Child Immigrant Post-Migration Mental Health: A Qualitative Inquiry into Caregivers' Perspectives

by

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Abstract

Middle Eastern caregivers believe their children experience mental health decline due to isolation and loneliness that they experience after migration. This study qualitatively explored the perceptions of six Middle Eastern immigrant caregivers about their children's post-migration mental health. A qualitative descriptive design was used with a constructivist approach to data analysis. Results suggest that children's experiences with family separation, exposure to racism at school, and parents' change in marital status contributed to children's loneliness and isolation. In addition, children's isolation and loneliness were magnified when caregivers had limited access to resources like income to support their children's transition into Canada. Nonetheless, caregivers identified social support as an asset to their families' mental health. This research highlights the importance of culturally responsive programs and policies in the health, employment, and education systems that provide the necessary resources for immigrant families to support their children's mental health after migration.

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Chapter 1: Introduction

The number of immigrant children from the Middle East in Canada is increasing; it is well documented that Middle Eastern immigrants in Canada experience more health issues after immigration compared to other ethnicities (Ng & Zhang, 2020). With the increase in Middle Eastern immigrant children in Canada, there is a need to understand how these children's mental health is impacted by their caregivers' post-migration experiences. This chapter begins by exploring immigrants' overall mental health status post-migration, immigrant children's mental health, and the need for this study. Then, I continue identifying how caregivers' post-migration challenges impact their children's health. Next, I explain the purpose of this study by providing a brief overview of the planned research methodology and presenting the research questions. Finally, this section concludes by indicating the study's significance and explaining my interest in the topic.

The Issue: Immigrants' Health Status Post-Migration

According to Statistic Canada, 21% of Canada's population consists of immigrants which is the highest rate of immigrants in the past few years (Statistic Canada, 2017). Recently, most immigrants migrating to Canada are from Asia, including the Middle East (Statistic Canada, 2017). Immigrants have tended to live in metropolitan cities like Toronto, Vancouver, and Calgary; however, in recent years, there has been an increase in the number of immigrants that have chosen to live in Atlantic Canada, including those from the Middle East (Statistic Canada, 2017). According to several studies, non-refugee immigrants, who account for 71% of the whole immigrant population, have experienced mental and physical health declines post-migration (Hyman, 2004; Khanlou, 2010; Robert & Gilkinson, 2012; Statistic Canada, 2017; Ng & Zhang, 2020).

This concept is called the healthy immigrant effect. According to this notion, it is found that immigrants in Canada arrive with better overall health compared to Canadian-born populations; however, immigrants' health tends to decline and become closer to the native-born population by longer duration of stay (Ali, 2002; Hyman, 2004; McDonald & Kennedy, 2004; De Maio & Kemp, 2010; Robert & Gilkinson, 2012; Lu & Ng, 2019; Ng & Zhang, 2020). For example, Ng and Zhang (2020) observed that immigrants who migrated to Canada for more than ten years reported poorer mental health compared to those who migrated for less than ten years. Most research on immigrants' mental health has been on youth and adults, although some researchers in Canada like Patterson et al. (2013), Islam (2015), and Yang (2019) claimed that migration during childhood was associated with more mental health issues, when compared to migration in adolescence or adulthood.

According to Bronfenbrenner and Evan (2000), children's experiences, interactions, and exposure to various events shape their growth and development. One of the main domains that these experiences take place is through the caregiver-child interactions (Bronfenbrenner & Evan, 2000). Immigrant children's mental health may be negatively influenced by the experiences of their caregivers with migration-related stressors. Unemployment, lack of social networks, language and cultural differences within healthcare services, and mental health decline are some of the issues faced by immigrants (Khanlou, 2010; Long, 2010; Klassen et al., 2012; Salami et al., 2019; Salami et al., 2020). For example, Salami et al. (2019) documented that African immigrant caregivers in Alberta felt inadequate in meeting their children's needs due to their unemployment, one of the main challenges of immigrant populations in Canada (Khanlou, 2010; Choi et al., Salami

et al., 2019; Salami et al., 2020). Strengths-based interventions that promote resilience among immigrant children have been found to positively contribute to their psychosocial development after migration (Crooks et al, 2020).

Immigrant Caregivers' Post-Migration Experiences

Many immigrants' post-migration challenges are related to structural discrimination. Structural discrimination like difficulty accessing employment and health care utilization impact immigrant caregivers' and their children's mental health (DeMaio & Kemp, 2010; Khanlou, 2010; Long, 2010; Salami, Salma, & Hegadoren, 2019). Language and cultural differences, lack of recognition of immigrants' previous education and training, and discriminatory hiring requirements were some of the barriers that immigrants from non-English speaking countries have been reported to experience when seeking employment (Khanlou, 2010; Choi et al., 2014; Rezazadeh & Hoover, 2018). Lack of access to employment has also led to economic challenges restricting immigrant's budgets to afford transportation, medication, dental and eye insurance, and counselling (Khanlou, 2010; Long, 2010; De Maio & Kemp, 2010; Salami et al., 2019; Statistic Canada, 2021).

Additionally, some researchers have found that barriers to accessing employment restricted immigrants' social networks and integration process in their host country, which may be related to isolation, confidence, and self-worth (Klassen et al., 2012; Choi et al., 2014; Dastjerdi & Mukherji, 2015). Caregivers' socio-economic situation is also related to children's mental health. This relationship could be because income and social networks are necessary resources for health which are provided by caregivers to the children (Link & Phelan, 1995; Jung & Zhang, 2016; Yang, 2019). Other researchers observed that

language differences, cultural barriers, and a lack of diversity among health providers led to immigrants' low utilization of health services, which negatively impacts immigrant caregivers' and their children's mental health (Khanlou, 2010; Long, 2010; Klassen et al., 2012; Salami et al., 2019). For example, mental health providers in Canada explained that some immigrants' low service utilization could be related to the different cultural views of mental health compared to the Canadian setting (Salami et al., 2019).

Caregivers' mental well-being is another factor that may impact children's mental health. Caregivers' poor mental health, which is a type of adverse childhood experience (ACE), may lead to children's experience with helplessness, depression, and anxiety (Flouri & Kallis, 2011; McLaughlin et al., 2012). ACE is defined as childhood exposure to events such as neglect, chronic stress, and parental depression (Boivin, 2012). The existence of depression symptoms among caregivers decreases the family warmth, quality of parenting, and may lead to child neglect (Levendosky et al., 2003; Owen, Thompson, & Kaslow, 2006). For example, Hamilton et al. (2010) and Jung and Zhang (2014) observed that immigrant children's anxiety level was positively correlated with the depression level of their parents.

Purpose and Overview

The purpose of this study was to explore the perspective of immigrant caregivers in Atlantic Canada regarding the impact of their post-migration experiences on their children's mental health. This study documented the voices of six non-refugee, Middle Eastern caregivers who have a **child(ren)** under the age of 18, migrated directly to Atlantic Canada when their child was under the age of 11, and have been there for at least three years. I documented the voices of caregivers as they have direct impact on children's

growth and development. To address the purpose of this study, the following research questions were explored:

1) How do immigrant caregivers conceptualize mental health based on their culture?
2) How do immigrant caregivers perceive their children's mental health post-migration?
3) What are some caregivers' post-migration experiences that they perceive to influence their children's mental health?

This research employed a constructivist paradigm, which values participants' voices, and experiences (Allen et al., 1986; Wahyuni, 2012). According to this worldview, there is no single reality or truth to describe a phenomenon (Wahyuni, 2012). Qualitative description was the strategy of inquiry. This strategy enables the researcher to investigate an understudied issue to gain knowledge of participants' experiences in relation to a specific phenomenon (Sandelowski, 2000). For this study, the interviewees had different levels of English proficiency. Therefore, the qualitative description was a good fit as it offers a summary of events close to the words spoken by the participants and includes less interpretation than other qualitative methods.

Key Terms

This research will focus on **non-refugee immigrants** who legally reside in Canada. In this study, non-refugee immigrants are considered individuals who legally migrated by choice and hold permanent residency or citizenship status (Government of Canada, 2019) Caregiver refers to an individual who provides direct care to someone ("Caregiver," n.d., para.1). For this study, a caregiver is considered an individual who has a parenting role to a child.

Mental health is the central concept in this study. According to the World Health Organization (WHO), mental health is defined as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (para 1). The definition of mental health varies among researchers; some researchers explored mental health by referring to one's emotions like the presence of depression and anxiety while others focused on behaviours like smoking and drug use (Hamilton et al., 2011; Huang et al., 2012; Patterson et al., 2013l Islam, 2015; Yang, 2019). As an Iranian immigrant, I believe mental health is a culturally constructed term, and for me it includes the individual's physical, spiritual, emotional, and social health, or as we say in Farsi, Salamat e rooh va ravan. This study recruited from a diverse population of immigrants. Therefore, the definition of mental health for this study was decided to be broad and included emotional, mental, spiritual, cultural, and social wellbeing.

The Middle East is loosely defined as a geographic area that includes countries located from Northeast Africa to Southwest Asia. Some of these countries are Iran, Israel, Gaza, Jordan, Turkey, Yemen, Qatar, Bahrain, Lebanon, Oman, Saudi Arabia, Syria, Bahrain, Iraq, and Egypt (Chen, 2020).

Atlantic Canada includes the provinces of Nova Scotia, New Brunswick, Prince Edward Island (PEI), and Newfoundland and Labrador (Government of Canada, 2019). The majority of immigrants in Atlantic Canada have been settled in Nova Scotia, New Brunswick, and PEI respectively (Statistic Canada, 2016).

Significance

There are some studies that have investigated adult and children immigrants'

mental health after immigration (De Maio & Kemp, 2010; Robert & Gilkinson, 2012; Patterson et al., 2013; Islam, 2015; Yang, 2019; Ng & Zhang, 2020). This study was important as it specifically explored Middle Eastern immigrant children's mental health in Atlantic Canada from their caregivers' perspective; to my knowledge a very few research studies dedicated their work to this population (Byers & Tastsoglou, 2008; Nyika et al, 2017). In addition, many studies that investigated immigrants' post-migration health were quantitative, and the voices of immigrants themselves were missing (Robert & Gilkinson, 2012; Lu & Ng, 2019; Ng & Zhang, 2020). Finally, most of the studies that investigated mental health outcomes among immigrants used clinical diagnoses or Western definitions of mental health, rather than focusing on how immigrant populations conceptualize their own mental health. Therefore, this research documented the voices of the Middle Eastern immigrant caregivers in Atlantic Canada using a qualitative approach.

Canada's Mental Health Strategy encourages further research regarding the mental health of populations with diverse backgrounds (Mental Health Commission of Canada, 2012; Gagné, Janus, Milbrath, Gadermann, & Guhn, 2018). This study was significant as it provided insight into immigrant children's mental health as perceived by their caregivers. Consequently, the results might inform organizations and programs that offer resources to immigrant populations. The results may encourage service providers to offer targeted, culturally appropriate, and accessible support to immigrant caregivers influencing children's post-migration mental health. Finally, the results may raise awareness regarding discriminatory policies and practices within different sectors such as employment and health systems that relate with immigrants' health.

Researcher's Interest in the Topic

I chose to explore immigrant children's mental health due to my background education and work experience with newcomer children. During my yearlong work as an early childhood educator, I had the privilege to work with immigrant families and their young children. I observed young immigrant children's development in a Canadian context and saw their resiliency and efforts to communicate and fit in with their classmates. I also witnessed their frustration and non-stop crying as they could not communicate their needs to their educators and connect with their peers. I also heard families' concerns and challenges as immigrant parents raising a children in new and unfamiliar environments without even having fluency in English. Observing the experiences of immigrant families and their children encouraged me to pursue my education in Child and Youth Study at Mount Saint Vincent University to learn how to support the development of young children with diverse backgrounds.

During my undergraduate degree, I became involved in a study that aimed to understand how immigrant families find and use services for their young children. This project gave me a more in-depth understanding of various immigrants and their unique day-to-day challenges in supporting their children's transition into Canada. After graduating from Mount Saint Vincent University, I decided to continue my education in Health Promotion program to identify structural barriers that influence young children's development, especially their mental health. Through my research, I hope to become a voice for immigrant children and advocate for those dealing with health and education inequities.

Summary

More research is needed to investigate the mental health experiences of immigrant

children migrating from Middle Eastern countries to Atlantic Canada. This chapter began by describing the health status of immigrant adults and children after immigration. Then, it continued discussing some potential challenges that this group face including, language barriers, finding employment, and low healthcare use. Next, the chapter explained the purpose of the study, provided a brief overview, and included the research questions. Finally, this chapter was concluded by stating the significance study and how this research will provide more information on how to best support immigrant families and their children.

Chapter 2: Literature Review

Immigrant children experience more mental health issues than their native-born counterparts and other age groups of immigrants (Patterson et al., 2013; Islam, 2015; Yang, 2019). In recent years, most immigrants, including children, are migrating from the Middle East to Canada (Statistic Canada, 2017). Some researchers suggest that immigrants from the Middle East experience more health decline post-migration than other immigrant groups (Robert & Gilkinson, 2012; Ng & Zhang, 2020). The Middle East region includes countries such as Iran, Gaza, Israel, Jordan, Turkey, Lebanon, Oman, Saudi Arabia, Syria, Bahrain, Iraq, and Egypt (Chen, 2020). Immigrant children's health and development are dependent on their caregivers' health, experiences, and resources (Bronfenbrenner & Evans, 2000). Research suggests that immigrants face challenges such as structural discrimination in access to employment and health services, which may negatively impact children's mental health (Hamilton et al., 2011; Yang, 2019). This literature review summarizes and critiques the research exploring the impact of immigrant caregivers' post-migration experiences on their children's mental health (McDonald & Kennedy, 2004; Khanlou, 2010; DeMaio & Kemp, 2010). This chapter begins by presenting immigration statistics and patterns in recent years. Then, the chapter discusses the available literature on the impact of migration during childhood and immigrant children's mental health. Next, it explores caregivers' experiences with structural discrimination, and it concludes by exploring the impact of caregivers' mental health on their children's mental health.

