isolation, enhance their sense of belonging and life satisfaction, mediate discrimination, and facilitate integration into the new society (Fernandez, Silvan-Ferrero, Molero, Gaviria, & Garcia-Ael, 2014; Foss, Chantal, & Hendrickson, 2004; Fox, Rossetti, Burns, & Popovich, 2005; Grewal, Bhagat, & Balneaves, 2008; Schweitzer, Melville, Steel, & Lacherez, 2006).

Recent migration in combination with the stresses of new parenthood and diminished support can negatively affect children's social development (Deng & Marlowe, 2013; Lewig, Arney, & Salveron, 2010). Sole responsibility for family support, family composition, and length of time in the new country influence refugees' experiences and perceptions of social support (Schweitzer et al., 2006). Lack of support from extended kin may compromise the adaptation of new parents who are refugee and their children. Newcomer mothers experience loss of support networks (Chung, Hong, & Newbold, 2013).

Types, sources, and appraisal of social support may differ cross-culturally (Paris, 2008; Simich, Hamilton, Baya, & Neuwirth, 2004), and social support produces differing adaptive results for migrants from different countries (Deng & Marlowe, 2013; Kirmayer et al., 2011; Wu & Hart, 2002). Canada is one of the top refugee destinations worldwide and Sudan and Zimbabwe are represented in the top countries of origin of refugees (Citizenship & Immigration Canada, 2013). The Sudanese are diverse, speaking Arabic as well as English or other Sudanese languages (e.g., Nuer, Dinka). Many Sudanese refugees have been exposed to violence, war, trauma, and isolation from family (Lietz, 2007; Simich et al., 2004). While most Sudanese refugees fled with the assistance of humanitarian organizations, most Zimbabwean refugees are economic refugees and often arrive with an advantage in educational, language, and occupational skills. Sudanese and Zimbabwean refugees can be targets of discrimination because of racialized status and cultural and

religious traditions (Schweitzer et al., 2006; Simich, Beiser, Stewart, & Makwarimba, 2005).

Although research suggests the potential beneficial effects of social support in ameliorating acculturative challenges, isolation, and resource deprivation (Foss et al., 2004; Grewal et al., 2008; Jaranson et al., 2004; Schweitzer et al., 2006), this knowledge has not been invoked to system-atically develop and evaluate interventions that help new parents who are refugee adapt to life in Canada. A review of the research literature from 1996 to 2011 found no social support intervention studies focused on African refugees (Stewart, 2014). Hernandez-Plaza, Alonso-Morillejo, and Pozo-Munoz (2006) point out that overall evidence regarding the effects of social support on migrants is scarce. A shift towards examining social determinants of refugee mental health is beginning to focus on the complex social factors affecting refugee mental health (Simich, 2010). Nonetheless, according to the Mental Health Commission of Canada there continue to be wide research gaps regarding the design and testing of interventions that could inform relevant services for refugees in Canada (Hansson, Tuck, Lurie, & McKenzie, 2010).

Conceptual Foundation

Social support is a resource for coping with social challenges (Gottlieb, 2000) (e.g., immigration, resettlement). Social support is defined here as interactions with family members, friends, peers, and professionals that function to communicate information, affirmation, practical aid, or understanding. Social networks provide varied types of support function, which should be specific to stressful situations (Cutrona, 1990). As most social relationships have positive and negative elements (Brunk & Hoorens, 1992; Rook, Thuras, & Lewis, 1990), the supportive and non-supportive elements of interactions and relationships should be appraised. Support can either endure or dissipate over time in stressful situations (e.g., migration) (Bernard, Johnsen, Killworth, & McCarty, 1990). *Support-seeking* as a coping strategy for managing stressful situations has been linked to greater provision of support, whereas people who use dis-tancing and avoidance coping strategies tend to have fewer support resources (Stewart et al., 2008). Supportive persons can alter appraisal of stressors, sustain coping efforts, and influence choice of coping strategies (Gottlieb, 2000). Social support and coping have bidirectional effects (Thoits, 1995). For example, the ways in which refugees cope can provide clues to potential supporters about the type of support needed. Conversely, the amount and type of support received can influence refugees' choice of coping strategies. Variables that influence social support include community size, socio-economic status, age, gender,

marital status, and ethnicity (Eriksen, 1992; Jones, 1998). As social support is conceptualized as interactions that improve coping, moderate stress, and alleviate loneliness and isolation (Gottlieb, 2000), this study was intended to assess the impact of the intervention on social isolation and loneliness (House, Umberson, & Landis, 1988), support seeking as a coping strategy (Anderson, 1996), and parenting stress.

Aim

The purpose of this pilot study was to design and evaluate the effects of an accessible and culturally appropriate social support intervention that meets the support needs and preferences identified by new parents who are refugee. The results of this study could inform the design of support-ive services that prevent and alleviate problems arising from stress and social isolation.

The study was guided by a four-part research question: What are the perceptions, values, and beliefs of new parents who are refugee about the impacts of the social support intervention on their (1) support resources (e.g., social, informational); (2) loneliness and isolation (discrepancies between ideal and perceived interpersonal relationships producing and maintaining feelings of loneliness and isolation [Cacioppo & Hawkley, 2009]); (3) coping (proactive coping using the resources of others — practical, informational, and emotional [Greenglass, 2002]); and (4) par-enting stress (attributed to the behaviour of the child, to difficulty man-aging parenting tasks, or to dysfunctional interaction between child and parent [Abidin, 1995])?
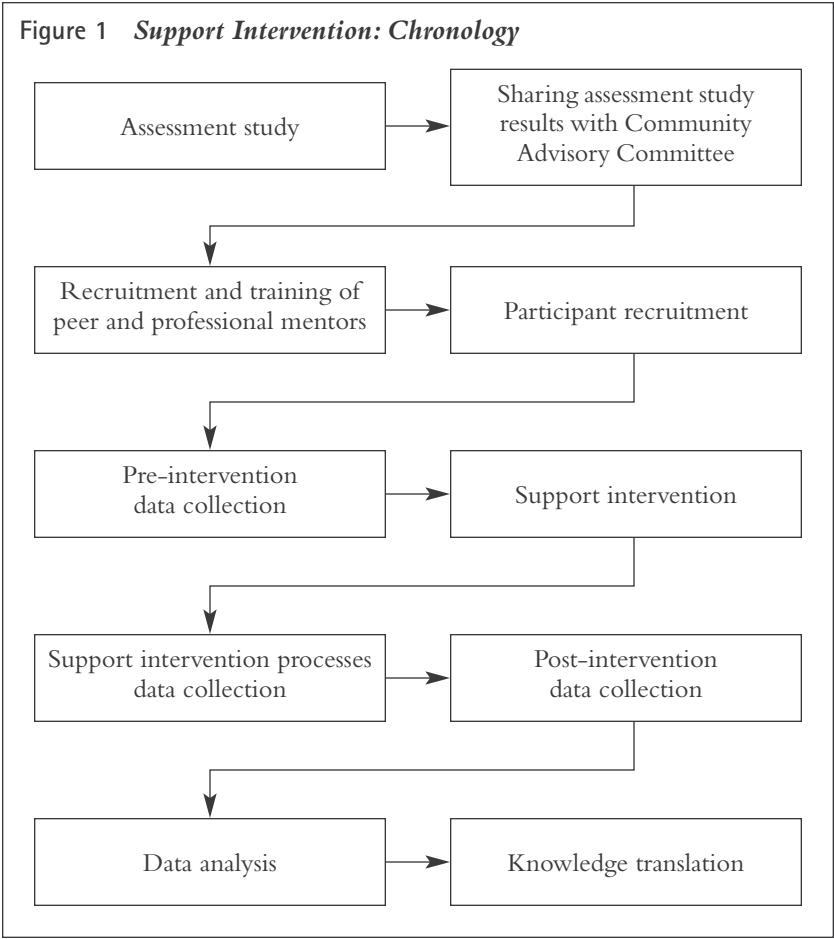
Methods