Immigration Patterns

According to the 2016 Census, Canada's immigration population has reached its highest rate in 2016 since its confederation; between 2011 and 2016, Canada became home

to 1,2012,075 permanent residents, which accounts for 3.5% of the total population (Statistic Canada, 2017). Permanent residents have permission to live in Canada and include both refugee and non-refugee immigrants (Government of Canada, 2019). Non-refugee immigrants are those who migrated by choice, whereas refugee immigrants are those who ran from their own country in seek of protection (Government of Canada, 2019). Non-refugee immigrants in Canada are divided into family-class immigrants, economic-class immigrants, and skilled worker immigrants. Family-class immigrants are newcomers who were sponsored by a Canadian citizen, or a permanent resident based on their relationship as a spouse, partner, parent, grandparent, or child (statistic Canada, 2019). Economic-class immigrants include those who are selected based on their ability to contribute to Canada's economy (statistic Canada, 2019). Skilled worker immigrants are those who are granted Canadian permanent residency if their foreign work experience was desired by Canadian immigration services (Government of Canada, 2021).

Based on the 2016 Census, most recent newcomers migrated from Asia (61.8%), which includes the Middle East, then Africa and Europe, respectively (Statistics Canada, 2017). Immigrants also have various spoken languages; the number of immigrants with English or French as a mother tongue decreased by 71.2% in the past 96 years (Statistic Canada, 2017). While many immigrants in Canada have settled in Toronto, Vancouver, and Calgary, the number of immigrants in Atlantic Canada also doubled in 2016 compared to the past 15 years, reaching 2.3% of the total immigrant population (Statistics Canada, 2017). With the increase in immigration among Middle Eastern immigrants in Atlantic Canada, there is a need to understand this population’s mental health post-migration.

Immigrants’ Health Status Post-Migration

Immigration procedures tend to favour non-refugee immigrants based on their education, job skills, income, and health (Hyman, 2004). Similarly, McDonald and Kennedy (2004), and Beiser (2005) suggested that in most cases, healthy and financially advantaged people are likely to be able to apply for immigration. As well, prior to migration, immigrants are subjected to health screening by Canadian authorities, facilitating the selection of healthy immigrants (McDonald & Kennedy, 2004). Despite efforts to select the healthiest, most educated, and skilled people, immigrants' overall health tends to decline with their duration of stay in Canada (Newbold & Danforth, 2003; McDonald & Kennedy, 2004; De Maio & Kemp, 2010; Hyman, 2004; Ali, 2002). This concept is referred to as the healthy immigrant effect.

Lu and Ng (2019) examined the healthy immigrant effect among immigrant adults in Canada. These researchers examined immigrants' non-life-threatening chronic diseases and self-rated health. Lu and Ng (2019) linked the data from the Canadian Community Health Survey (CCHS) and longitudinal Immigration Database (IMDB) from 2007 to 2014. They observed that those who had migrated for fewer than three years had lower rates of chronic conditions and higher self-rated health than those who migrated for more than four years (Lu & Ng, 2019). In another study, Newbold and Danforth (2003) compared immigrants' health status to the Canadian-born population and found that immigrants reported lower self-assessed health. The sample included immigrants aged 12 and older who settled in Canada. Newbold and Danforth (2003) also reported that the immigrants' self-assessed health was significantly lower than non-immigrants; 2.5% of immigrants reported poorer health status than the 1.6% Canadian-born population. Immigrants consist of a heterogeneous group and variables such as immigration status, duration of stay in

Canada, and country of origin may lead to their different health experiences post-migration (Khanlou, 2010).

Immigration Status

One of the primary factors influencing immigrant caregivers' and their children's health is their immigration status. Across immigrant categories, refugee immigrants and then skilled workers had the highest rates of stress and emotional problems (Robert & Gilkinson, 2012). According to various studies, refugees may arrive with poor health conditions in Canada due to their experiences of traumatic events such as war, violence, or the death of a family member; also, their health may be compromised as many refugees lived in poor-condition camps prior to arriving in Canada (Fenta et al., 2004; Khanlou, 2010; Hadfield, Ostrowski, Ungar, 2017; Ng & Zhang, 2020). In contrast to Robert and Gilkinson (2012), Ng and Zhang (2020) confirmed that family-class immigrants reported poorer mental health compared to other non-refugee immigrant groups (Ng & Zhang, 2020). Country of origin is another factor that influences immigrant caregivers and their children's health status post-migration.

Country of Origin

Country of birth is important as it is related to people's culture and language which shapes their post-migration experiences. For example, some researchers found that immigrants from non-English speaking countries experienced poorer health conditions due to their unfamiliarity with the English language, Canadian culture, and its health care system compared to immigrants from countries such as the United States, UK, Ireland, and Australia (McDonald & Kennedy, 2004, Choi et al., 2014). McDonald and Kennedy (2004) also found that immigrants from non-English speaking countries (continental Europe and

Asia) experienced more prevalence of asthma, back pain, high blood pressure, and ulcers after their immigration than those from English-speaking countries. Similarly, Robert and Gilkinson (2012) found that immigrants from Africa and the Middle East, followed by Asian and Pacific immigrants, had the highest rate of self-reported stress levels and emotional problems; but immigrants from North America, UK, and western Europe had the lowest rate of mental health issues. Similarly, Ng and Zhang (2020) found that newcomers from the Middle East and Asia informed the lowest self-reported mental health. As observed, most researchers agreed that immigrants from the Middle East experienced poorer mental health compared to other ethnicities (Robert & Gilkinson, 2012; Ng & Zhang, 2020).

Duration of Stay

Researchers have agreed that there are differences in immigrants' health status based on the number of years that they have been residing in Canada, however, there are inconsistencies in the literature on the duration of stay that impacts immigrant health (Newbold & Danforth, 2003; De Maio & Kemp, 2004; Khanlou, 2010; Lu & Ng, 2019). For example, Newbold and Danforth (2003) observed poorer health status among those immigrants who have been in Canada more than ten years. In contrast to Newbold and Danforth (2003), Lu and Ng (2019) observed poor health conditions for immigrants who migrated between four to nine years concerning chronic conditions and self-rated health.

Immigrants' Post-Migration Mental Health

Though mental health remains understudied among immigrant populations, in recent years more attention has been given to this topic. Like physical health, researchers suggest that immigrants' mental health tends to decline as they identified immigration and

settlement as stressful events (De Maio & Kemp, 2010; Khanlou, 2010; Robert & Gilkinson, 2012; Ng & Zhang, 2020). Robert and Gilkinson (2012), and De Maio and Kemp (2010) found that immigrants' emotional problems and stress levels increased from 5% to 30% in two years after migration. Ali (2002) also described higher rate of depression among those immigrants who have been in Canada between 10 to 15 years compared to those who have been in Canada for four years. More recently, Ng and Zhang (2020) also observed that recent immigrants who migrated fewer than ten years had better self-reported mental health compared to those who have been migrated for more than ten years. It seems researchers agree that immigrants experience mental health disparities as they continue to live in Canada.

Most of the available literature on immigrants' mental health has been on adults and less attention has been given to those who migrated during childhood even though the number of immigrant children in Canada is increasing. Based on the 2016 Census, two out of five Canadian children were foreign-born or had at least one foreign-born parent (Statistic Canada, 2017). Further, the number of immigrant children from the Middle East is also increasing; 74% of immigrant children under the age of 15 are from non-English speaking countries like Asia, including the Middle East (Statistic Canada, 2017). This chapter will continue by explaining the influence of migration on children's mental health.

Immigrant Children's Mental Health

Some researchers have suggested that immigrant children experienced more mental health issues after migration than the native-born population and immigrants from other age groups (Huang et al., 2012; Patterson et al., 2013; Islam, 2015; Yang, 2019). For example, Huang et al. (2012) compared the mental health of Asian immigrant children to

their US-born White counterparts. These researchers measured children's mental health by analyzing self-control, interpersonal relationships, and externalizing and internalizing problems reported by their parents. Based on the parents' report, Huang et al. (2012) found that immigrant children had more externalizing problems (like aggressive behaviours), more internalizing problems (like social withdrawal), and fewer interpersonal relationships than the native-born children. While this study provided insight into immigrant children's mental health, the mental health measurements for this study may be designed based on Chinese cultural definitions which may not be relevant when studying Middle Eastern immigrant children's mental health. Also, the mentioned research was conducted in the United States, which has different policies and practices toward immigrants compared to Canada.

Patterson et al. (2013), Islam (2015), and Yang (2019) observed that among all age groups, child immigrants experienced poorer mental health. According to the allostatic load, environmental stressors change children's stress response pathways influencing their health and development over their lifespan (Seeman et al., 1997; Berg et al., 2017). Allostatic load in this context is described as prolonged exposure to environmental stressors due to post-migration experiences, negatively impacts children (Seeman et al., 1997; Berg et al., 2017). Though previous researchers agreed that childhood migration is related to poor mental health, there were inconsistencies in the literature in terms of childhood age groups (Patterson et al., 2013; Islam 2015; & Yang, 2019). For example, Patterson et al. (2013) compared the prevalence of mood disorders, anxiety disorders, and substance use disorders among three groups of immigrants, including those who migrated before the age of 6, between 6-17, and above the age of 18. Patterson et al. (2013) found

that among all the age groups, the prevalence of mood disorders and anxiety disorders was higher among those who migrated before the age of six. Islam (2015) also found that the prevalence of mood disorders was significantly higher among immigrants who migrated below the age of 18.

Though the reviewed studies provide insight into immigrant children's mental health, several gaps have been identified in the literature. First, most research on immigrant children's mental health has been conducted using quantitative surveys (Patterson et al., 2013; Isalm, 2015; Yang, 2019). Even though quantitative studies provide general information on a topic, they do not speak to the complexity of multiple perspectives (Creswell, 2018). Qualitative research focuses on learning the meaning that participants have about phenomena while creating enough flexibility for participants to explain their reality in the context of their cultural backgrounds (Creswell, 2018). A survey from these studies mentioned above did not consider cultural and age differences in understanding some terms such as mental health and well-being; also, it might have not captured different perspectives based on people's various ethnicities.

Second, most of the studies that measured immigrant children's mental health were either based on clinical diagnosis or used mental health measurements that were developed by researchers and lacked immigrants' voice and their perceptions of mental health. For example, Yang (2019) looked at drug use behaviour and Islam (2015) focused on smoking status for those who migrated during adulthood compared to those who migrated in their childhood. Further, Patterson et al. (2013) and Islam (2015) measured children's mental health based on clinical diagnosis of mood disorders or substance use disorders which might not reflect on how mental health is conceptualized in different cultures. Hence, to

address these gaps, I will use qualitative methodology to collect more in-depth information about children's mental health based on their caregivers' perceptions and experiences.

Caregivers' Post-Migration Experiences and Children's Mental Health

Children's development is influenced by their interaction with the environment and experiences, while caregivers are one of the important factors that shape these experiences (Bronfenbrenner & Evans, 2000). In the context of migration, immigrant caregivers face migration-related stressors that influence their ability to provide necessary resources for their children's health and impact the quality of their interaction with their children (McDonald & Kennedy, 2004; Khanlou, 2010; Choi et al, 2014; Salami et al., 2019). In the next few sections, caregivers' post-migration experiences with structural discrimination in employment and health systems, two critical factors influencing children's mental health, will be discussed.

Caregivers' Experiences with Structural Discrimination

Many researchers discussed racism as a fundamental cause of health disparities (Etowa et al., 2007; Xanthos et al., 2010; Siddiqi et al., 2017). Racism limits access to resources such as employment and income necessary for maintaining health (Etowa et al., 2007; Xanthos et al., 2010; Siddiqi et al., 2017). People who encounter racism are less willing to seek support for their health due to discriminatory practices in the health system (Etowa et al., 2007; Xanthos et al., 2010). Siddiqi et al. (2017), Xanthos et al. (2010), and Etowa et al. (2007) suggest that racism increases the psychological distress influencing people's mental and physical health. Immigrants may experience discrimination based on their skin colour, accent, and cultural differences (Khanlou, 2010). Among immigrant populations, exposure to discrimination has also found to have a relation to poor mental

health (De Maio & Kemp, 2010; Khanlou, 2010; Mckenzie, 2009).

Significant research has focused on interpersonal discrimination and its influence on marginalized populations' health; however, the impact of structural racism on wellbeing remains understudied (Baily et al., 2017). Immigrants face structural discrimination, which refers to embedded discriminatory policies and practices in the society that restrict access to resources such as income and social networks, both critical for maintaining health (Stuber et al., 2008; De Maio & Kemp, 2010; Khanlou, 2010; Long, 2010; Salami et al., 2019; Link & Phelan, 1995). Currently, public and private sectors' policies are set against a backdrop of racism; policies favour White people and exclude equity-deserving groups from having the same rights to access resources such as employment, social network, and health care (Etowa et al., 2007; Xanthos et al., 2010; Siddiqi et al., 2017).

Current policies lack diversity and include discriminatory practices giving power and privilege to White people (Baily et al., 2017; Rezazadeh & Hoover, 2018). For example, many employers in Canada prefer to hire employees who have a degree or certificate from a Canadian institution, and employers often do not recognize immigrants' education and training from their home country (Choi et al., 2014; Rezazadeh & Hoover, 2018; Salami et al., 2019). Further, many employers hire people who can communicate in English, though 6% of Canada's population do not communicate in English or French (Choi et al., 2014; Statistic Canada, 2017; Government of Canada, 2018; Rezazadeh & Hoover, 2018). The next sections will discuss how immigrants' experiences with employment and health services impact their children's mental health.

Structural Discrimination and Employment. Income, unemployment, and underemployment, which are all significant determinants of health, have been identified

by many researchers as a primary challenge of immigrants' post-migration that directly influences mental health (Link & Phelan, 1995; Adler & Rehkopf, 2008; DeMaio & Kemp, 2010; Khanlou, 2010; Long, 2010; Salami et al., 2019). While immigrants in Canada have access to universal health care, lack of income may restrict their budget for transportation, dental and eye exams or insurance, medication, and mental health services (De Maio & Kemp, 2010; Khanlou, 2010; Long, 2010; Salami et al., 2019). Even though in 2020 the employment gap for immigrant populations was decreased still more immigrants were unemployed compared to native-born Canadians (Statistic Canada, 2021). Immigrants who have been landed less than five years experienced a higher rate of unemployment than those who were in Canada longer (Statistic Canada, 2021). Therefore, one possible explanation for immigrants' post-migration health decline can be related to low employment rate and income.

Some researchers found that the exclusion of immigrants from accessing employment opportunities could be due to language differences. For example, Choi et al. (2014) conducted in-depth interviews with female Korean immigrants who resided in western Canada about their employment experiences. These researchers found that language differences were the first concern of participants in accessing employment. Similarly, Rezazadeh and Hoover (2018) found in their systematic review that non-English speaking immigrants had a harder time finding employment or were employed in low-paid occupations; these immigrants felt powerless and helpless in their workplace (Rezazadeh & Hoover, 2018).

Immigrants may also have difficulties accessing employment for reasons other than language. Islam et al. (2014) found that unemployment was a leading risk factor for anxiety

disorders among Southeast Asian immigrants in Canada for both first- and second-generation even though potentially Canadian-born immigrants would have better English proficiency. Wong et al. (2015) also identified hiring requirements such as Canadian work experiences and providing references as barriers to employment among non-English speaking immigrants. Additionally, some researchers observed that a lack of recognition of immigrants' credentials and training might lead to their unemployment or underemployment (Khanlou, 2010; Choi et al., 2014; Salami et al., 2020). These practices are discriminatory and act as barriers to opportunities for immigrant populations, which may explain their mental health decline after migration.

Though researchers suggest immigrants' mental health is related to their economic position, De Maio and Kemp (2010) found that economic indicators like household income were not significant predictors in self-report health status among immigrant populations. Similarly, Ali (2002) established that, though being employed was associated with a lower risk of depression, the odds of depression stayed the same between the immigrants and Canadian-born population when employment status was included. These observations demonstrate that economic difficulties may not be the only factor that influences immigrants' mental health. For example, some ethnicities such as immigrants from China and South Asia discussed language and cultural barriers within the health services as their main source of stress (Klassen et al., 2012).

There are inconsistencies in the literature about the relationship between immigrant families' socio-economic position and their children's mental health (Jung & Zhang, 2016; Yang, 2019). For children whose socio-economic position is dependent on their families, some researchers suggest that immigrant children's mental health is impacted by the

economic challenges experienced by their parents, while others suggest otherwise. For example, Salami et al. (2020) found that low socioeconomic status was one of the main concerns of African immigrant parents in Alberta, Canada. They found immigrants were most often hired for multiple minimum wage part-time jobs, limiting their capacity to care for their children (Salami et al., 2020). In contrast, when Elsayed et al. (2019) measured the relationship between Syrian refugee mothers' financial challenges and their children's emotional regulation, they did not find a significant relationship.

Immigrants also face family separation and loss of social networks, which influencse their mental health (McDonald & Kennedy, 2004; Khanlou, 2010; Choi et al., 2014). Social networks can promote health by increasing immigrants' self-esteem and filling the gaps of family separation (Bouchard & Gilbert, 2005). Employment opportunities are one of the ways that allow immigrants to build social networks in the host country (Moussa et al., 2015). Therefore, discrimination in their access to employment restricts non-English speaking immigrants' attempts to build social networks, which is also necessary for health (Link & Phelan, 1995; Adler & Rehkopf, 2008). For example, some researchers argued that language and cultural exclusion in employment negatively influenced immigrants' integration and acculturation process led to their isolation, low self-confidence, and self-worth (Choi et al., 2014; Dastjerdi & Mukherji, 2015; Rezazadeh & Hoover, 2018). As discussed previously, immigrants' poor mental health negatively influences their children (Boivin, 2012). Therefore, this study included exploration of how Middle Eastern immigrants in Atlantic Canada believed their social networks impact their families' mental health.

Structural Discrimination and Health Systems. Structural discrimination in the

health system, may explain immigrants' mental health decline post-migration, especially in the first few years following arrival (Khanlou, 2010; Long, 2010; Rezazadeh & Hoover, 2018). Structural discrimination within health services could take many forms. Cultural and language differences, and lack of diversity among health providers are some of the structural issues faced by immigrant populations (Khanlou, 2010; Long, 2010; Klassen et al., 2012; Salami et al., 2019). In the next few sections, I summarize the experiences of immigrant families with the Canadian health system.

Some researchers suggest that immigrants' cultural needs in terms of diagnosis or making decisions about their children's health were not met in health systems (Klassen et al., 2012; Salami et al., 2019). For example, in an interview with service providers in Alberta between 2016 and 2017, Salami et al. (2019) found that immigrants had especially low access to mental health services due to different cultural conceptualizations of mental health. Similarly, Klassen et al. (2012) found that cultural differences between parents and healthcare providers in disclosing children's diagnoses were the source of tension and stress among some immigrant parents. In this research, Chinese and South Asian immigrant parents in Canada felt that protecting children by not sharing their diagnosis with them was a culturally appropriate practice which conflicted with the age of consent in Canada and hospital rules (Canadian Institutes of Health Research et al., 1998; Klassen et al., 2012).

Language differences may also be related to immigrants' lack of access to health services (Khanlou, 2010; Long, 2010; Klassen et al., 2012; Salami et al, 2019). Chinese and South Asian parents discussed their difficulty understanding medical terminology and completing medical forms in English (Klassen et al., 2012; Salami et al, 2019). Also, due to a lack of English proficiency, these immigrants were not aware of available programs or

resources that could enhance their experience accessing health services (Klassen et al., 2012). Finally, a lack of cultural diversity among health providers was also identified as a barrier for immigrants' access to health services (Long, 2010; Robert & Gilkinson, 2012; Shakya et al., 2015; Salami et al., 2019). For example, in Alberta, mental health providers discussed how they felt unequipped to address mental health issues of immigrants (Salami et al., 2019). As mentioned, there is a gap in research about the experiences of health system utilization of the Middle Eastern caregivers in Atlantic Canada.

Access to Social Support for Immigrant Families

Literature suggests that access to social networks enhances immigrant families' mental health as social support facilitates their integration process in Canada (Khanlou, 2010; Immigration, 2015; Stirling Cameron et al., 2022). Some researchers suggest that the informal support that immigrant families receive from their social circles helps them to participate in the labour market while enhancing their social and cultural connections (Khanlou, 2010; Dastjerdi & Mardukhi, 2015; Immigration, 2015). Especially for immigrant women, social connections were critical as new friends provided emotional support after birth and cared for their children when they needed help (Stirling Cameron et al., 2022). For example, Syrian mothers in Nova Scotia appreciated their friends who provided child care, cleaned their house, and cooked them food after they gave birth (Stirling Cameron et al., 2022). In a scoping review, Brown et al. (2020) also argued that social networks help immigrant families to access necessary information about available programs for their children. The importance of access to social support is also essential for immigrant families as they prefer to live in metropolitan cities like Toronto which has more immigrant populations (Statistic Canada, 2017). Therefore, in this project, I explored the

experiences of immigrant families in Atlantic Canada, which has a smaller immigrant population, in accessing social support.

The COVID-19 pandemic was an additional barrier for immigrant families in Canada to access social support (Edmonds & Flahault, 2021; Stirling Cameron et al., 2021a). Limited access to social support exacerbated the loneliness and isolation these families were already feeling due to family separation and challenges navigating the Canadian systems (Stirling Cameron et al., 2021; LaRochelle-Côté & Uppal, n.d.). Immigrants' parents in Ontario also felt that their families were affected by a lack of social and cultural support during the COVID-19 pandemic isolation (Guruge et al., 2021).

Immigrant Caregivers' Mental Health

As discussed, many immigrant caregivers experienced mental health decline post-migration due to migration-related stressors such as lack of access to employment, low health system utilization, language and cultural barriers, and limited social networks (McDonald & Kennedy, 2004; De Maio & Kemp, 2010; Khanlou, 2010). Caregivers' poor mental health status, a type of adverse childhood experience (ACE), influences children's mental health. The exact definition of ACE varies among researchers, but overall, it is defined as childhood exposure to events such as violence, abuse, chronic stress, and parental depression (Boivin, 2012). Depression symptoms among caregivers can decrease family warmth, quality of parenting, and may lead to child neglect (Levendosky et al., 2003; Owen et al., 2006; Bogels et al., 2011). People exposed to ACEs might experience helplessness, depression, anxiety, and affective disorders in their adolescence or adulthood (Flouri & Kallis, 2011; McLaughlin, Green, Gruber, Sampson, Zaslavsky, & Kessler, 2012). Individuals who were exposed to ACEs feel less ability to predict or power to

change their future (Thompson, Wiley, Lewis, English, Dubowitz, & Litrownik, 2012). ACEs also disrupt emotional regulation skills during the sensitive period of childhood (Bucci, Marques, Oh, & Harris, 2016; Sonu, Post, & Feinglass, 2019).

Some researchers found significant relationships between immigrant caregivers' mental health and their children's mental health. For example, Hamilton et al. (2010) who investigated the relationship between parental depression levels and children's anxiety levels among Chinese, Korean, and Philippian parents reported that parental depression and family dysfunction, respectively, had the strongest influence on children's emotional distress. As it can be observed caregivers' mental health is a strong predictor of children's mental well-being (Levendosky et al., 2003; Owen et al., 2006; Hamilton et al., 2010; Bogels et al., 2011; Bovini, 2012). Despite the importance of this topic, less is known about how the Middle Eastern caregivers' mental health influenced their children's well-being, even though the immigrants from the Middle East experienced more mental health issues post-migration (Ng & Zhang, 2020).

Similarly, Jung and Zhang (2014) reported that parents' feelings about school were positively associated with immigrant children's overall development in the United States. These researchers analyzed data from New Immigrant Survey for new immigrant families with children and measured children's cognitive development (Jung & Zhang, 2014). Jung and Zhang (2014) reported that parents' involvement in school positively correlated with children's cognitive development. Similarly, Gee et al. (2012) explained that parental poor experiences of interpersonal discrimination may cause psychological distress among parents which may negatively influence their children's mental health. Even though there have been studies that investigated the relationship between immigrant caregivers' mental

health and their children, limited studies were conducted in Atlantic Canada with the non-refugee Middle Eastern population through the qualitative methodology to gain in-depth insight into their perception.

Summary

In summary, this chapter discussed immigrant health post-migration and explained the impact of migration during childhood on children's mental health. Also, this chapter presented the influences of structural discrimination in employment and healthcare access faced by immigrant caregivers on their children's mental health. In addition, the impact of caregivers' mental health on their children's mental health was explored.

Based on the reviewed literature, it can be concluded that immigrants' health status and their post-migration challenges are complex concepts that vary from one group of immigrants to another based on factors such as age, gender, country of origin, religion, race, and ethnicity (Khanlou, 2010; McDonald & Kennedy, 2004, & Yang, 2019). Most studies on this topic have been quantitative, and the voices of immigrants are missing. Even though quantitative studies are useful in terms of general knowledge they may not provide rich and in-depth information on an understudied topic like the Middle Eastern immigrant children's mental health. Further, most of the research, with some exceptions, has described and measured mental health based on the Western definition. Therefore, I chose a qualitative study, which allows a deeper and culturally sensitive investigation of caregivers' perceptions regarding their children's mental health.

Chapter 3: Methodology

This chapter includes the methodology and methods of this research that explored the perception of immigrant caregivers on their children's post-migration mental health. The chapter begins by introducing the study's conceptual framework, including the paradigm, (constructivism) and strategy of inquiry (qualitative description). The chapter continues to describe participants and recruitment. Then, the procedures for data collection, semi-structured interviews, and thematic analysis are explained. Next, this chapter reviews the steps I took to ensure quality and rigour. Finally, this chapter is concluded by explaining my positionality as a researcher within this project.

Conceptual Framework

Paradigm: Constructivism

This research took place in the constructivist paradigm. The constructivist ontology is relativism, meaning that there is no single truth or reality, but multiple (Allen et al.; Wahyni, 2012). According to this worldview, reality is constructed by social actors based on their differences in background and experiences; hence, social reality may change or have different implications based on who is describing it (Wahyuni, 2012). Therefore, constructivist researchers value participants' voices and unique realities (Weaver & Olsen, 2006; Benner, 1994). The epistemology of constructivism is subjective or intersubjective, meaning that findings are extracted from dialogue between participants and researchers (Guba & Lincoln, 1994; Weaver & Olsen, 2006; Wahyuni, 2012). Therefore, constructivist researchers engage in conversation with the participants to understand their social reality raised from their experiences.

Some research has employed constructivism for their work with immigrant

populations. For example, Shah et al. (2019) encompassed constructivist grounded theory to illustrate the perception of refugees regarding family separation and the impact of technology on their mental health in the United States. I believe the constructivist paradigm was also the best fit for my research about immigrant caregivers' perceptions regarding their children's mental health because each immigrant family has their own unique set of experiences before and after immigration that informs their reality and perception (Wahyuni, 2012; Allen et al., 1986). Therefore, constructivism allowed me to appreciate and document caregivers' voices and value their experiences (Benner, 1994; Weaver & Olsen, 2006).

Strategy of Inquiry: Qualitative Description

Qualitative description was the chosen strategy of inquiry for this research. Qualitative description is helpful for understudied research topics because it includes less philosophical interpretation of events. Qualitative description also presents findings in everyday language (Sandelowski, 2000). Therefore, this strategy offers a summary of events described by the participants; it includes less in-depth interpretation and stays closer to the data itself (Sandelowski, 2000; Sandelowski, 2010; Willis et al., 2016). Previously, researchers have used qualitative description to explore immigrant populations' mental health (McCann et al., 2018). McCann et al. (2018) used qualitative description to examine the experiences of African immigrants in Melbourne regarding mental illness stigma and help-seeking behaviour. They suggested that qualitative description enabled them to collect rich insight into an understudied topic relevant to their population (McCann et al., 2018).

I believe qualitative description was the best fit for my research study with immigrant caregivers for two main reasons. First, to my knowledge, there are not many

studies that investigated immigrant children's mental health post-migration from their caregivers' perspectives. Therefore, qualitative description, useful for emergent and understudied areas, was appropriate. Additionally, interviews were conducted in English, and participants had different levels of English proficiency; Qualitative description, which requires less in-depth interpretation, allowed me to present the findings closer to the words spoken by the participants (Sandelowski, 2000). Interviews were the data collection method, which aligns with both constructivism and qualitative description methodology and will be discussed in the following sections (Sandelowki, 2000; Wahyuni, 2012).