Given the wide gaps in research on support interventions for new parents who are refugee, this pilot intervention study used multi-methods with pre-test and post-test measures in a quasi-experimental design to assess outcomes (Bergold & Thomas, 2012; Tashakkori & Teddlie, 2003). Moreover, participatory approaches (Ahmed, Beck, Maurana, & Newton, 2004; Bergold & Thomas, 2012; Boffa, King, McMullin, & Long, 2011) enabled (1) assessment of refugees' perspectives, which informed the development of the customized support intervention; (2) engagement with community advisory committees comprising refugees and refugee-serving organizations to guide the study; and (3) training and inclusion of refugee mentors and interviewers.

The study was built on the research team's preceding assessment study of support needs and intervention preferences. New mothers and fathers from Sudan and Zimbabwe who had migrated to Canada as refugees in the previous 5 years reported major support needs and preferences: infor-

mation about culturally appropriate services, more supportive service providers, and peer support to complement professional support (Stewart et al., 2014).

A Community Advisory Committee was formed prior to initiation of the pilot intervention study to provide guidance in the conduct of the study. Committee members were invited by the research team and included partners from public, practice, program, and policy areas across various sectors (e.g., health, immigration); they guided the planning and implementation of the study and the dissemination of its results. Committee members were consulted about recruitment and cultural appropriateness of the intervention and data-collection tools (see Figure 1).

Figure 1 *Support Intervention: Chronology*

Both qualitative and quantitative methods were used to corroborate, elaborate, and illuminate understanding of the phenomena under study, thereby enhancing validity, transferability, and confidence (Creswell, 2013; Tashakkori & Teddlie, 2003). Qualitative methods were employed to facilitate understanding of sensitive issues and meanings, perceptions, beliefs, values, and behaviours (Ahmed et al., 2004; Schulze, 2003) of African new parents who are refugee. Qualitative data can reveal social validity (participants' subjective perspectives on the intervention), transportability (utility of the intervention in a natural setting), cultural elements of the intervention (Meyers & Sylvester, 2006), and perceived impacts of psychosocial interventions (Tashkkori & Teddlie, 2003). Qualitative methods are emphasized in this article.

Verification strategies were used throughout the research process to ensure rigour. These included coherence or fit between the research question and the research method, concurrent data generation and analysis, documentation of evolving interpretations and decisions, and theoretical thinking as emerging data interpretations were reconfirmed or modified in subsequent data (Morse, Barrett, Mayan, Olson, & Spiers, 2002).

Quantitative measurements were used to assess the psychosocial and health-related outcomes of the intervention (Lietz, 2007; Sosulski & Lawrence, 2008) and to potentially enhance relevance to other refugee or newcomer populations. These measures also elucidated distinctions among pertinent variables and extended, refined, and cross-checked qualitative data (Foss et al., 2004; Jamil, Nassar-McMillan, & Lambert, 2007; Liebkind & Jasinskaja-Lahti, 2000).

Sample and Context

Participants were selected using purposive and snowball sampling. The study included both "convention refugees" (persons outside their country of origin with a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion [Canadian Council for Refugees (CCR), 2010]) who had their refugee claims accepted, and "refugee claimants" (persons who have fled their country and are asking for protection in another country [CCR, 2010]) who were waiting for their asylum case to be settled. Recruitment was facilitated by community agencies and organizations and by research staff knowledgeable about the two refugee groups. Successful recruitment strategies (e.g., ethnic newspapers, staff of community organizations, radio announcements, flyers) from the team's previous studies with vulnerable populations were used.

The study was conducted in two urban sites in the provinces of Alberta and Ontario (Edmonton and Ottawa). A total of 85 new parents who were refugee (48 Sudanese and 37 Zimbabwean) were recruited for the intervention. The sample size was selected to ensure that qualitative data saturation by national origin was achieved for the two culturally diverse refugee groups. For quantitative analyses, these numbers are sufficient for larger pilot studies such as this, enabling analysis within each ethnic group. Infant age (over 4 months) was selected to ensure that infants were no longer newborn (a period of peak parenting stress). Since reports suggest that economic and employment integration is a challenge in the first 5 to 9 years after immigrating, the participants were refugees living in Canada for less than 5 years.

Participants were mothers and fathers of one or more children (including single/lone parents) who had arrived in Canada in the preceding 60 months from Sudan or Zimbabwe and who had a preschool child between the ages of 4 months and 5 years born in Canada. The countries of origin were Sudan (57%) ($n = 48$) and Zimbabwe (43%) ($n = 37$). Over half (55.3%) of the participants were male ($n = 47$). Most (75%) of the participants who reported marital status were either married or in a common-law relationship, 19% were single, 5% separated, and 1% widowed. Of those who indicated maximum level of education achieved, 5% had completed elementary school ($n = 3$), 25% secondary school ($n = 16$), 30% college ($n = 19$), and 41% had university undergraduate or graduate degrees ($n = 26$). The ages of those who provided this information were 21 to 30 (15%), 31 to 40 (24%), 41 to 50 (27%), or 50 and older (34%).

Intervention

Eight face-to-face support groups were created consisting of like-ethnic and like-gender peers (e.g., Sudanese females, Zimbabwean males). Each of the support groups was co-led by a Sudanese or Zimbabwean peer mentor who had a child in Canada and a Sudanese or Zimbabwean professional mentor (experienced service provider for immigrant and refugee populations) from the health, education, or social-service sector. Mentors participated in a 1-day training session, which oriented them to assessment phase results, intervention phase objectives, mentor roles and responsibilities, support group topics, session reporting, and the survey instrument. Professional mentors were consulted regarding concerns raised by peer mentors or participants. Peer mentors facilitating the support groups were established refugees who had experiential knowledge of immigration and integration, relationships with community agencies for refugees, and connections to their cultural communities. The

support groups were facilitated by 12 peer mentors (3 Zimbabwean and 3 Sudanese women; 3 Zimbabwean and 3 Sudanese men) and 8 professional mentors (2 men and 2 women each from Zimbabwe and Sudan). An additional female Zimbabwean research assistant facilitated participant recruitment in Alberta. The support groups met for 1 to 2 hours biweekly during the 7-month-long intervention. Strategies to sustain participation were essential and included the following: transportation — bus tickets or rides provided by mentors; child care — babysitting by older children of participant mothers; refreshments; and familiar venues.