Population

This study recruited six Middle Eastern caregivers. The number of participants for this research was appropriate as the sample size of studies using qualitative design tends to be small to emphasize and understand each participant's unique experiences (Bradshaw et al., 2017). It is recommended that researchers include a tentative sample size in their proposal and then assesses the quality of their sample in answering the research questions (Fawcett & Garity, 2009; Bradshaw et al., 2017). For my study, I proposed to recruit five to eight immigrant caregivers. Other research like Dastjerdi and Mardukhi (2015) recruited eight Iranian female immigrants in Toronto, and Dhillion and Humble (2020) recruited five Punjabi women in Nova Scotia to explore the influence of social factors on these two populations' mental health. My study's recruitment process was concluded in consult with my supervisor and based on the richness of the interviews in answering the research questions (Fawcett & Garity, 2009; Bradshaw et al., 2017).

This study invited participants based on six inclusion criteria. First, participants must have migrated to Canada as legal non-refugee immigrants. To be a legal immigrant,

participants must have permanent residency or citizenship status. This study did not include other immigrants such as those with work visas or student visas as they have different experiences after immigration based on their immigration status. Second, participants must have directly migrated to Atlantic Canada and lived there for at least five years. Third, participants must have migrated from the Middle East region. Fourth, participants must have at least one child under the age of 11 at the time of migration. Fifth, this child must be under the age of 18 to reduce recall errors among the caregivers. Finally, this study only included participants who have conversational English proficiency,

Exclusion criteria. This study excluded refugee caregivers as this population has a unique set of pre-migration experiences compared to non-refugees (Fenta et al., 2004). Participants who were not originally from Middle Eastern countries were also excluded. Next, caregivers who currently had a child older than 18 and were older than 11 when migrated were excluded from this study. This study also excluded families who have migrated for less than five years and lived outside of Atlantic Canada. Finally, participants who did not have English proficiency for day-to-day conversation were excluded.

Recruitment. A broad range of methods was used to recruit participants. First, a recruitment email was sent to organizations that provide support to immigrant populations like ISANS, YMCA, and other similar organizations across Atlantic Canada. In addition, the recruitment poster was emailed to some Middle Eastern cultural communities and faith groups like Muslim, Christian, and Jewish communities across Atlantic Canada. I reached out to these organizations and communities via email, introducing myself and the project to see if they would distribute the recruitment poster among their clients and networks.

Also, I emailed academic programs and departments like the School of Health and Human Performance at Dalhousie, the Health Promotion program, the Faculty of Graduate Studies, and the Early Childhood Collaborative Research Centre at Mount Saint Vincent University to request that they post the recruitment poster on their social media. Further, the recruitment poster was posted on my Twitter account, and I tagged DalHealth, Dal_HAHP, DalGradStudies, ECCRC, and ISANS accounts. All my participants found about the study through settlement agencies and by word of mouth. Once the participants shared their interests, I offered them the option of phone interviews, online interviews through Microsoft Teams, and in-person interviews (if permitted by public health guidelines at the time of interview).

Informed Consent. Informed consent was conducted at the beginning of the interview session (Appendix F). Participants were emailed a copy of the consent form shortly after they scheduled an interview. Whether the participants chose a virtual or in-person interview session, a similar informed consent process was conducted. At the beginning of the interview, I read through the informed consent script, which included the study details, participant's role, risk and benefits, and significance. Participants were then asked to provide their verbal understanding of the study and whether they consent to participate. Then, in tracking sheet, I wrote down the participant's name, the date of the interview, and whether or not the participants provided their consent. The verbal informed consent eased the participants who joined the interviews virtually as they were not required to mail the signed informed consent paper back to me. In addition, this process to obtain consent is appropriate for the immigrant populations as signatures may mean something different to participants (TCPS2, 2018).

Data Collection

Semi-structured interview

Semi-structured interviews were the method of data collection. The semi-structured interview included a set of predetermined questions, but it also offered enough flexibility for interviewees to share their views about topics raised in the interview session (Wahyuni, 2012). Interviews are often the data collection method in qualitative studies because they involve communication between the researcher and the participants to understand peoples' real-life experiences (Wahyuni, 2012). Interviews as a data collection method is aligned with constructivism and qualitative description (Sandelowki, 2000; Wahyuni, 2012). In the constructivist worldview, meaning is established through researcher and participant interaction (Guba & Lincoln, 1994). Interviews are also a standard method of data collection in the qualitative description as they can provide insight about an understudied topic such as mental health in immigrant populations (Willis et al., 2016).

Previous research has used semi-structured interviews as the method of data collection with immigrant populations regarding their mental health (Shah et al., 2019; Ganann et al., 2020). For example, Shah et al. (2019) used interviews to document the perception of mental health and its relation to family separation among refugees in the United States. Ganann et al. (2020) also conducted face to face semi-structured interviews to document in-depth information about the experiences of immigrant women in Scarborough, Canada, about post-partum depression and access to care. The semi-structured interview was appropriate because my participants also had various pre- and post-migration experiences that influenced their perspectives on their children's mental health. Semi-structured interviews enabled the participants to elaborate or share their views

that were unique to their circumstances which might not have been reflected in the pre-determined research questions (please see the interview guide in Appendix H).

The interview guide included general questions about families' mental health after immigration and no specific question about families' experiences with mental illnesses were asked from the participants. In the interview session, I used predetermined questions such as "what does mental health mean to your family?", "how would you describe your child's mental health post-migration?", and "what are some factors impacting your child's mental health post-migration?" to document caregivers' perceptions (Wahyuni, 2012). Further, I had the flexibility to ask probing follow-up questions, such as "can you expand on that?" or "what do you mean by saying that?" to gain a better understanding of participants' views (Bryman, 2012). In addition to pre-determined questions, interviewees also had the freedom to discuss important issues which might not have been touched on directly in the interview guideline (Wahyuni, 2012). As the participants were required to have English proficiency for day-to-day conversation, all the interviews were conducted in English.

The participants had expressed interest in the study by contacting me through email or phone. Then the interview session was scheduled based on the availability of the participants. Five participants joined the interview session virtually, and one participant preferred to have an in-person interview. For the in-person interview, I booked a private room at a local public library. Each interview lasted 60-90 minutes, and with the participants' permission, was audio recorded. All participants were provided with a $15 honorarium via e-transfer.

Analysis

Data Management

The interviews were audio-recorded and transcribed verbatim by me using ExpressScribe software. All identifying information was removed, and pseudonyms were used to present participants' quotes. Transcripts were transferred to qualitative analysis software, MAX QDA, for data management, organization, and thematic analysis.

Data Analysis

Reflexive thematic analysis was used for data analysis (Wahyuni, 2012; Braun & Clarke, 2006; Braun & Clarke, 2021). In qualitative studies, data analysis involves dismantling and segmenting data to describe participants' perceptions and experiences about a phenomenon, while the research questions guide the process of cutting and recombining data (Wahyuni, 2012). Thematic analysis is a type of qualitative analysis that identifies trends and patterns within the data to portray the participants' realities.

Thematic analysis has also been previously used by research with immigrant populations. For example, McCann et al. (2018) followed Braun and Clarke's (2006) six-step thematic analysis to illustrate the lives of African migrants. Because previous research has utilized thematic analysis to portray immigrant populations' experiences, I used thematic analysis with my similar population. Thematic analysis was appropriate for my study as participants' perceptions varied based on their backgrounds, and I was interested in finding shared meanings of their experiences (Allen et al., 1996). Therefore, thematic analysis enabled me to develop themes that responded to my research purpose.

This research followed the step-by-step guide to reflexive thematic analysis developed by Braun and Clarke (2006, 2021). Even though in this thesis I explain the data analysis in steps the process of analyzing the data was iterative meaning that it was an

ongoing process, and I moved between and across the steps to develop themes that best describe my participants' stories. First, I familiarized myself with the data while I transcribed and de-identified the interviews. In addition, I read the interview transcripts multiple times while actively searching for meanings (Braun & Clarke, 2006). The goal of this step was to find shared experiences among the participants' stories and think of potential codes. In the second phase, I generated the codes using MAX QDA software. After familiarizing myself with the transcripts, I created a codebook which was produced through my engagement with data, reflection, and interpretation (Braun & Clarke, 2006; Braun & Clarke, 2021). Examples of codes were: caregivers' mental health post-migration, children's interaction with school teachers, children's connection with peers, children's experiences with family loss, and caregivers' employment difficulties. After coding the data, I re-focused the analysis at the broader level to generate themes (Braun & Clarke, 2006; Braun & Clarke, 2021). In this step, I focused on the relationships between codes to understand how they could combine to form themes that represent most of the data. The individual codes were collapsed together or contracted to generate themes (Braun & Clarke, 2021). For example, I decided to merge the two codes 'children's interaction with school teachers" and "children's connection with peers" as one theme that was named "exposure to racism at school led to immigrant children's isolation and exclusion" as both of these codes described the experiences of immigrant children in school (Braun & Clarke, 2006).

In the fourth phase, I reviewed the developed themes to decide if they needed to be merged with other themes or broken down into separate themes. For example, later I decided to add the code "children's experiences with family loss" to the theme "exposure

to racism at school led to immigrant children's isolation and exclusion" as they both described the reasons behind immigrant children's isolation after migration. Then, I defined and re-named this them in a way that I felt represented most data. For example, I decided to change the name of the theme "exposure to racism at school led to immigrant children's isolation and exclusion" to "parents feel their children are isolated and lonely after migration" for two reasons: It better represented the experiences of caregivers who described their children's experiences with loneliness after migration, and this name was closer to the words spoken by the participants.

As this research employed qualitative description, the codes and themes remained close to the data and the participants' words; however, some level of interpretation was required to understand the participants' perspectives. My subjectivity influenced the interpretation of data as an immigrant who have faced post-migration challenges, and as an educator who has witnessed immigrant children and caregivers' efforts in navigating life after migration. The theoretical framework, the constructivist paradigm, and my level of training and experience have also influenced my interpretation of codes and themes (Braun & Clarke, 2021). Coding and theming were an ongoing process as my insight changed through my understanding of data (Braun & Clarke, 2021). Finally, I produced a description of the findings which can be found in chapter four.

Ethical Considerations

Ethical approval was established through Dalhousie University Research Ethics Board. Several ethical considerations were considered for the study. During the interviews, participants were reminded that their participation was voluntary. The participants could leave the interview or skip any questions; however, all the participants completed their

interviews. Additionally, though the participants could withdraw their responses one week after the interviews, no one reached out for removing their data. Participants were also reminded of the procedures to protect their privacy and confidentiality. The audio files and transcripts were saved on a password-protected computer to ensure privacy. Then, interviews were deleted from the audio-recording device. Further, at the beginning of each interview, the researcher encouraged the participants not to use specific names to ensure confidentiality. All identifying information such as participants' names, children's names, and locations were removed from the transcripts and replaced with pseudonyms. The transcript files and informed consent tracking documents were securely stored on the Dalhousie OneDrive and shared only with the supervisor.

Quality and Rigour

Researchers consider credibility, transferability, dependability, and confirmability in qualitative studies to ensure quality (Wahyuni, 2012; Creswell, 2018). This research used the four methods mentioned above to ensure the quality of this research. Credibility considers the accuracy of the presented data regarding the observed phenomena (Wahyuni, 2012). Credibility helps the study measure what it intended to, and can be established by approaches including debriefing, member checking, and reflecting on researcher position (Wahyuni, 2012; Creswell, 2018). In this study, I had my supervisor review the codes and themes. In addition, I continuously reflected on my position which may have impacted the findings. Being an immigrant and having first-hand experiences with post-migration challenges I encountered participants who had strong feelings about their settlement journey. To ensure that I did not highlight and pay more attention to situations like my own experiences I was mindful of my interpretations of data. I practiced mindfulness by

thinking about stories that were shared with me and whether or not I faced those experiences first-hand. If I did not have similar experiences, I tried to recall stories and experiences that I heard from other immigrants or I read in the literature.

Transferability is the second method of ensuring rigour and trustworthiness in qualitative studies. As many researchers discussed, qualitative studies' findings are not reproducible, but this does not mean that the data from the qualitative studies cannot be applied to other settings (Wahyuni, 2012; Creswell, 2018). Transferability means that findings and practices from one study have the possibility of being transferred to another study in a similar field (Wahyuni, 2012). In the case of this research, I encouraged transferability by providing a rich and detailed description of the context in which the study was conducted.

Dependability is concerned with the consistency of the research process over time (Wahyuni, 2012). Dependability can be achieved by providing a detailed description of the research design and step by step explanation of the research process (Wahyuni, 2012). For this research, I provided a detailed research design stated in this chapter. Finally, the researcher encouraged confirmability to ensure the rigour of this project. Confirmability is concerned with the extent that which the findings reflect participants' experiences. Lincoln and Guba (1985) suggested journaling to ensure confirmability. In the case of this study, I used a reflexive journal throughout data collection and data analysis by documenting my reflections during and after interview sessions, coding, and theming analysis. For example, one of the participants cried during the interview, and I had the documentation of that in my journal; I noted the participant's feelings in the result chapter when I shared the participant's quotes on the topic that upset her.

Researcher's Positionality

I was an immigrant in my country even before I migrated to Canada. Immigration to Canada was in my families' planning since I was born, and all my education and upbringing were designed to prepare me for migration. Unfortunately, things on the other side of the world were not as magical as we pictured, and my preparations were not enough once the migration was granted. Cold winters, family separation, loss of social networks, loss of independence, language difficulties, cultural barriers, and being deprived of social interactions were the reality that I was not prepared for. After migration, I felt helpless and hopeless, especially when my family could not navigate the health, education, and employment systems here. Our situation here made me question how things could get better for all immigrants, especially those with children. My own experiences as an immigrant and as an early childhood educator who felt the experiences of immigrant mothers and saw immigrant children's effort to connect with others shaped my interpretation of the data and informed the reflexive thematic analysis of this research.

Summary

This chapter included the methodology and methods that were used for this research study. First, this chapter introduced constructivism and qualitative description as the research paradigm and strategy of inquiry. Next, this chapter continued explaining the research procedure, including the participants and recruitment process. Then, the data collection, semi-structured interviews, and data analysis (thematic analysis), were described in detail. Afterwards, this chapter listed approaches that were employed to ensure quality and ethical considerations. Finally, this chapter ended by explaining how my experiences as an immigrant researcher influenced the interpretation of data.