Support program content was guided by challenges and parent preferences articulated in the previous face-to-face support intervention study, by participant preferences identified in the initial online group sessions, and by feedback from the Community Advisory Committee. A guide to relevant topics and resources was developed for peer and professional mentors by the research team in consultation with the Community Advisory Committee. The guide included modules on social support, mentoring, team-building, group facilitation, reflective listening, and problem-solving. In addition, members of each support group suggested topics pertinent to their specific support needs. In consultation with the research team, peer and professional mentors ensured that topics covered were related to the challenges faced by refugee new parents. The following topics were addressed during support group sessions: parenting education and personal development, parenting across cultures, how we discipline our children in Canada, teaching native languages and culture to our children, managing finances within a marriage, clash of cultures — coping with gender issues in families, health matters — weight gain among newcomers, and careers and education. Throughout the discussion sessions, peer mentors provided support to group members. Peer mentors used their personal experiences to help participants feel more comfortable sharing their own stories. Representatives of refugee-serving agencies were invited to make presentations relevant to participants' needs and requests (e.g., women's health, parenting skills). Online videos and reading materials were used as facilitation aids.

Data Collection

Qualitative interview guides and quantitative instruments were translated into the participants' first languages: Shona and Ndebele for Zimbabwean refugees and Arabic for Sudanese refugees. Surveys were reviewed by at least two people fluent in the language of the instrument and the surveys were pre-tested. Interviews were conducted in the participant's preferred language, which sometimes entailed switching between their first language and English. Consent forms were translated into Arabic for

Sudanese participants and into Shona and Ndebele for Zimbabwean participants, and were administered by research assistants who spoke the participant's language. Participants provided written informed consent. The study was approved by university ethics committees in Edmonton and Ottawa.

Qualitative Data Collection

Following each support group meeting, peer mentors used field notes to document the number of participants, topics discussed, types of support provided, and out-of-session contacts with participants.

Eight group interviews ($n = 67$), with a range of 4 to 13 participants in each group, and in-depth individual interviews ($n = 37$) were conducted following the intervention. Individual interviews yielded insights and clarification on issues raised during group interviews. Moreover, individual interviews with participants who were not available for group interviews ensured that the views of articulate and reticent refugees were represented. In both group and individual interviews, participants were asked about (1) factors influencing impacts of the intervention; (2) perceived impacts of the intervention (e.g., coping, loneliness); (3) communication with participants and peer or professional mentors outside group sessions; and (4) continued contact with other participants. For example, interview questions included the following: "Do you think differently about your situation as a newcomer? How? Why?" "Were the people in your life affected by your being in this program?" "Did this support program affect the way you cope with stressful situations/challenges in your life?"

In-depth individual interviews were conducted with all peer and professional mentors ($n = 21$) following the intervention. The semi-structured interview guide helped to elicit mentors' perceptions of impacts of the intervention. For example, questions included the following: "What did the participants in your group want to/need to talk about?" "Please describe the limitations of this support program." "What changes, if any, should be made to the program?"

Quantitative Data Collection

Standardized measures were administered at pre- and post-intervention to examine the impact of the intervention on (a) support needs — Personal Resource Questionnaire (PRQ) (Weinert, 2003); (b) loneliness and isolation — Revised UCLA Loneliness Scale (Russell, 1996); (c) coping, in particular support-seeking — Proactive Coping Inventory (PCI) (Greenglass, Schwarzer, & Taubert, 1999a); and (d) parenting stress — Parenting Stress Index (PSI) (Abidin, 1990).

The PRQ Part 2 (Weinert, 2003) is a 25-item scale based on five dimensions of support: worth, social integration, intimacy, nurturance, and assistance. Each item's response is scored on a seven-point Likert scale, with scores ranging from 25 to 175, higher scores indicating higher levels of perceived social support. In a systematic review the PRQ was found to be a reliable and valid tool for measuring perceived social support across a wide range of populations (Tawalbeh & Ahmad, 2013) and the alpha reliability of Part 2 has been demonstrated to be approximately .90 (Brandt & Weinert, 1981).

The Revised UCLA Loneliness Scale is a 20-item questionnaire measuring general perceptions of social connection or isolation (Russell, 1996). Participants are asked to rate each item on a scale of 1 (never) to 4 (always). After reverse coding appropriate items, the loneliness score is obtained by summing the 20 items, giving scores ranging from 20 to 80 with higher scores indicating higher levels of loneliness. This scale has been extensively used with a variety of ethnic populations and has been found to have a high degree of cross-cultural invariance (Chalise, Kai, & Saito, 2010; Wilson, Cutts, Lees, Mapungwana, & Maunganidze, 1992). The measure has internal consistency reliability ranging from 0.89 to 0.94. The reliability coefficient for the present study was 0.89.

The PCI (Greenglass et al., 1999a) is a multidimensional measure of coping wherein higher scores indicate increased coping. Participants indicate the truthfulness of statements in each subscale on a scale of 1 (not at all true) to 4 (completely true). The eight-item Instrumental Support Seeking scale focuses on obtaining advice, information, and feedback from people in social networks when dealing with stressors. Greenglass (2002) reports acceptable psychometrics for the scales, including cross-cultural validity. Greenglass, Schwarzer, Jakubiec, Fiksenbaum, and Taubert (1999b) report reliability coefficients of 0.85 for a Canadian sample and 0.84 for a Polish-Canadian sample. The alpha reliability coefficient for the present study was 0.71.

The PSI–Short Form (Abidin, 1990) was designed to measure relative stress in the parent–child relationship. This 36-item measure is used for early identification of dysfunctional parent–child interactions, parental stress, family functioning, and risk for child abuse and neglect. The Index yields a total stress score from three scales: parental distress, parent–child dysfunctional interaction, and difficult child. Higher scores indicate higher levels of parenting stress. Reliability and validity tests of the PSI found that parenting stress is a useful measure across diverse populations, with an internal consistency reliability of 0.80 to 0.91 (Abidin, 2012). The reliability coefficient for the present study was 0.96.

Data Analysis

All qualitative interview data were audiorecorded, transcribed, translated, and analyzed using thematic content analysis. Post–intervention interviews of participants and intervention agents (mentors) were analyzed for perceived impacts of the intervention and factors influencing its impacts. Qualitative data were organized and classified by one coder according to themes, concepts, and emergent categories. The coding framework contained key themes pertaining to the research questions as well as themes emerging from the transcripts. NVivo 8 software was used to organize quotations into themes. Common themes within and across groups were identified through the coding process. Data were analyzed until no new themes or categories emerged (Creswell, 2013). The final stage of qualitative data analysis involved interpreting the data followed by synthesizing data from the post–test group interviews and individual interviews of participants and post–test interviews of mentors.

Quantitative data analyses began with descriptive statistics employed to summarize demographic data (e.g., age, marital status, ethnicity). Nonparametric tests appropriate for a small sample size were employed in this pilot intervention study. The Wilcoxon signed–rank non–parametric statistical test was used to determine whether there was a median difference between paired or matched observations and to compare pre- and post–intervention scores on each instrument. This analysis was conducted only for participants who had complete sets of pre- and post–intervention quantitative data ($n = 59$).