Chapter 4: Results

This chapter describes the themes developed through reflexive thematic analysis (Braun and Clarke 2006, 2021). It begins with a description of the participants and their characteristics. Prior to describing themes, this chapter summarizes how participants define mental health to understand how they perceive their children's mental health after migration. Three themes are identified as the product of my reflexive thematic analysis: parents feel their children are isolated and lonely after migration, caregivers' limited access to resources contributes to children's mental health; and connections with other immigrants enhance families' mental health. Each theme is organized into sub-headings to present the participants' experiences in a logical manner, and as there were not enough evidence to develop sub-themes.

Participants and Context

Six immigrant caregivers were recruited to participate in semi-structured interviews. Although it was not my intention to exclude participants based on gender, all caregivers in this study identify as mothers. All participants reside in Nova Scotia except for one who resides in New Brunswick. Three of the participants are Farsi speakers from Iran, and the other three are Arabic speakers from Libya, Palestine, and the United Arab Emirates. Two participants have one child, three have two children, and one has five children. Three participants have lived in Atlantic Canada for less than five years, two for seven years, and one participant has lived in this region for nine years. The ages of caregivers vary between 37 and 47 (M= 42; SD= 4.3). Each caregiver has a postsecondary degree from their home country; however, except for one, all participants worked or studied in a different field following migration. Pseudonyms were assigned to each participant to

present the quotes throughout this chapter. A summary of participants' characteristics is summarized in table 1. Quotes are presented verbatim, with minor edits for readability indicated by brackets. Further, the word "sic" in a bracket, [sic], is used within quotes, if participants' narratives did not follow the English grammar. The interviews were conducted in September 2021, during the COVID-19 pandemic. Though data collection occurred between waves and not during lock-down, there were significant concerns about increasing cases at the time, and the pandemic had caused disruption in children's schooling, challenges in accessing services, and isolation due to social distancing.

Table 1: Participants' Characteristics

Participant pseudonym	Age	Country of origin	First language	# of children	The age of child at the time of migration	Immigration status	# of years since migration	Province of stay
Sara*	47	Iran	Farsi	1	4	Citizen	9	NS
Farah*	37	Libya	Arabic	2	3.5	Citizen	7	NS
Aaliyah*	37	Palestine	Arabic	2	11	Citizen	3	NS
Tara*	45	Iran	Farsi	2	8	PR	6	NS
Aisha*	42	UAE	Arabic	5	5, 7, 9	PR	3	NB
Shima*	42	Iran	Farsi	1	1	Citizen	5	NS

Parents' Definition of Mental Health

To understand how participants from a variety of cultural backgrounds perceive their children's mental health post-migration, they were first asked about how they describe mental health. The participants did not provide a formal definition of mental health, but they did talk about the indicators of their mental status. First, it was clear that participants believe their mental well-being influences other aspects of their health including their physical and emotional health. More than half of the participants described a relationship

between their physical and mental health. Sara, who saw her physical health decline after immigration due to her stress said: *"When I came to Canada, I used just only half of the metformin [diabetes medication] but because of my stress, these medications increased around 2018 [when migrated]. I took twice as per day because of my stress."* Participants shared how their post-migration stress provoked physical health challenges, including hair loss, insomnia, diabetes, and weight loss. Farah believed that her stress led to sadness and loss of appetite, "*[after immigration], I get depression some day, so far I am always losing weight… I don't have any more appetite to eat*." Though the relationship between mental and physical health was discussed by some participants, all caregivers talked about their families' mental health in relation to feelings and emotions. They talked about their feelings of confusion, disappointment, exclusion, and low self-esteem while trying to address their families' post-migration challenges in Canada. Aliya recalled how disappointed she felt when she could not find employment, she said: *"[In my country] I worked in the neurological department, I was the manager there and I speak [different] languages but here I'm nobody like I am starting even from less than zero."* The participants described the relationship between their mental, physical, and emotional health as part of their definition of mental wellbeing.

All the participants also discussed a relationship between their environment and mental health. The participants shared their belief that their environment influences how they feel. The environment included their interactions with people and adjustments to life circumstances. For example, Aisha believes in the importance of supportive people and a positive environment for her mental wellbeing: "*The good environment indicates even the people around you: So when people around you understand you, helping you and*

supporting you." The importance of a healthy and supportive environment was indicated by all participants when discussing their mental health. For example, Farah considers an environment healthy when it is based on equity rather than equality. She shared:

> *"[Mental health for me] is the environment [where] people around me [are] supporting and understanding the different [sic], and [they] don't judge [but try] to understand you. So, we know here in Canada, we're always talking about to be equal, but at the same time, not just giving you and me the same things: understanding you . . . Understand your situation and then, depend[ing] on that, [providing support*]."

Participants agreed that when they live in an environment where differences are respected and they have what they need to care for their families, family mental health is stable. Participants placed a similar emphasis on the role of the environment in their children's mental health. Caregivers believed policies, communities, schools, teachers, peers, and caregivers have direct and indirect impacts on their children's mental health. The main issues identified by the participants about their children's mental health following immigration was children's experiences with loneliness, exclusion, and isolation. The following themes describe how participants understand their children's mental health after immigration.

Theme 1: Parents Feel Their Children Are Isolated and Lonely After Migration

The participants believed their children were isolated, excluded, and lonely after immigration. They described how factors, like children's experiences with family loss, exposure to racism, and parents' change in marital status contributed to their children's mental health challenges through feelings like isolation and loneliness. The following sections describe each of these experiences.

Children's Experiences with Family Loss Leads to Their Isolation and Loneliness

The participants thought that their children's isolation and loneliness was related to their loss of pre-migration connections with relatives who had held a significant role in their children's lives before migration. 'Family loss', in this context, means the loss of connections with family due to separation resulting from migration. More than half of the participants explained that their children were close to their grandparents, uncles, and aunts before migration. In addition, relatives provided the children with a sense of identity and belonging, which may have been challenged following separation. For example, Farah recalled how much her daughter missed her family back home:

> *"Since I came here, she's always asking me each year, 'I need to go back. I need to live there.' And, uh, from the beginning, she's all, she was crying. 'Why? When we are here in Canada, why you bring us here? Why didn't we then stay with my family? I need to enjoy, especially the good moment: it weddings or Eid and see all the kids and all the family gathering.' She's crying. She's lonely."*

According to these caregivers, their children have felt lonely in Canada due to missing out on spending time with family during cultural celebrations or participating in significant family gatherings, like birthdays and weddings.

Children's Experiences with Racism Leads to Their Isolation and Loneliness

Caregivers also expressed their belief that their children were lonely and felt excluded due to racism experienced at school. Half of the caregivers described that their children have faced discrimination that has provoked feelings of isolation and exclusion. Two participants shared that the teachers made false assumptions about their children's language ability, nationality, immigration status, and premigration education. For instance, Aaliyah recalled that her daughter's school thought that she was a Syrian refugee with no

education because she spoke Arabic. Thus, they placed her in a math class for lower grades. She recalled her feelings about visiting her daughter's school and speaking to her teacher:

> *"I was shocked, and I went to camp, I spoke to the counselor. I say, she got 17 because she's only one month here. And she has, she doesn't speak English, like what [do] they expect from her? And a lot of the math problems are word problems. And he was, oh my God? And I said, yes, like, what did you expect? My daughter is, she's a genius in math. She's good at math. I was angry."*

Sara also expressed that her son's first-grade teacher treated him unjustly when he received a poor grade on his assignment. Sara said that the teacher was unaware of her son's language proficiency; she shared, "*... Because English, uh, it was very new for him, for my son, and he misunderstand [sic] and this teacher wants [to] compare my son with the Canadian, but, maybe the teacher said do this activity, but my son didn't understand."* Farah also believed that her son faced physical abuse from his teacher because of his immigration status, Farah shared: *"my son didn't want to sleep, and I saw the director of the daycare sat on his back, I told her "what are you doing, are you doing the same for a Canadian kid? That affected my son."* These participants agreed that their children's exposure to racism led to experiences of stress, isolation, and loneliness.

Some of the parents also felt that other children at school also seemed hesitant to socialize with their children. Three participants shared that their children faced challenges building relationships at school due to language or cultural barriers upon arrival. For example, Aaliyah recalled how lonely her daughter felt at school when she could not connect with her peers. She shared:

> *"My daughter is very sociable and she's very . . . She wants to be engaged in everything. And she had higher expectations. She thought, once we come . . . when she comes here, she will be friends with everyone, no matter what their colour or background or race. But she felt that she was rejected because of the fact that her English was imperfect and she's an immigrant."*

Finding friends was also difficult for children with adequate English. Tara and Heba, who were confident in their children's English abilities, believed their children felt lonely when they arrived. Tara, whose child went to a bilingual school before migration and had no issue communicating in English, shared "*it wasn't easy to find friends […] It took her some time to find her place at school, but she's fine now."* Children who arrived very young also seemed to have difficulty building friendships. Shima, who came to Canada when her child was only one year old and learned to speak English by the time she started school, was upset that her child felt lonely; she said: *"[my child's] alone. Finding friend here is too hard. I cannot become so close to the Canadian because they don't want to be so close. I have to find somebody for her, and she's always coming to home and crying."* According to these participants, unfair treatment from teachers and difficulty developing friendships led to children's exclusion and loneliness.

Change in Caregiver Marital Status Contributes to Children's Isolation and Loneliness

Two participants who went through a separation after immigration believed their children experienced additional stress related to the change in parental marital status. Farah remembered how her child was affected by her separation from her husband, "*I separate with my ex-husband, that's affecting [my child] a lot. She's very sensitive about this… That's affecting her too much… she always [wants] to change her last name… it's bothering her."* Sara also discussed that her divorce complicated her relationship with his son. Sara shared that his son was angry at her once she "*applied for divorce*" and considered her "*guilty*" for their family's separation. These participants considered their separation as an additional factor that influenced their children's mental health post-migration.

Change in parent marital status also indirectly influenced their children's mental health as these mothers had fewer resources to support their transition. Participants who could share child-rearing responsibilities with partners and had mental, emotional, and financial support felt more able and confident in supporting their children's transition post-migration. For example, Aaliyah mentioned that she could not bear post-migration challenges if it wasn't for her partner. She shared the following:

> *"[after immigration] I was very anxious all the time. I couldn't sleep well. Um, um, I didn't want to go outside. The thing that helped me was my husband. My husband is an amazing person. Uh, he's very, um, easy going and relaxed and he's not, he doesn't get anxious easily. And he, he looks, he sees that, you know, when he thinks about the immigration, his vision is, uh, is different than mine and his existence in my existence, in my life helped me to survive [in Canada]."*

The two caregivers who were separated after immigration did not feel they could adequately support their children's transition as they felt lonely, tired, and financially unstable. For example, Sara felt that she did not have enough support from her ex-husband to go through the settlement journey. She said: *"I had challenge with the new culture, a challenge for my son,…. My ex-husband look[ed] he's beside me, but I didn't get enough support. I separate[d] two years ago, but actually in reality, I separated when I came to Canada."* Farah felt physically, emotionally, and financially exhausted because her spouse did not share any responsibilities toward her children since migration. Farah said: *"I can't do lots of things with my kids as a single immigrant mom, the income not high… every month I have to think about my money, how I'm going to separate for [different things] to make the life easy."* The caregivers who could share parenting responsibilities with their partners and had access to emotional support to navigate post-migration challenges seemed optimistic about supporting their children.

This theme described the perception of the participants on their children's mental health post-migration. All participants agreed that upon arrival their children felt excluded, isolated, and lonely after immigration due to direct negative experiences of family loss, exposure to racism at school, and parents' separation. These participants also acknowledged that their capacity to support their children's mental health upon arrival became limited as they faced many challenges to establish their families in Canada. The following two themes will explain factors that influenced the factors that impacted the caregivers' capacity to support their children's transition into Canada.

Theme 2: Caregivers' Limited Access to Resources Contributes to Children's Mental Health

All participants felt access to resources influenced their capacity to support their children's mental health after migration. Accessing income, the health system, and social networks were the primary resources discussed by these caregivers. Accessing social support as a necessary resource for families' mental health warrants its own theme as participants emphasized the critical role that their cultural network play in their families' settlement; this will be presented separately as Theme 3. The participants' stories on how they perceived the impacts of their challenges in finding income and using the health system on their children's mental health are discussed below.

Caregivers' Challenges in Securing Income

Participants believed their financial situation, directly and indirectly, influenced their ability to support their children's mental well-being. A small number of participants talked about the direct impact of their financial issues on their children's mental health. Two of the participants reported that their children either became anxious about their

family's financial difficulties or felt different than their peers because of families' low income. For example, Aliyah shared*: "[my child] is very concerned about our financials. So now [he keeps] asking questions about, 'Now you're going to go to school. How would we survive?' Uh, he knows that his dad works in part-time jobs."* Farah also explained that her child felt excluded and different from her peers because her family could not afford the fees for her to engage in activities and buy materials. She explained*, "[My child] is not finding herself like the other kids . . . Sometimes, she's asking for program that her friend go, and I can't offer that money. Sometimes she's crying, but what [should I] do*?" Other participants felt that their children were not directly impacted by their financial situation as these families either concealed their financial problems from their children or arrived with better financial conditions.

While only two participants discussed the direct impact of their finances on their children's mental wellbeing, most agreed on its indirect impact. The participants who thought their children needed emotional and mental assistance for transitioning into Canada believed that caregivers' stress and disappointment resulting from challenges in finding employment impacted their ability to support their children. For example, Aaliyah said she felt worthless and frustrated as she faced rejection from employers recalled how hard it was to support her children while being in a difficult emotional state. She shared:

> "*I remembered myself crying all the time. I wanted to go back. Um, it was really, really hard for me. And especially … at the same time, I have to [sic] care for my family and my kids who were new to the school, and they were facing many challenges there. And the system here just shocked me."*

Caregivers who faced mental health decline due to their financial challenges felt pressured to support their children's mental health during their transition into Canada.

Some participants were also physically unavailable to support their children as they had to either go to English classes or go back to school to find employment; four out of six participants decided to return to school to gain Canadian accreditation and access higher-paying jobs as their past trainings were not accepted in Canada. Gaining Canadian experience by continuing their education or participating in English classes was how some participants managed to overcome their employment issues. Nonetheless, some caregivers believed the time that they put to enhance their English language or continue their education took the time and energy that they could've spent with their children and to support their transition. For example, Shima who had to go back to school to re-certify her massage therapy certificate felt that she did not have enough time. Shima shared:

> *"The association asked for a Canadian certificate, so I go [sic] back to school and I was forced to leave my daughter with my mom, I was nervous, I had to study… and I couldn't spend much more time with my child, I couldn't enjoy my child."*

Addressing the barriers to finding income limited the physical and emotional capacity of the immigrant caregivers to support their children's mental health.