Results

Increased Perceived Support (Research Question 1)

Increased information support. Peer mentors identified knowledge gaps revealed during group meetings and community resources to address these information support needs. They linked new parents who are refugee with community resources such as camping, sports, tutoring for children's homework, tenants' rights, immigration issues, and interpreter services. Moreover, representatives of community agencies were invited to share information on available services and access strategies. Participants indicated their degree of satisfaction with support provided during the intervention:

> *Now the practical support to each of them was that in some instances we were able to provide support of information about child care, child subsidy, and even we filled the forms and made follow-ups and a few of them were able to get it.* (Sudanese male mentor)

The support group gave me the opportunity to socialize with other Sudanese and South Sudanese women under the same roof while learning more about other services available to them in the area despite political differences back home. (Sudanese female participant)

Through group discussions, participants gained valuable knowledge about subjects important to new parents who are refugee, such as diminishing marital disharmony, raising children in Canada, coping with youth facing drug challenges, enrolling children in recreation programs, and integrating into economic and social life in Canada. Participants revealed the value of gaining new information and support:

You know the information you gave us about how to register our kids for that 1-week overnight summer program? It gave me a whole week of rest and focus only on myself in a quiet and not very busy environment . . . it was great to have such a program, especially for some of us with no other relatives in this country. (Sudanese female participant)

The best experience was sitting with a bunch of guys sharing information, something that we have never done, actually. When we used to gather we used to talk about something else. Family matters were always, like, untouchable subjects because you don't know how far you go. You don't want to offend someone. (Zimbabwean male participant)

I think I am lucky to have been involved in the wealth of information, sharing, and support. I am more prepared to work with my pre-teen kids. It has made me a real and responsible parent with no excuses at all. I now think more of a settled adult than thinking I am just new waiting to go back to South Sudan. (Sudanese male participant)

Improved spousal relationships. Participants talked extensively about marital challenges prevalent among refugee couples. Some participants were single parents, divorced or separated, while some married participants reported conflicts in their marriages. Peer mentors linked refugee parents with salient services and helped participants explore the root causes of marital challenges. Defining roles and responsibilities and managing family finances within the marriage were seen as leading causes of conflict. Mentors explained that marriages in Canada have legal implications and responsibilities. According to a peer mentor, female participants conceded that their husbands were struggling to adjust to Canadian society.

Comparison of challenges faced by spouses helped refugee couples understand that some of their domestic problems were experienced by other refugee families. While participants attributed marriage break-ups

to various factors, they concurred regarding financial costs and consequences for children and family. Participants believed that support groups helped them to avoid conflicts and disagreements and to deal with family matters. Some female participants believed that their self-worth was enhanced by the support group, as they realized that their husbands' extramarital relationships were not their fault. They felt more confident in their ability to deal with future family problems:

> *One of them said that since separating with his wife he has had time to think things through and reflect on his time with his wife. He blamed himself for failing to adjust to the new Canadian environment where women are more empowered. He advised all present to start making personal changes in their relationships. His advice was, "Please have time for your families and listen to them."* (Sudanese peer mentor)

Participants reported learning from support groups about the implications of Canadian society for gender roles in marriage. Resentment of Canadian society for perceived erosion of their masculinity and patriarchal status emerged during some men's support group discussions. Some male participants initially thought that their role as "head of the house" diminished when they came to Canada, because they perceived that their partners became more empowered to make decisions. Men reported that support group sessions focusing on the value of mutual decision-making, taking more responsibility for household chores, and raising their children were beneficial. Men noted that, after the intervention, they respected their wives more and embraced the new cultural setting in which they were raising their families. Some participants said that support group meetings improved their communication of concerns with partners:

> *It used to be either my way or no way. So I have changed that attitude which I had prior to this group meeting. I now try as much as I can to contribute in the house and in any things. I used to think that as long as I bring money in the house that's it, you don't need to worry about the rest. But now I understand it's more than that, because we are by ourselves here and if I don't put my effort in the house, then it falls back to all of us.* (Zimbabwean male participant)

> *As time went on, she benefitted from what I have learnt and we now have a better understanding of how to communicate and be a real team in the family.* (Sudanese male participant)

> *I have changed my ways. I am trying to be involved more, taking my son for swimming, soccer, and stuff like that, things that I usually did not do. So the group helped me that way.* (Zimbabwean male participant)

Participants shared strategies for handling money and expenses at home. Female participants believed it was their responsibility to ensure that family income was used to pay bills, purchase food, and support family members in their home country.

Enhanced engagement with ethnic community. Participants reported improved relationships with neighbours and members of their ethnic community following the intervention. Through teamwork and recreational activities offered during the support intervention, participants learned the importance of looking beyond ethnic differences and supporting members of their cultural community. To illustrate, Zimbabwean participants reported improved perceptions of other ethnic groups who spoke a different language (Ndebele versus Shona). Participants were inspired by the fact that group members congregated in times of adversity, which reinforced the importance of staying connected with each other and their ethnic community. Group members provided support to grieving participants. Support exchange continued after the conclusion of the intervention:

> *Now my son can go out and hang out with five neighbours or so and he can go into their house and play and everything. And the other kids do the same thing. And we have liked two people in the neighbourhood who offer to babysit for free just to help out.* (Zimbabwean male participant)

> *In my opinion they really supported each other well because they learned from each other and they were able to embrace the experiences of others.* (Sudanese male mentor)

Quantitative results for the use of personal resources, such as community support, were not statistically significant. An increase in median scores of the PRQ from pre- to post-intervention was found for 47.4% of all participants. A Wilcoxon signed-rank analysis indicated that the increase in the post-intervention median score was not statistically significant ($Z = 1.045$, $p = .295$).

Decreased Loneliness and Isolation (Research Question 2)

Participants reported feeling less lonely after joining the support group. Some female participants noted that before the intervention they did not make time for meeting their personal support needs, as their time was consumed with household chores and family needs. However, the support group provided an opportunity for them to connect with others outside their homes:

> *I like the group because . . . enhance social connections between us Sudanese women.* (Sudanese female participant)

Participants said that the support group brought them together with their peers and built trust and confidence among them. Friendships established during support meetings were extended to other aspects of their lives. By the end of the program, they reported attending each other's family birthday celebrations, visiting one another in hospital, providing support during bereavement, and attending cultural events together. One male participant who described feelings of loneliness as a single parent prior to joining the support group said that following the intervention group members became like his "uncles" or "brothers," providing timely support:

> *When I first arrived in Canada I felt frustrated and alone, life was so difficult . . . oh, my God, it was difficult! I felt like withdrawing from normal activities. I also felt the loneliness, isolation, and loss of everything that is important to me, like my family support and my culture. The support group and the community meeting gave me the senses that I am not alone.* (Sudanese female participant)

> *. . . most of the ones who were single mums and here without their families, it's really hard to get support apart from the group.* (Sudanese female mentor)

Some participants reported exclusion and isolation linked to discrimination. They observed that sharing experiences of racism and discrimination with their peers in the support group was beneficial. Parents maintained that learning how peers in the support groups coped with similar challenges informed them regarding their children's isolation and exclusion. They discovered that children of other parents had similar experiences of discrimination and exclusion, and they agreed that they could teach their children that they were not different from other kids:

> *My children . . . one is now doing Grade 1 and I think this is where this race thing begins. That's when they are beginning to notice about the differences. People laugh about the type of hair, whether they have short hair, colour of their hair, the hair is too curly — all these things start coming up, and I guess with the discussion that we had it will teach you how to approach it and how to talk to your son about it so that he can keep his confidence and know who he is and where he come from, be proud of that and not be discouraged by the fact that his hair is not straight and he is not as light as all the other children.* (Zimbabwean male participant)

The Revised UCLA Loneliness Scale was used to complement qualitative data on experience of loneliness. Half of the participants who completed this scale had lower mean scores after the intervention, indicating decreased loneliness. A Wilcoxon signed-rank test did not detect a

statistically significant change in perceived loneliness among participants ($Z = 0.313$, $p = 0.754$).

Increased Coping Strategies (Research Question 3)

Improved coping with stress. Support group meetings provided a platform for relieving stress from home or work. Discussing personal experiences and possible solutions with peers was viewed as a strategy to "de-stress." Participants reported that the group sessions provided relief and relaxation. Coping strategies learned to help ease marital friction included spousal communication, mutually approved family budget, anger management, and positive thinking. Participants noted that knowledge and coping strategies shared during support group meetings gave them more comprehensive perspectives on challenges affecting them as parents in a new country. They stated that the group had shaped and sharpened their skills for coping with stressful situations:

> *The group gave me a break from the family, especially the children, and when I get home I found that I am more energized and relaxed when dealing with family stressful situation.* (Sudanese female participant)

> *We also learned how to cope . . . especially in terms of parenting and family life, and to adapt to the culture of this country, like the fact that you cannot beat your child in this country.* (Sudanese male participant)

Enhanced capacity. Support meetings provided a platform for discussion of barriers faced by newcomers in the job market and relevant community resources. Although most participants received education in their country of origin, they believed that some employers did not value their qualifications. Group members and mentors shared ideas on training expected by employers, gaining Canadian work experience, and relocating to small towns with minimal competition for jobs. Parents' efforts to upgrade their own education were viewed as role modelling the value of education to their children. Participants made connections with other group members, leading to employment opportunities and upgrading of educational qualifications. Some participants secured employment through people they met in the support group:

> *I saw this guy at our last meeting. He told me he is in my line of work. I gave him the number and they talked to each other and now they work together, so I thought that was a positive [impact].* (Zimbabwean male mentor)

The PCI–Instrumental Support Seeking Subscale was used to measure coping. Analysis of data from the measure revealed that some participants (46.6%) had higher support-seeking scores following the

intervention. A Wilcoxon signed–rank test revealed that this encouraging trend was not statistically significant ($Z = .792$, $p = .428$).

Decreased Parenting Stress (Research Question 4)

Discussions of parenting challenges and strategies for managing stress during support group sessions were considered helpful and informative. Female participants discussed practices learned from their mothers, such as gradually feeding babies with solid food and giving the baby a sooth–ing bath before bedtime. Parents talked about bullying and its effects on children and learned that some victims of bullying at school do not report this abuse. Parents agreed that good parent–child relationships increase the opportunities for children to disclose stressful events. They described improved parent–child relationships following the support group intervention:

> *When I interacted with the group, one thing I gathered was that it's not all about me being mad. It's all about me sitting down with my son and talking and say if anything like this happen next time this how we are going to deal with the situation. Before, the way I used to do things is, like, as soon as the mother tells me that he has done this, the only thing I think of is yelling at him or wanting to beat him up. That has kind of changed me. I take a different approach and say I have to sit down with him and talk to and try to find out why.* (Zimbabwean male participant)

> *Since the group, I pay attention to my children's schoolwork and stuff.* (Sudanese female participant)

> *I find it more relaxing when we just sit and talk, especially when we make comparison of the different child-rearing methods from back home and here in Canada, it makes me laugh . . . sometimes I am home and I think of some of the things that the other women were talking about and I will be laughing alone.* (Sudanese female participant)

Analysis of the PSI–Short Form revealed that 59% of participants who completed the measure had lower scores following the support intervention, suggesting decreased parenting stress. However, according to the Wilcoxon signed–rank test this difference between pre- and post-intervention scores was not statistically significant for this group of par-ticipants ($Z = 1.101$, $p = .27$).

Discussion

Newcomers to Canada face substantial cultural changes that, in combi-nation with a lack of social support, challenge their ability to cope with

stress. This pilot intervention study demonstrated that a culturally sensitive intervention can increase participants' social support by (1) providing information on relevant resources, ranging from parenting resources to interpretation services; (2) enhancing spousal relationships through discussion of cultural differences in gender relations in Canada and the country of origin; and (3) helping them to engage with their ethnic community, thus decreasing loneliness and isolation. This pilot intervention also increased coping by helping participants to (1) identify strategies for coping with stress, (2) enhance their ability to secure education and job opportunities, and (3) improve their parenting competence with shared strategies ranging from infant-feeding to coping with bullying to increasing parent–child communication. As the world becomes more globalized and immigration continues, particularly from Sudan (Simich, 2006) and other troubled African nations (Bloch, Sigona, & Zetter, 2011), nurses who are employed in Canada and/or in similar multi-ethnic societies or work settings may appreciate the insights offered by both the findings and the intervention approaches.

This study has illuminated the merits of a participatory approach to program design and cultural sensitivity/appropriateness by focusing on marginalized African refugees representing two countries of origin. Foremost, the content of the intervention emerged from the knowledge gaps and learning objectives identified by individual groups and sought to address their unique ethno-cultural support needs and intervention preferences. This participatory approach ensured that participants received information that filled their gaps in knowledge and that allowed them to take advantage of formal support services and better navigate health, education, housing, banking, and other systems. Information enabled them to obtain concrete benefits for themselves and their families, and was perceived by them to have enhanced their sense of empowerment and their ability to function in Canadian society.

The group discussion format helped to reduce isolation, as other families were seen as facing similar issues. Group exchanges also reinforced the possibilities for ongoing mutual aid and helped to demonstrate the supportive power of like-ethnic peers, who in this instance were those who acted as peer facilitators as well as group participants. Another advantage of this format is its potential to ease intragroup tensions, as members of subgroups who may not have much interaction with one another had the opportunity to discuss challenges they had in common. Moreover, the group discussion format served as a spark for supportive relationships that continued post-intervention.

The ongoing nature of the intervention and the use of both peer mentors and professional information specialists allowed the group process to evolve, relationships to develop, and participants to feel com-

fortable sharing their concerns and opinions. Opening up about problems is often difficult in a group setting — even with those who share one's heritage and gender identity — particularly when one feels isolated. Peer facilitators created safe spaces where participants in gender-segregated groups could frankly discuss intimate family issues such as marital relations and intergenerational tensions. During these sessions, participants learned not only about patterns of responses and behaviours pertaining to family members' adjustment to Canadian society, but also about ways to deal with potential problems through more open communication and to mitigate the stress that some problems may cause. Importantly, gender segregation enabled participants to open up about their concerns regarding changing gender roles and ideologies. Some men felt that their status and masculinity were eroding; by working with peer mentors, they came to see the ways in which they could make important contributions to their family and to appreciate those of their female partner.

Moreover, the culturally appropriate support program and the support communicated in first languages by peers helped refugees to overcome challenges. Differences among refugees reinforce the need to elucidate the role of ethnicity in the design of culturally relevant social support interventions. Consideration of both gender and ethnicity in the composition of support groups and matching of peer facilitators with refugees in face-to-face groups is congruent with the reported need for ethno-specific interventions (Barrio, 2000; Beiser, Wiwa, & Adebajo, 2010).