Some participants shared their main challenges in securing income: Language barriers and lack of recognition of past experiences. For example, Aliyah's partner, a pharmacist for 17 years and who graduated from a well-known university, decided to change his occupation and work as a delivery person as the English qualification exam was too hard to pass. Aliyah shared the following:

> *"[My husband] needed to get a seven in each branch and the English and the items in the academic one. And he just, he didn't do, he didn't do it. It just, he didn't want to go through all of it. And then he needed to do oral exams, which was a lot of money."*

Lack of recognition of past experiences was a common issue that most participants encountered. Shima and her family, who were granted immigration status because of their

education and employment credentials, felt deceived when neither she nor her partner could find employment with the accreditation that allowed them to migrate to Canada in the first place. Shima shared the following: *"before coming here, we sent our educational documents to Canada to be evaluated. And based on that [Immigration office] gave us maximum score and asked me to come, If you didn't want me, I [would have] never applied to come here."* From the participants' perspectives, challenges in finding income contributed to their children's mental health as it restricted families emotional, physical, and financial capacity to support their children's mental health.

Caregivers' Difficulty in Using the Canadian Health System

The caregivers' capacity to address their families' physical and mental health needs was another factor that contributed to their children's mental health. Difficulty in navigating the health system, long waitlists, and lack of diversity among health professionals were some of the participants' challenges in using the Canadian health system for their families. These challenges are discussed below.

Half of the participants specifically discussed their lack of awareness in navigating Canada's health system. Participants described how they did not know how to access family doctors or book appointments with specialists. For example, Aliyah mentioned that at the beginning she didn't know how to find health professionals to address her families' health needs. She said: "*I didn't know how to find the family doctor. Why do I need the family doctor? Um, what if I wanted to see a specialist? Uh, is there private medicine here?"* Long waitlists were another factor that led to families' low health system use. Shima, who has been on specialist waitlists for her and her daughter, felt disappointed that the accessibility of the health system was better in the Global South compared to Canada,

she said: "*Canada is a first world country. I cannot understand how the quality of the life is much higher in Iran, Oman, and Qatar. They have access to everything much more easily."* These participants shared that it took them some time to become aware of the available services and understand how the Canadian health system works.

Participants also mentioned a lack of diversity among health professionals in the Canadian health system as a barrier to addressing their families' health needs. Participants shared that their families had rarely encountered a health provider who spoke their language or understood their cultural background. For example, Tara recalled that, when she gave birth to her premature baby at a Nova Scotia hospital, she was not allowed to have her baby in her room, about which she felt "*unsatisfied*." She shared the following:

> *"My daughter was born with a [health issue]. I had some issue with the doctor because I, uh, wanted to breastfeed my daughter, and they were not allowing me, um, um. It wasn't a good experience I had so much stress. I asked them to bring the child to my room, [they didn't allow her] to stay with me, because I thought, if she was me and she was getting better sooner."*

Aliyah also felt that it would be helpful for her family to talk about their concerns and feelings with someone who knew their language and understood their cultural background. Overall, the participants believed lack of awareness of how to navigate the Canadian health system, long waitlists, and lack of representation among health care providers restricted their abilities to address their children and their own physical and mental needs.

Families' Difficulty in Accessing Counselling Services

All participants believed that mental health services like counselling should be offered by someone familiar with the patient's culture and language. For example, Sara, shared that her Canadian therapist did not know how to guide her to navigate her marital problems after immigration; she mentioned: *"[my therapist] tried to speak slowly and very*

clearly. Uh, but most of the time, uh, she was listening, and she didn't have any idea or suggestion, just listening." Aliyah also described her recognition of the value in therapy provided by someone familiar with their patient's language. She shared:

> *"When it comes to mental health, I feel that I need to talk to someone who speaks my native language and who understands where I'm coming from. Like, I've never thought about services here. Cause I know there's a, there is no one that I could talk to. Yeah. How could I express myself, my feelings, my mental health things in English."*

Sara and Shima, who saw value in counselling for their children, decided to connect with virtuak services from their home countries to address the lack of representation in the Canadian mental health system. For example, Sara stated: "*[my son] after my separation… spoke a bit [to] a counsellor in my country through online... because this counsellor already know about everything about us."* Participants agreed that counselling should be offered by someone who is familiar with patients' backgrounds.

Further, all participants raised concerns about high fees related to counselling. Farah said: *"[therapists are] very expensive. I can't afford it. So, I called and then I found it expensive. So, I said, no, it's too much on me."* Due to the fees associated with mental health services in Canada, more than half of the participants expressed that they would appreciate schools providing counselling services to immigrant children to support them in navigating their feelings after immigration. Such services could help in preparing for school and building relationships. Aliyah who could not afford the counselling services fees also wanted her daughter to meet with a therapist shared: *"mental health should be integrated into the care system, especially [for] kids, because I can't afford it."* Tara also agreed that such a role should exist in Canadian schools to support immigrant children:

> "*Yeah, maybe a person in the school should be there just to, to meet with them on a regular basis and then check about what they are missing and then correspond to the needs, to offer more, uh, services related to what the challenges they have."*

Participants saw value in counselling services for their and their children felt that lack of representation and high fees limited their access to these services.

Caregivers' Exposure to Overt Racism

Caregivers' exposure to overt racism at work or in their daily lives was another factor that influenced the capacity of caregivers to support their children's mental health after migration. Half the participants shared that their direct experiences with overt racism caused fear, stress, and anxiety. Two participants specifically mentioned racism in their workplaces led to their low self-esteem and provoked feelings of hopelessness. For example, Aliyah, who arrived in Canada with postsecondary education felt that her previous education and her own experiences as an immigrant in Canada, which potentially could've helped immigrant students at school, was not appreciated by the school counsellor. Aliyah said: *"There's a hierarchy here and when you are a support worker and you are an immigrant, you have a lot of experiences to help but because you are a support worker, you can't do… They don't consider me as valuable."* Moreover, Farah, who identified as an immigrant single mother, recalled that her director did not treat her equitably and was inconsiderate of her immigration status when asked her to work long shifts, she shared: *"sometimes they ask us to work late. I said: 'I can't, I have to take my kids.' [She said:] 'don't put excuse as single mom', but I am an immigrant, single mom is common but they have people that help."* Tara also recalled that her encounter with racist verbal language at the bank made her feel fearful. She shared the following:

> *"An old white couple [were] standing beside us. And we were counting the money to leave them in our account. And the old lady told to her husband in a voice that*

> *we could hear that she said, "look at this fucking [Middle Eastern], 'oh, fucking brown people are here taking our money and putting in their accounts.' I [was] scared, honestly."*

The participants who were victims of racism felt fearful, scared, and desperate. According to previous comments from the participants, it is possible that these negative feelings limited the caregivers' emotional and mental capacity ability to support their children's mental health after immigration.

Through this theme, participants explained that their post-migration challenges limited their capacity to support their children's mental health and contributed to children's loneliness and isolation post-migration. The participants' difficulty in securing income and addressing their families' needs were the major issues that directly and indirectly impacted their children's mental health. Even though participants believed their post-migration challenges contributed to their children's mental health they considered their post-migration social connections as an asset to for their children's transition into Canada.

Theme 3: Connections with Other Immigrants Enhance Families' Mental Health

All the participants discussed the importance of social connections as a resource for their families' post-migration mental health; these participants believed that their connections with people who identify as immigrants enhanced their capacity to support their children. Also, as discussed, the participants questioned their capacity to address their children's mental health needs due to their difficulty accessing resources and their mental health challenges resulting from post-migration stress. Therefore, the participants considered their connections as an asset to their families' mental health and their settlement journey as they provided emotional and informational supports that facilitated their transition into Canada. New friends also acted as family members who took care of their

children while caregivers were away. The ways in which social connections enhanced families' mental health are discussed below.

Cultural Connections Increase Families' Emotional Capacity

The caregivers who felt tired and lonely in addressing their families' post-migration challenges believed new relationships enhanced their emotional capacity to support their children's transition. These caregivers thought cultural connections increased their sense of belonging and facilitated their settlement journey. More than half of the participants shared that engaging with cultural organizations, by going to mosques or attending special celebrations held by their communities, allowed them to meet people with similar backgrounds who experienced similar challenges after migration. For example, for Aliyah, seeing new people at the mosque was comforting, "*I didn't know anybody for at least six months. During Ramadan, I was going to the mosque and, I met some people… and it was nice to talk to people and to know them."* Tara, who also complained about loneliness after migration, valued socialization opportunities and spending time with her Iranian friends to protect her mental health when she felt "*bad*." Tara mentioned the following:

> *"I prefer to spend some time with friends whenever I was [sic] bad. It really helped me a lot. It was, uh, four months after, uh, we came to Halifax, we met a family, um, and, um, the lady introduced me to some Iranian ladies in Halifax."*

Connecting with people from the same cultural backgrounds was a positive experience that enhanced the capacity of some caregivers to support their children.

The caregivers also encouraged their children to build new friendships to overcome their loneliness. For example, Tara shared that the new families she met created opportunities for her daughter to connect with Iranian children. Tara shared the following, "*I met some Iranians in Halifax who had kids, with friends I felt much better, [my daughter]*

made friends who is still connected to them in Halifax." Aisha also encouraged her children to build friendships through participating in YMCA programs. Aisha shared: *"I usually take my kids to a program that takes care of the leadership skills and personal skills… It also helps them to build new friendships [with] people in the community."* Shima said she tried to plan play dates for her daughter to stay connected with her peers after school. She said: *"when I see mother of my daughter's classmate, I'm trying to be friendly, inviting them [to my house]. If they don't want to come to my house, I invited them to the playground, I asked to have a play date."* Sara also encouraged his son to plan outings with his friends instead of staying at home playing video games. Caregivers addressed their children's loneliness by creating opportunities for them to build new friendships.

Connections with other Immigrants Increase Families' Informational Capacity

In addition to the emotional support, the caregivers also highlighted the role that other immigrants played in accessing resources like income and information that contributed to their capacity to support their families' mental health and integration into Canada. Farah, Aliyah, and Aisha discussed that their new friends helped them to find employment. Aliyah, who struggled to find employment upon arrival, found a job through her friend's connections. She added the following:

> *"I applied for many places, but no, no one gets back to me until I met a friend, this friend that is my friend now, she worked at the [resettlement agency name] so she told the many, like one of the managers about me and this supervisor spoke to me and she listened to me to my story. And then she told me apply to this front desk this job. So I applied, I got accepted."*

Aisha also shared that she found employment once she built social connections through her volunteering position at a settlement agency. She said: "*I started with volunteering at the [settlement agency name] and from there, I got to know so many information and I started*

working with them as part-time and found other streams [when] looking for other jobs." For these participants, accessing social networks enhanced their families' capacity to support their children's transition into Canada.

Some caregivers also discussed how their friends provided information regarding how to navigate Canadian systems; access to this information enhanced the caregivers' capacity to address their families' needs after migration. For example, Farah, who arrived with limited English, shared that her new friend, whom she found through her involvement with a settlement agency, provided interpretation at the hospital, helped her to submit her families' Permanent Resident (PR) applications, supported her to report her son's child care director who abused him, and accompanied her to court when she filed for divorce. Farah said: "*... Since I arrived here, [my Egyptian friend] was translating to me because I came no English. She was translating [for] me at court [and] at hospitals because I came [with] no English… I get the PR through her too."* Sara's friend also introduced her to a settlement agency to start practicing English and prepare for employment. She shared, *"When I became [sic] here, there was [a lady], uh, and maybe who was from my country, she introduced ISANS [Immigrant Services Association of Nova Scotia] and I went to ISANS, and ISANS helped us it was very good for my ex-husband [and] for me."* Aisha and Farah also shared that through their involvement with settlement agencies, they became knowledgeable about available resources and programs for their and their children's mental health. These caregivers highlighted the role that their new friends played in providing them with the knowledge that they needed to take care of their families after migration.

Immigrant Friends Support Families Through Child Care

On some occasions, participants received child care support from their friends while working or attending classes. Farah and Tara shared that their friends provided child care for their children and offered emotional support during challenging situations like divorce and during pregnancy. Tara, who had a difficult pregnancy, said that her friends helped her as a family member, "*[My friends] had a baby shower for me, surprised me, they visited me at hospitals. Uh, they took care of my daughter when I was not at home*." Farah also stated, *"when I was studying English as a second language, [my friend] was babysitting my son, so we became as a family, they are very close to me, supporting me."* Accessing informal child care enhanced these caregivers' ability to address their families' post-migration needs and increased their capacity to support their children post-migration.

Caregivers' Difficulties in Expanding Their Cultural Connections

Participants who valued connecting with people from the same cultural and language backgrounds identified challenges in building relationships with people from their own communities. Small immigrant populations in Atlantic Canada, immigrant friends who were also busy and tired from navigating their settlement journey, and the pandemic were some issues described by the participants. All participants agreed that Atlantic Canada's immigrant community is small. This means families have had a hard time finding friends of their culture and ethnicity who understand their unique experiences. Shima described her challenges in finding local friends:

> *"I never get a chance to make any friendship relation with a person because, we have a very limited population of Iranian [people here]. If I want to speak specifically about Iranian [topics in] our relationship, it's that, uh, in Iran, there's . . . 70 million [people]. So, you have a much more choices. You can find people that are in the same line as you."*

Further, though participants liked to connect with people with similar backgrounds, they expressed that their friends, who were busy navigating life after immigration and exhausted from the resettlement process, were not always available. For example, Aisha shared the following: "*[My friends] have changed, so they become more dependent and, uh, um, like they go through also more challenges."* In addition, some participants also raised concerns about the impact of the COVID-19 pandemic on their relationships.