Improved spousal relationships, enhanced engagement with the participants' ethnic communities, increased informational support and capacity, improved coping with stress, decreased parenting stress, and decreased loneliness and isolation were the main results of this study. The support intervention had two impacts: mobilization of coping strategies for dealing with stressful challenges, and an associated decrease in perceived parenting stress. Nurses need to be aware that social support is a resource for coping with stressful situations linked to migration, resettlement, and new parenthood. Support-seeking as a coping strategy for managing stressful situations has been linked to greater provision of support, whereas people who use distancing and avoidance coping strategies tend to have fewer support resources (Thoits, 1995). Social support and coping have bidirectional effects (House et al., 1988). For example, the ways in which refugees cope can provide clues to potential supporters about the types of support needed. Conversely, the amount and types of support received can influence refugees' choice of coping strategies. Thus, nurses ought to consider the stressors faced by patients who are immigrants and to offer or advocate for culturally sensitive supports in order to promote coping, build capacity, and reduce stress, social isolation, and loneliness.

Support can either endure or dissipate over time in stressful situations (Lawrence & Kearns, 2005) such as migration. Decreased loneliness was another reported impact of the intervention, likely linked to increased perceived support resources. Research suggests potential beneficial effects of social support in ameliorating isolation and resource deprivation (Simich et al., 2004; Warner, 2007) of newcomers and mediating discrimination (Brooker & Eakin, 2001; Din-Dzietham, Nembhard, Collins, & Davis, 2004). Other authors have also found that social support can reduce isolation and loneliness among refugees (Beiser et al., 2010, 2011; Bhui et al., 2006; Jaranson et al., 2004). However, previous support interventions were not designed to meet the unique needs of new parents who are refugee.

The multi-method approach (Tashakkori & Teddlie, 2003) enhanced the knowledge generated from the present study. Non-statistically significant trends were reinforced, supplemented, and interpreted by the qualitative data. To illustrate, the qualitative data revealed participants' sense of increased ability to seek support following the program, although the quantitative trend in increased support-seeking was not statistically significant. Moreover, the statistically non-significant decrease in loneliness was illuminated by the qualitative data, which indicated that refugees felt less isolated following the intervention. However, we need further nursing research using randomized controlled trial (RCT) designs, control groups, and larger samples. Such research might also use participatory methods to inform intervention design and maximize the likelihood of intervention effectiveness. Additionally, a multi-method approach can inform the design of subsequent community-based intervention trials. Future research based on participatory research principles could explore the support intervention preferences of refugees or other migrant groups in order to design and test interventions that are culturally appropriate and that address the unique support needs of each group.

Insights from this study contribute to knowledge that can inform nursing practice in diverse health-related settings, as well as program and policy development to support new parents who are refugee. The experiences of Sudanese and Zimbabwean refugee participants reveal the importance of targeted services within health-care systems for which nurses can advocate. Moreover, nurses could promote coordination and communication among agencies and organizations that provide health services, while programs could mobilize and sustain support for new parents who are refugee. Potential outcomes include improved cultural relevance and uptake of health interventions; improved ability of new parents who are refugee to manage health risks and challenges; increased use of accessible, appropriate programs to address health inequities faced

by refugee families; and expanded research and knowledge mobilization capacity relevant to vulnerable refugee parents and children.

Limitations

The study had several limitations. The sample was small, only 70% of participants completed both pre- and post-intervention quantitative measures, and the measures were self-report. The volunteer sample, which could be viewed as a study limitation, seemed sufficiently robust to provide relevant qualitative data to address the research questions. Psychometric evaluation of the quantitative measures had not been conducted with the two specific populations in the study, although these measures have been used with ethnically diverse populations by other researchers and were translated and administered to these unique cultural groups in other studies conducted by the research team (comprising four nurses, two sociologists, and one anthropologist). These measures may not have been sufficiently sensitive to detect significant differences following the intervention. While the intervention was not explicitly evaluated for relevance and feasibility, qualitative data pointed to acceptability and the fact that 70% of participants completed the post-test measures is evidence of acceptability for the majority of potential participants. In future, an external evaluation could be conducted to assess these factors.

Conclusion

This pilot intervention study provides insights and evidence that advance the body of knowledge needed to guide support for refugees and newcomers to Canada. The findings demonstrate that peer support interventions can help to diminish African refugees' loneliness and parenting stress, address factors that influence health, and enhance support-seeking skills for coping with health-related challenges. Culturally and linguistically appropriate, gender-sensitive support programs could be adapted and tested in community-based intervention trials prior to integration into health services for vulnerable refugees. The next research step would be to conduct a larger RCT to examine clinical outcomes among these parents (e.g., postpartum depression, parental stress, co-parenting). The present findings underline the need for culturally appropriate nursing practices and programs that support new parents who are refugee from diverse cultures. Knowledge about cultural diversity is vital in all areas of nursing practice, including research. Canada is a plural society of immigrants from diverse cultural backgrounds. The need for culturally relevant health care has become a national concern given the escalation in global migration. While nurses and other health professionals must attend to the cultural aspects of healing, we need more nursing research in order to

collect and publish valid and reliable information with respect to immigrant populations, particularly visible minorities. Nursing research approaches and designs must be culturally appropriate, especially to new immigrants. Culturally suitable research provides nurses and other health professionals with valid and reliable knowledge about the health-support needs of new immigrants. It also enables nurses to develop theory and practice that translate into culturally suitable care (Clarke, 1997). It is no longer sufficient, in culturally diverse societies, to implement dominant cultural models in the construction of research approaches. Ethnocentric approaches to nursing research and practice are ineffective in meeting the health-care and health-support needs of diverse populations. Knowledge about cultures and their impact on health-care interactions is essential for nurses, whether they are practising in clinical, educational, research, or administrative settings. Because nurses are in a position to influence policies and practice, they should continue to look for ways and means to satisfy the health-care needs of Canada's various population groups.

References

Abidin, R. R. (1990). *Parenting Stress Index Short Form*. Lutz, FL: Psychological Assessment Resources.

Abidin, R. R. (1995). *Parenting Stress Index professional manual 3*. Odessa, FL: Psychological Assessment Resources.

Abidin, R. R. (2012). *Parenting Stress Index* (4th ed.). Lutz, FL: Psychological Assessment Resources.

Ahmed, S. M., Beck, B., Maurana, C. A., & Newton, G. (2004). Overcoming barriers to effective community-based participatory research in US medical schools. *Education for Health, 17*(2), 141–151. doi:10.1080/1357628041 0001710969

Anderson, J. M. (1996). Empowering patients: Issues and strategies. *Social Science and Medicine, 43*(5), 697–705.

Anderson, J. M., Reimer, J., Khan, K. B., Simich, L., Neufeld, A., Stewart, M., & Makwarimba, E. (2010). Narratives of "dissonance" and "repositioning" through the lens of critical humanism: Exploring the influences on immigrants' and refugees' health and well-being. *Advances in Nursing Science, 33*(2), 101–112.

Barrio, C. (2000). The cultural relevance of community support programs. *Psychiatric Services, 51*(7), 879–884.

Beiser, M., Wiwa, O., & Adebajo, S. (2010). Human-initiated disaster, social disorganization and post-traumatic stress disorder above Nigeria's oil basins. *Social Science and Medicine, 71*(2), 221–227.

Beiser, M., Zilber, N., Simich, L., Youngmann, R., Zohar, A. H., Taa, B., & Hou, F. (2011). Regional effects on the mental health of immigrant children: Results from the New Canadian Children and Youth Study (NCCYS). *Health and Place, 17*(3), 822–829.

Bergold, J., & Thomas, S. (2012). Participatory research methods: A methodological approach in motion. *Historical Social Research, 37*(4), 191–222.

Bernard, H. R., Johnsen, E. C., Killworth, P. D., & McCarty, C. (1990). Comparing four different methods for measuring personal social networks. *Social Networks, 12*(3), 179–215.

Bhui, K., Craig, T., Mohamund, S., Warfa, N., Stansfeld, S. A., Thornicroft, G., . . . McCrone, P. (2006). Mental disorders among Somali refugees: Developing culturally appropriate measures and assessing socio-cultural risk factors. *Social Psychiatry and Psychiatric Epidemiology, 41*(5), 400–408.

Bloch, A., Sigona, N., & Zetter, R. (2011). Migration routes and strategies of young undocumented migrants in England: A qualitative perspective. *Ethnic and Racial Studies, 34*(8), 1286–1302.

Boffa, J., King, M., McMullin, K., & Long, R. (2011). A process for the inclusion of Aboriginal people in health research: Lessons from the Determinants of TB Transmission Project. *Social Science and Medicine, 72*(5), 733–738.

Brandt, P., & Weinert, C. (1981). The PRQ: A social support measure. *Nursing Research, 30*(5), 277–280.

Bronstein, I., & Montgomery, P. (2011). Psychological distress in refugee children: A systematic review. *Clinical Child and Family Psychology Review, 14*(1), 44–56.

Brooker, A., & Eakin, S. (2001). Gender, class, work-related stress and health: Toward a power-centred approach. *Journal of Community and Applied Social Psychology, 11*(2), 97–109.

Brunk, B. P., & Hoorens, V. (1992). Social support and stress: The role of social comparison and social exchange. *British Journal of Clinical Psychology, 31,* 445–447.

Cacioppo, J. T., & Hawkley, L. C. (2009). *Loneliness.* Chicago: Centre for Cognitive and Social Neuroscience, University of Chicago. Retrieved April 2, 2013, from http://psychology.uchicago.edu/people/faculty/cacioppo/jtc reprints/ch09.pdf.

Canadian Council for Refugees. (2010). *Refugees and immigrants: A glossary.* Retrieved January 7, 2013, from http://ccrweb.ca/en/glossary.

Chalise, H. N., Kai, I., & Saito, T. (2010). Social support and its correlation with loneliness: A cross-cultural study of Nepalese older adults. *International Journal of Aging and Human Development, 71*(2), 115–138.

Chung, K., Hong, E., & Newbold, B. (2013). Resilience among single adult female refugees in Hamilton, Ontario. *Refuge, 29*(1), 65–74.

Citizenship and Immigration Canada. (2012). *Facts and figures 2012 – immigration overview: Permanent and temporary residents.* Ottawa: Author. Retrieved January 7, 2013, from http://www.cic.gc.ca/english/pdf/research-stats/facts2012.pdf.

Citizenship and Immigration Canada. (2013). *Immigration and citizenship.* Ottawa: Author. Retrieved February 12, 2014, from http//www.cic.gc.ca/English/information/times/temp.asp.

Clarke, H. F. (1997). Research in nursing and cultural diversity: Working with First Nations peoples. *Canadian Journal of Nursing Research, 29*(2), 11–25.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Cutrona, C. (1990). Stress and social support: In search of optimal matching. *Journal of Social and Clinical Psychology, 9*(1), 3–14.

Deng, S. A., & Marlowe, J. M. (2013). Refugee resettlement and parenting in a different context. *Journal of Immigrant and Refugee Studies, 11*(4), 416–430.

Din-Dzietham, R., Nembhard, W. N., Collins, R., & Davis, S. K. (2004). Perceived stress following race-based discrimination at work is associated with hypertension in African-Americans: The Metro Atlanta Heart Disease Study, 1999–2001. *Social Science and Medicine, 58*(3), 449–461.

Eriksen, T. H. (1992). *Us and them in modern societies: Ethnicity and nationalism in Mauritius, Trinidad and beyond*. Oslo: Scandinavian University Press.

Fazel, M., Reed, R. V., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: Risk and protective factors. *Lancet, 379*(9812), 266–282. doi:10.1016/S0140-6736 (11)60051-2; 10.1016/S0140-6736(11)60051-2

Fernandez, I., Silvan-Ferrero, P., Molero, F., Gaviria, E., & Garcia-Ael, C. (2014). Perceived discrimination and well-being in Romanian immigrants: The role of social support. *Journal of Happiness Studies, 16*(4), 857–870. doi:10.1007/s10902-014-9537-0

Foss, G. F., Chantal, A. W., & Hendrickson, S. (2004). Maternal depression and anxiety and infant development: A comparison of foreign-born and native-born mothers. *Public Health Nursing, 21*(3), 237–246.

Fox, P. G., Rossetti, J., Burns, K. R., & Popovich, J. (2005). Southeast Asian refugee children: A school-based mental health intervention. *International Journal of Psychiatric Nursing Research, 11*(1), 1227–1236.

Gottlieb, B. H. (2000). Accomplishments and challenges in social support intervention research. In M. Stewart (Ed.), *Chronic conditions and caregiving in Canada: Social support strategies* (pp. 294–310). Toronto: University of Toronto Press.

Gottlieb, B. H., & Bergen, A. E. (2010). Social support concepts and measures. *Journal of Psychosomatic Research, 69*(5), 511–520. doi:10.1016/j.jpsychores.2009.10.001

Greenglass, E. (2002). Proactive coping. In E. Frydenberg (Ed.), *Beyond coping: Meeting goals, vision, and challenges* (pp. 37–62). Oxford: Oxford University Press.

Greenglass, E., Schwarzer, R., Jakubiec, S. D., Fiksenbaum, L., & Taubert, S. (1999b). *The Proactive Coping Inventory (PCI): A multidimensional research instrument.* Paper presented at the 20th International Conference of Stress and Anxiety Research Society, Cracow, July 12–14.

Greenglass, E. R., Schwarzer, R., & Taubert, S. (1999a). *The Proactive Coping Inventory (PCI): A multidimensional research instrument.* Berlin: Health Psychology Resources. Retrieved January 7, 2013, from http://userpage.fu-berlin.de/~health/greenpci.htm.

Grewal, S. K., Bhagat, R., & Balneaves, L. G. (2008). Perinatal beliefs and practices of immigrant Punjabi women living in Canada. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 37*(3), 290–300. doi:10.1111/j.1552-6909.2008.00234.x

Hansson, E., Tuck, A., Lurie, S., & McKenzie, K. (2010). *Improving mental health services for immigrant, refugee, ethno-cultural and racialized groups: Issues and options for service improvement.* Ottawa: Task Group of Services Systems Advisory Committee, Mental Health Commission of Canada. Retrieved April 2, 2013, from http://www.mentalhealthcommission.ca/English/system/files/private/Diversity_Issues_Options_Report_ENG_0.pdf.