The pandemic context was described by half of the participants as an additional barrier for the families to connect with others. Sara, Farah, and Tara talked about the fact that the COVID-19 restrictions exacerbated their families' feelings of isolation and loneliness. For example, Sara said: "*after the pandemic, all this isolation is become [sic] more and more, before our community has [sic] some events that we could attend but after this pandemic, just isolated."* Farah also shared the following: *"especially this year and last year, it's lockdown, we were just sitting home, we didn't even go out."* Tara also agreed that the pandemic restricted her abilities to interact with their friends, Tara said: "*due to COVID-19, we lost a lot of connections; we couldn't travel to Halifax, and we didn't visit them [our friends], we were affected."* According to these participants, the pandemic created a situation that limited their families' opportunities to interact with others. Though the participants valued their social networks through their settlement journey, the small population of immigrants in Atlantic Canada, the fatigue of immigrant friends, and the pandemic created challenges for the participants to maintain their social interactions.

This theme explained the importance of connections with other immigrants for immigrant families' mental health. The immigrant families, who felt isolated and lonely post-migration from family separation, agreed that connections they built with other

immigrants after migration positively influenced their families' mental health. Connection with immigrant families enhanced families' mental health as they increased families' sense of belonging and their access to emotional, informational, and child care support. Even though these caregivers identified connections with other immigrants as an asset to their families' integration process in Canada, they thought that the small immigrant communities in Canada, busy immigrant friends, and the pandemic made it difficult to build and maintain their social networks.

Summary

This chapter has presented the findings of this research by categorizing the participants' narratives into themes to explain the findings. Findings were presented under three themes: parents feel their children are isolated and lonely, caregivers' limited capacity contributes to children's mental health, and connections with other immigrants enhance families' mental health. Before discussing the themes, this section discussed how participants described mental health. Participants believed that their mental health was closely related to their feelings, emotions, and environment. They believed that their children's exposure to post-migration stressors led to their mental health decline through the isolation and loneliness that they experienced. In the first theme, the participants explained that their children's exposure to family loss, racism at school, parents' marital status change after immigration contributed to children's isolation and loneliness.

In the second theme, the caregivers described that their exposure to post-migration challenges limited their access to resources contributes to children's mental health. Low access to necessary resources like income and the health system were the major issues that lowered the caregivers' ability to support their children. In addition, the negative emotions

that the caregivers experienced while addressing their post-migration challenges influenced their mental and emotional capacity to help their children's transition into Canada. Finally, the third theme explained the importance of access to connections with other immigrants for immigrant families' mental health. The families' mental health was enhanced through the support that they received from other immigrants; other immigrants offered emotional and informational support, improved participants' sense of belonging, and provided child care when the caregivers were at work or attending classes. New social networks supported the children's mental health as the caregivers became emotionally and informationally equipped to support their integration into Canada.

Chapter 5: Discussion

This study aimed to explore the perspective of Middle Eastern immigrant caregivers in Atlantic Canada regarding the impact of their post-migration experiences on their children's mental health. The research questions were: How do immigrant caregivers conceptualize mental health based on their culture? How do immigrant caregivers perceive their children's mental health post-migration? What are some caregivers' post-migration experiences that they perceive to influence their children's mental health? Semi-structured interviews with six Middle Eastern immigrant caregivers helped explore the research questions. The following discussion investigates parents' perceptions to respond to the research questions.

How Do Immigrant Caregivers Conceptualize Mental Health?

As immigrants belong to heterogeneous groups and the meaning of mental health differs across populations, I examined how my participants conceptualized mental health to better understand their perceptions. The participants' definition of mental health was to some extent like the definition of mental health described by the World Health Organization (2007). Like the World Health Organization, the participants believed that their mental well-being shaped their adaption process to life circumstances. Previously, researchers discussed immigrants' mental wellbeing in relation to stigma to better understand their access to mental health support (Livingston et al., 2018; Salami et al., 2019; Salami et al., 2022). The next sections examine participants' understanding of mental health in relation to research that focused on mental illness stigma among immigrant populations.

Studies have suggested that immigrant populations in Canada have a stigma toward

mental illnesses or mental health services which negatively influences their access to mental health support (Livingston et al., 2018; Salami et al., 2019; Salami et al., 2022). Having stigma toward mental illnesses in the context of mentioned studies is described as having negative views and negative attitudes toward people who experience mental health concerns. For example, Livingston et al. (2018), argued that a significant level of stigma toward mental illness led to low use of mental health support among Asian immigrants in British Columbia. Nevertheless, the results from this study suggest that stigma toward mental illness and mental health programs was not a barrier to my participants' access to mental health support as these participants demonstrated awareness and willingness to support their families' mental health after migration.

Participants demonstrated an awareness of their families' mental health concerns post-migration. These caregivers defined mental health as an emotional and physical response to experiences with people, systems, and policies. They believed their families were isolated, lonely, and stressed after migration due to their interactions with Canadian school, employment, and health systems. Similarly, service providers in Alberta believed that their immigrant clients with knowledge and education around mental well-being had better access to mental health programs (Salami et al., 2019). Participants in this study were aware of their families' mental health concerns and shared strategies to support their families' mental wellbeing. For example, to address their families' isolation and loneliness, caregivers created opportunities for their children to spend time with their peers while encouraging family members to expand their social networks and connect with people from their own cultural backgrounds. In addition, more than half of the participants saw value in mental health programs like counseling for their families mental health after migration.

These results contrast previous research, such as that from Guruge et al. (2021) who found that the stigma held by migrant women in Canada toward mental illness negatively influenced their use of mental health supports to address their post-partum depression. The presence of stigma was not found to be a barrier obstructing access to mental health support in this study. Rather, lack of diversity among mental health professionals and high fees were their main barriers. Moreover, even with these mentioned barriers, some caregivers tried to navigate their families' mental health by finding free of charge counselling services or connecting with therapists from their home countries.

A few explanations could address the difference found between my project and previous research arguing that the existence of mental illness stigma among immigrant populations led to their low access of mental health programs. One possible explanation for this difference could be related to participants' heterogeneous characteristics such as their country of origin, level of education, and employment situation. Country of origin is important in the perception of mental health as it shapes people's cultural approach and understanding of concepts like mental health. My participants were from the Middle East, and it is possible that mental illnesses are less stigmatized in this region compared to other studies like Salami et al. (2019) and Salami et al. (2022) whose focus were on immigrants who were originally from Africa.

In addition, it is possible that my participants did not hold a stigma toward mental health illnesses or programs as they had post-secondary education, and either were employed or were at school at the time of their interviews. Similarly, Livingston et al. (2018) found a relationship between mental illness stigma and level of education and employment. These researchers shared that their immigrant participants in Canada who had

less education and were not employed tended to have a negative view of mental illness that impacted their access to support. It is also a possibility that during the COVID-19 pandemic, awareness has been raised about mental health issues, such that my participants may be more aware than those in studies conducted earlier. Overall, immigrants' heterogeneous characteristics and the timing of the interview, may explain some of the contradictions that were identified between my project and other studies. Finally, it is a possibility that caregivers who hold a stigma toward mental illnesses did not choose to participate in this project.

In summary, contrary to previous research studies that discussed negative attitudes toward mental health illnesses as one of the issues that the immigrant population face to address their mental wellbeing, I believe my participants did not hold stigma toward mental illnesses or services. My participants were aware of their families' mental health needs, and they were willing to find resources to support their families after migration. The disparity between my study and other research once again highlights the fact that immigrants are from heterogeneous groups and their post-migration experiences vary based on culture and background.

How Do Immigrant Caregivers Perceive Their Children's Mental Health Post-Migration?

Researchers have shown concern about the mental health of immigrant children following migration (Huang et al., 2012; Patterson et al., 2013; Islam, 2015; Yang, 2019; Salami et al., 2022). Some researchers indicate that immigrant children have poorer mental health after immigration than native-born children due to their unique pre- and post-migration experiences (Huang et al., 2012; Patterson et al., 2013; Islam, 2015; Yang, 2019).

Like previous research findings, all participants in this study believed that immigration negatively influenced their children's mental health. Caregivers said that exposure to racism at school, parent change in marital status, and parent mental health after migration led to children's feelings of stress, loneliness, isolation, and exclusion. The following relates my findings to previous research on immigrant children's mental health.

Children's Exposure to Racism. Some participants felt that their children were excluded and lonely due to overt and structural racism at school. For example, participants felt teachers either had unrealistic expectations from their children by not understanding their post-migration challenges or held incorrect assumptions about their children's abilities. Some participants also felt that their children were lonely as other students were hesitant to interact with them due to language and cultural differences. Likewise, other research has showed that immigrant children faced discrimination at school based on race, culture, religion, and language and that children may be bullied, excluded, and physically and verbally abused at school (Kia-Keating & Ellis, 2007; Islam, 2015; Patterson et al., 2013; Stewart, 2012; Yang, 2019; Walker & Zuberi, 2020; Jacobson, 2021). In another study conducted in Winnipeg, teachers and immigrant students expressed concern about the spatial segregation of classrooms into immigrant and non-immigrant students (Stewart, 2012). More recently, African immigrant parents also shared problems about their children's encounters with unequal treatment from school authorities and receiving offensive commentary from teachers and other students (Salam et al., 2022, p.148). Exposure to overt and structural racism at school was found in my study and other relevant research studies that negatively contribute to immigrant children's mental health.

Parents' Marital Status Change. Change in marital status was another factor that two participants believed influenced their children's mental health after immigration. The two participants who separated after migration believed their children experienced additional stress and confusion related to their families. Salami et al. (2022) also found a high rate of single parents among the African immigrants in Alberta which negatively influenced the children's emotional and material well-being. Some Somali parents in Alberta also believed that family tensions raised by changes in families' roles had a negative influence on children (Salami et al., 2020). Changes in the family dynamic are discussed in the literature as one of the post-migration experiences that shape immigrant families' settlement journey (Shirpak et al., 2011; Salami et al., 2020; Salami et al., 2022). For example, Iranian immigrant families in Toronto believed that their post-migration labour force experiences, where women found employment and men engaged in domestic tasks at home, negatively impacted their marital relationships (Shirpak et al., 2011).

The research identified this dynamic change due to changes in gender roles and Western cultural values of gender equality (Shirpak et al., 2011; Salami et al., 2020; Salami et al., 2022). In my study, less than half of the participants experienced separation after migration and changes to gender roles and Western ideology were not discussed by these participants as a threat to their families' cohesion. It is possible that my participants' separation was not impacted by changes in gender roles as both participants had post-secondary education and were employed before their arrival in Canada. It is also possible that participants did not talk about changes in families' dynamics and gender roles after migration as this was not the focus of this study. Nevertheless, it seems that all my

participants have taken traditional gender roles as they all were identified as mothers who seemed to have the primary role in taking care of their children.

Caregivers' Post-Migration Mental Health. Immigrant caregivers' mental health has an influence on immigrant children's mental well-being, as previous research highlighted that children develop within the context of their families, and families' abilities and experiences directly influence children's growth and development (Bronfenbrenner & Evans, 2000; Massing & Matheson, 2021). Some participants also questioned their ability to support their children's transition into Canada while experiencing emotions like sadness, disappointment, loneliness, and exclusion. Other research in Canada also found significant relationships between immigrant parents' emotional distress and their children's anxiety level (Hamilton et al., 2011). This research noted that children whose parents had a favourable view of school had less anxiety toward school (Hamilton et al., 2011). Literature also suggests that caregivers' poor mental health, such as experiences with depression and sadness, negatively influence the quality of parenting (Levendosky et al., 2003; Owen et al., 2006; Bogels et al., 2011). Further, parent depression, part of adverse childhood experiences, which is defined as childhood exposure to events such as chronic stress, abuse, and parental depression, influence children's emotional-social development (Boivin, 2012; Bucci, Marques, Oh, & Harris, 2016; Sonu, Post, & Feinglass, 2019). Immigrant caregivers' mental health is closely related to their caregivers' mental health as it influences caregivers' quality of parenting and their emotional capacity to support their children's integration into Canada. This notion is represented in some of my participants' narratives and is aligned with other research studies mentioned above.

In summary, like previous research that identified migration as a risk for immigrant

children's mental health, my participants also expressed concern about their children's mental health after migration. According to the participants, previous researchers, and my interpretation of data, immigrant children experience isolation and loneliness due to their exposure to racism at school, parental separation, and caregivers' mental health decline. The next research questions examines how caregivers' post-migration challenges influence their children's mental health.

How do caregivers' post-migration experiences to influence their children's mental health?

As previously mentioned, the caregivers who felt that their children experienced mental health decline due to isolation and loneliness after migration believed their children needed additional support to transition into Canada. These participants thought that their capacity to support their children became limited due to their encounters with structural discrimination in the employment sector and the Canadian health system and overt racism. The systemic discrimination in accessing employment and health services and exposure to racism was discussed by all the participants as factors that limited their capacity to support their children. Systemic discrimination is defined as subtle practices and attitudes that limit the access to rights and opportunities for a certain group of people (Stuber et al., 2008). Systemic discrimination in the Canadian employment and health sectors were two main areas that the participants talked about as these two sectors provide the necessary resources for families' successful settlement. Nonetheless, social networks were found to be an asset to families' mental health after immigration. Each of these experiences is discussed in relation to literature in the following sections.

Discriminatory Practices in Accessing Income

Immigrant children's mental health is impacted directly and indirectly by their caregivers' challenges in securing income. Systematic discrimination in Canadian employment resulted in the caregivers' limited emotional and financial capacity to support their children's mental health and transition into Canada. The below explores how discriminatory practices in these sectors impacted the caregivers' capacity in relation to other available literature.

Income and Caregivers' Emotional Capacity. Difficulty in securing income was a major post-migration stressor for immigrant caregivers which limited their emotional capacity to support their children's mental well being. Even though all participants arrived with post-secondary education, the majority faced difficulty in securing employment due to a lack of recognition of their past education and experiences. This lack of recognition made the caregivers either work in an entry-level job or continue their education which took away their time and mental energy to spend with their children.

More than half of the participants were concerned about their quality of parenting while facing the upheaval of emotions due to lack of access to secure income. These participants found parenting hard when they felt pressured, excluded, and unworthy. Likewise, previous research has found that the mental health of immigrants who were not employed was worse than those who had income security (Newbold & Danforth, 2003; De Maio & Kemp, 2010). For example, Beiser and Hou (2016) found that parent stress from poverty negatively influenced children's mental health. African immigrants in Western Canada also believed their challenges in finding employment negatively affected their children by decreasing their children's hope and motivation (Salami et al., 2022). As

discussed, like previous research, my participants felt isolated and excluded from accessing income due to a lack of employment opportunities; feeling these negative emotions impacted the participants' ability to support their children's mental health after migration.