Hernandez-Plaza, S., Alonso-Morillejo, E., & Pozo-Munoz. C. (2006). Social support interventions in migrant populations. *British Journal of Social Work, 36*(7), 1151–1169.

House, J. S., Umberson, D., & Landis, K. R. (1988). Structures and processes of social support. *Annual Review of Sociology, 14*(1), 293–318.

Jamil, H., Nassar-McMillan, S. C., & Lambert, R. G. (2007). Immigration and attendant psychological sequelae: A comparison of three waves of Iraqi immigrants. *American Journal of Orthopsychiatry, 77*(2), 199–205.

Jaranson, J. M., Butcher, J., Halcon, L., Johnson, D. R., Robertson, C., Savik, K., . . . Westermeyer, J. (2004). Somali and Oromo refugees: Correlates of torture and trauma history. *American Journal of Public Health, 94*(4), 591–598.

Jones, S. (1998). *The archaeology of ethnicity: Constructing identities in the past and present.* London and New York: Routledge.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., . . . Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal, 183*(12), E959–E967. doi:10.1503/cmaj.090292;10.1503/cmaj.090292

Lawrence, J., & Kearns, R. (2005). Exploring the "fit" between people and providers: Refugee health needs and health care services in Mt. Roskill, Auckland, New Zealand. *Health and Social Care in the Community, 13*(5), 451–461.

Lewig, K., Arney, F., & Salveron, M. (2010). Challenges to parenting in a new culture: Implications for child and family welfare. *Evaluation and Program Planning, 33*(3), 324–332. doi:10.1016/j.evalprogplan.2009.05.002

Liebkind, K., & Jasinskaja-Lahti, I. (2000). The influence of experiences of discrimination on psychological stress: A comparison of seven immigrant groups. *Journal of Community and Applied Social Psychology, 10*(1), 1–16.

Lietz, C. A. (2007). Uncovering stories of family resilience: A mixed methods study of resilient families, Part 2. *Families in Society, 88*(1), 147–155.

Meyers, A. B., & Sylvester, B. A. (2006). The role of qualitative research methods in evidence-based practice. *NASP Communique, 34*(5). Retrieved January 14, 2013, from http://www.nasponline.org/publications/cq/cq345research.aspx.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 13–22.

Paris, R. (2008). For the dream of being here, one sacrifices . . . : Voices of immigrant mothers in a home visiting program. *American Journal of Orthopsychiatry, 78*(2), 141–151.

Rook, K. S., Thuras, P. D., & Lewis, M. A. (1990). Social control, health risk-taking, and psychological distress among the elderly. *Psychology and Aging, 5*(3), 327–334.

Russell, D. (1996). UCLA Loneliness Scale (version 3): Reliability, validity, and factor structure. *Journal of Personality Assessment, 66*(1), 20–40.

Schulze, S. (2003). Views on the combination of quantitative and qualitative research approaches. *Progressio, 25*(2), 8–20.

Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry, 40*(2), 179–187. doi:10.1111/j.1440-1614.2006.01766

Simich, L. (2006). Hidden meanings of health security: Migration experiences and systemic barriers to mental well-being among non-status migrants. *International Journal of Migration, Health and Social Care, 2*(3/4), 16–27.

Simich, L. (2010). Refugee mental health and the meaning of "home." *Canadian Issues,* Fall, 68–72. Retrieved January 14, 2013, from http://www.metropolis.net/publications/aec_citc_fall2010_e.pdf.

Simich, L., Beiser, M., Stewart, M., & Makwarimba, E. (2005). Providing social support for immigrants and refugees in Canada: Challenges and directions. *Journal of Immigrant Health, 7*(4), 259–268.

Simich, L., Hamilton, H., Baya, B. K., & Neuwirth, G. (2004). *The study of Sudanese settlement in Ontario: Final report*. Ottawa and Toronto: Citizenship and Immigration Canada, Settlement Directorate, Ontario.

Sosulski, M. R., & Lawrence, C. (2008). Mixing methods for full-strength results: Two welfare studies. *Journal of Mixed Methods Research, 2*(2), 121–148.

Stewart, M. J. (2014). Social support in refugee resettlement. In L. Simich & L. Andermann (Eds.), *Refugees and resilience: International perspectives on migration* (pp. 91–107). Heidelberg: Springer Science. doi:10.1007/978-94-007-7923-5_7

Stewart, M., Anderson, J., Beiser, M., Makwarimba, E., Neufeld, A., Simich, L., & Spitzer, S. (2008). Multicultural meanings of social support among immigrants and refugees. *International Migration, 46*(3), 123–159.

Stewart, M. J., Dennis, C. L., Kariwo, M., Kushner, K. E., Letourneau, N. L., Makumbe, M., . . . Shizha, E. (2014). Challenges faced by refugee new parents from Africa in Canada. *Journal of Immigrant and Minority Health, 17*(4), 1146–1156. doi:10.1007/s10903-014-0062-3

Tashakkori, A., & Teddlie, C. (2003). *Handbook of mixed methods in social and behavioural research*. Thousand Oaks, CA: Sage.

Tawalbeh, L. I., & Ahmad, M. M. (2013). Personal Resource Questionnaire: A systematic review. *Journal of Nursing Research, 21*(3), 170–177.

Thoits, P. A. (1995). Stress, coping, and social support processes: Where are we? What next? *Journal of Health and Social Behavior, 35,* 53–79.

Warner, F. R. (2007). Social support and distress among Q'eqchi refugee women in Maya Tecun, Mexico. *Medical Anthropology Quarterly, 21*(2), 193–217.

Weinert, C. (2003). Measuring social support: PRQ2000. In O. Strickland & C. Dilorio (Eds.), *Measurement of nursing outcomes,* Vol. 3: *Self-care and coping* (pp. 161–172). New York: Springer.

Wilson, D., Cutts, J., Lees, I., Mapungwana, S., & Maunganidze, L. (1992). Psychometric properties of the Revised UCLA Loneliness Scale and two short-form measures of loneliness in Zimbabwe. *Journal of Personality Assessment, 59*(1), 72–81.

Wu, Z., & Hart, R. (2002). Social and health factors associated with support among elderly immigrants in Canada. *Research on Aging, 24*(4), 391–412.

Miriam Stewart, RN, PhD, FCAHS, FRSC, is Professor, Faculty of Nursing, University of Alberta, Edmonton, Canada. Edward Makwarimba, PhD, MA, MSc, is Senior Research and Evaluation Consultant, Research and Evaluation, Alberta Health Services, Calgary. Nicole L. Letourneau, RN, PhD, FCAHS, is Professor, Faculties of Nursing and Medicine, University of Calgary, and Palix (formerly Norlien)/ACHR Chair in Parent–Infant Mental Health, Alberta Children's Hospital Research Institute for Child and Maternal Health. Kaysi Eastlick Kushner, RN, PhD, is Professor, Faculty of Nursing, University of Alberta. Denise L. Spitzer, PhD, is Associate Professor, Institute of Feminist and Gender Studies, University of Ottawa, Ontario, Canada. Cindy-Lee Dennis, PhD, MScN, is Professor, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, Ontario. Edward Shizha, PhD, is Associate Professor, Society, Culture and Environment and Youth and Children's Studies, Wilfrid Laurier University, Brantford, Ontario.