Income and Caregivers' Financial Capacity. Less than half of the participants also agreed that their financial situation after immigration limited their capacity to support their children's transition into Canada. Lack of access to secure income and poverty, which are social determinants of health, are discussed as major post-migration issues for children's mental health (Choi et al., 2014; Chang, 2019). Beiser et al. (2002) also identified poverty as a significant factor for depression among immigrant children in Canada. Some participants thought their children became concerned about their families' financial needs, while others felt their low budget contributed to their children's isolation and exclusion as they could not afford to register their children in activities that required fees or materials. Similarly, African immigrant parents in Western Canada also believed that unemployment restricted their ability to invest in materials essential for their children's mental and emotional development (Salami et al., 2022). Families' lack of access to secure income and poverty were also an issue for immigrant children in Nova Scotia.

The 2020 *report card on child and family poverty* in Nova Scotia showed the highest child poverty among recent immigrant children (Frank et al., 2020). In contrast to the high rate of poverty among immigrant groups in Nova Scotia, my participants did not talk about their experiences with extreme poverty at the time of the interview. The reason for this difference could be that these participants were highly educated, were employed at the time of the interview, and chose to immigrate; it is possible that they had some knowledge and resources to help navigate Canadian systems and were able to find

employment faster than for example, refugee populations who were forced to migrate. Nevertheless, the participants agreed their challenges in securing income limited their capacity to support their children's mental well being after migration.

Discriminatory Practices in the Canadian Health System

Systemic discrimination in health services influences immigrant caregivers' capacity to support their children's mental health. Participants believed a lack of diversity among health professionals and high fees related to mental health programs limited their use of the Canadian health system to address their families' needs. Similarly, previous research also agreed that immigrants' encounters with systemic discrimination within the Canadian health system led to their limited use of these services (Long, 2010; Khanlou, 2010; Long, 2010; Rezazadeh & Hoover, 2018; Brown et al., 2020). The caregivers' experiences in accessing the Canadian health system are discussed below.

Lack of Diversity. The participants believed that a lack of diversity among health professionals limited their capacity to address their families' needs. Participants believed they could communicate more effectively about their families' needs with professionals who spoke their language and understood their cultural backgrounds. Health providers who supported African immigrants also believed that lack of cultural awareness among them resulted in low access of the health system among this population (Salami et al., 2019). Language differences were also suggested by many studies as one of the discriminatory factors that explained immigrants' lack of access of the health system. For example, Long (2010) revealed that immigrants' access to the health system increased when health services were offered by individuals who were familiar with their language and culture. Similarly, language barriers in communicating with health professionals and filling out

forms were found to be the main concerns of immigrant populations in navigating the health system in Canada (Salami et al., 2019, 2020; Brown et al., 2020). Lack of diversity among health professionals is found to be a primary concern for my participants in their use of the Canadian health system, which aligns with similar research.

Lack of diversity is also an issue in Canadian mental health services. Some of the participants, who relied on counselling services for their and their children's mental health, believed that mental health services in Canada were not accessible due to the lack of cultural representation. Similarly, Khanlou (2010) suggest that "culturally sensitive and specific mental health programs" could enhance the mental health challenges that immigrant populations face in Canada post-migration. It is also stated that a lack of cultural practices among mental health programs in Canada was a major barrier to access among first and second generation Chinese immigrants (Chen, 2010). In my study, more than half the participants were using or interested in using mental health programs for their children or themselves. These participants believed that mental health services like therapies would be more accessible if the service was provided by someone who spoke the same language and had the same cultural background as the patient. Service providers in mental health programs also argued that more immigrants should be hired in mental health services as they are more equipped in addressing the mental health needs of this population due to the fact that they have lived experiences (Salami et al., 2019). Some participants also discussed that they could not afford to use counselling services in Canada for their families.

High Fees Related to Counselling Services. In addition to the lack of diversity, some participants thought that the high fees related to counselling services limited their access to mental health programs for their families. Similarly, economic accessibility is

discussed in the literature as an important barrier to services like mental health programs as the universal health program does not cover them (Long, 2010). A scoping review by Brown et al. (2020) also identified financial challenges as one of the main issues influencing immigrant families' lack of access to programs and services designed for their children. In this study participants who valued mental health services for their and their children believed that high fees and lack of cultural representation were the main issues influencing their use of mental health programs.

Caregivers' Experiences with Overt Racism

The immigrant caregivers expressed that their exposure to racism after immigration led to their mental health decline due to the fear and stress that they experienced. These negative emotions experienced by immigrant caregivers influenced their mental and emotional capacity to support their children's mental well being. Many researchers also consider racism a fundamental cause of mental health disparities (Etowa et al., 2007; Xanthos et al., 2010; Siddiqi et al., 2017). It is found that discrimination increases stress and anxiety among those who are exposed to racism (Etowa et al., 2007; Xanthos et al., 2010; Siddiqi et al., 2017). The next few sections describe more in-depth the caregivers' experiences with overt racism in relation to other studies.

Half of the study participants discussed the mental health implications of their experiences with racism at their workplace or when running errands outside. At the workplace, people in authority questioned immigrant caregivers' ability to address their responsibilities. One participant shared that she faced aggression and verbal racism on multiple occasions while shopping. Similarly, Khanlou (2010) stated that immigrants experience racism in Canada due to their skin colour and language differences (Khanlou et

al., 2010). Hunt et al. (2020) also suggested immigrants experience verbal and physical abuse due to their religious practices. Exposure to racism left the study participants feeling lonely, scared, unworthy, disappointed, and stressed. Likewise, Hunt et al. (2020) also suggested that Muslim immigrant women who faced verbal and physical abuse because of their religion experienced isolation, low self-esteem, and difficulty with self-identity. The negative implication of racism on immigrants' mental health is identified in my study and other research.

Caregivers' exposure to racism also negatively influences immigrant children's mental health (Bronfenbrenner, & Evans, 2000; Bovini, 2012). Based on my findings and other research, exposure to racism is identified as a factor influencing caregivers' mental health (Khanlou, 2010; Honlu et al., 2020). Parental mental health decline, which is part of the definition of an ACE, may lead to children's experiences with mental health decline as caregivers' quality of parenting becomes impacted by their feelings of stress and sadness (Levendosky et al., 2003; Owen et al., 2006; Bovini, 2012). Immigrant children, who need extra support to navigate post-migration stressors, may face isolation, loneliness, and sadness as their caregivers' emotional and mental capacity becomes limited to support their children's transition.

Even though racism was found to have a meaningful impact on immigrants' mental health, only half of the participants in my study talked about their or their children's exposure to overt racism, while all of them talked about their experiences with structural discrimination. Similarly, Hunt et al. (2020) revealed less overt discrimination than subtle discrimination among Muslim immigrants in Waterloo Region, Canada (Hunt et al., 2020). One explanation for these differences could be that because racism is a stressful topic and

recalling racism incidences could cause anxiety, some participants chose not to discuss that. In this study, I did not ask a specific question about explicit racism unless the participant brought up the topic to ensure I respected participants' comfort on this topic.

In brief, like previous research, my study also highlighted that caregivers' exposure to structural discrimination and overt racism limited their capacity to support their children's mental health and transition into Canada. Caregivers' difficulty in accessing necessary resources like income limited some families' financial capacity to take care of their children. Further, the lack of diversity among mental health providers and high fees related to counselling limited some caregivers' access to mental health programs for their families. Finally, exposure to overt racism is found in my study and other research that negatively influences immigrant caregivers' mental health. According to ACE, parental mental health challenges negatively influence children's mental health as well. Aside from challenging factors that led to the participants' mental health decline post-migration, this study found that participants' social networks after immigration can improve the families' mental health through the support, they offer to them to enhance their integration process.

Access to social support

The study participants revealed that their access to social support after immigration facilitated their families' integration into Canada and enhanced their capacity to support their children's mental health after migration. Likewise, other studies also emphasized the role of social support in immigrant families' settlement journeys (Khanlou, 2010; Dastjerdi & Mardukhi, 2015; Stirling Cameron et al., 2022). For the study participants, the social networks increased their capacity to support their children as they provided the emotional and information support necessary for their integration. Below examines how immigrant

families' social networks enhance their capacity to support their children.

Enhancement of Caregivers' Emotional Capacity. Social networks enhanced the study participants' capacity to support their children's transition into Canada. The participants who were distant from their relatives and felt isolated believed their interaction with people from their own cultural backgrounds enhanced their sense of belonging. Similarly, Iranian women in Toronto shared that they built new social connections to overcome isolation by participating in community-based activities (Dastjerdi & Mardukhi, 2015). In addition, some participants thought that their new friends became like family members who offered them emotional support during difficult times like pregnancy and provided child care when they needed help. Likewise, Syrian mothers in Nova Scotia also stressed that their new social groups improved their mental well-being after giving birth as they become like their "chosen family," providing support and taking care of their children (Stirling Cameron et al., 2022, p. 105). Based on my research and other studies, access to social networks is suggested to be critical for immigrant families as they enhanced their emotional capacity to support their children's mental health after migration.

Enhancement of Caregivers' Informational Capacity. Further, the participants believed their social networks enhanced their capacity to support their children's transition into Canada through informational support that they offered to families. Informational support increased caregivers' access to necessary resources like income and health services. For example, some participants shared that they were able to secure employment through the connections that they built after immigration. Also, some caregivers shared that their friends helped them to navigate different Canadian systems like health and child care and provided them with interpretation when they needed. Social integration is also

one of the Citizenships and Immigration Canada's (CIC) central policies (Immigration, 2015). The government of Canada has encouraged immigrants' social integration and active civic participation as its priority by providing the most funding for these programs at settlement agencies (Immigration, 2015). Khanlou (2010) also suggested that social networking among ethnic communities improved immigrants' mental health as they enhanced their abilities to navigate post-migration challenges like finding employment. In a scoping review, Brown et al. (2020) also found that social connections helped immigrant families to find information about available programs and services for their children. My study and other research suggest that social connections provide immigrant caregivers with information and resources that increase their capacity to support their children after immigration.

Challenges in Expanding Social Networks. Social networks' critical role in providing emotional and information support for immigrants is emphasized in my study and other literature; however, finding and receiving help from friends was not easy for the study participants. First, all participants shared that they faced difficulties meeting people from their own countries as the communities in Atlantic Canada are not very diverse. According to Statistics Canada (2017), the number of immigrants is increasing in Atlantic Canada. Still, it is found that migrants tend to live more in metropolitan cities like Toronto, Vancouver, and Calgary, where the population is more diverse. Second, all participants believed that the support they received from friends here in Canada was different from back home as friends themselves were also immigrants who were tired and busy navigating their post-migration challenges. Similarly, Chinese and South Asian immigrants facing their children's sickness alone felt that they could not ask for support from their immigrant

friends who were also busy (Klassen et al., 2012). Syrian refugee mothers also believed that they could not always ask for help from their Syrian friends as they were also occupied (Stirling Cameron et al., 2022).

Finally, some immigrant caregivers considered the pandemic and COVID-19 restrictions as an additional barrier to their access to informal support when they needed it the most. Other researchers also argued that the pandemic restricted families' access to support from their social connections (Stirling Cameron et al., 2021; LaRochelle-Côté & Uppal, n.d.). For example, Syrian mothers shared that they could not receive informal help and child care support during the pandemic from their social circles (Stirling Cameron et al., 2021b). In addition, other researchers also believed that immigrant families had less access to information about available programs and services during the pandemic due to their isolation and physical distancing rules (LaRochelle-Côté & Uppal, n.d.). Even though social connections are vital for immigrant families' settlement and caregivers' capacity to support their children's transition into Canada, my project and other studies highlight the challenges in building new social networks and accessing their support for immigrant families after immigration.

In summary, the importance of access to social support for immigrant families' mental health is emphasized through my research and other relevant studies. The social connections provided the immigrant families with the emotional and informational support that they needed to help their families' settlement process after immigration. Nevertheless, my study and other research have identified some barriers that immigrant families face in accessing social support.

Study Strengths and Limitations

Several strengths have been identified in this research study. First, this study provided space for an underrepresented group to share their perspectives. In addition, as the topic of mental health is understudied, especially among children from marginalized populations, this research included the voices of marginalized groups with respect to how they understand mental health. Many researchers suggest that to enhance immigrants' access to mental health services, it is crucial to understand the cultural context of mental health (Khanlou, 2010; Salami et al., 2019). Nonetheless there are researchers who analyzed immigrants' surveys based on the Western definition of mental health (McDonald & Kennedy, 2004; Islam, 2015; Yang, 2019; Ali, 2002). For example, Robert and Gilkinson (2012) referred to WHO definition of mental health which is defined as "state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community." This study attempted to understand what mental health meant to each participant. Finally, through this study, shared and specific challenges and barriers of immigrant caregivers that they believed to influence their children's mental health were identified. Finally, this research is strengthened by my position as an immigrant. I have an insider voice in this project meaning that I also felt and experienced many challenges that my participants faced after migration.

Some limitations of this study have also been identified. First, this study examined the mental health of children from their caregivers' perspectives. Considering children are capable and experts in their own lives, I could have better understood their realities if I interviewed them. I chose caregivers because I wanted to know what their perceptions were

about their children's post-migration mental health, as children's development is impacted by their environment, which is influenced by caregivers, schools, communities, culture, and policies (Bronfenbrenner, 1994). Nonetheless, I do understand this was a limitation of my study and I intend to investigate more about children's experiences during my doctoral research. The interviews with caregivers instead of their children also resulted in another limitation of this study; some participants might have had more than one child who met the inclusion criteria, so it is possible that they mixed up their children's experiences. To mitigate this, I asked the participants to focus on one of their children's experiences. In addition, recall bias is another limitation of this study; it is possible that the caregivers might have misremembered their child's experiences. To address this, I designed my interview guide with questions about children's experiences. Asking specific questions might have helped participants to describe their child's experiences.

Second, this study has limitations because of my recruitment inclusion criteria and the topic of the study. Due to my budget restrictions and not being able to hire interpreters, I only recruited participants who had English proficiency for day-to-day conversations. Therefore, I missed the voices of caregivers who had limited to zero English proficiency. I hope in my future work, I have access to enough funding to be able to offer interpretation during interviews. Furthermore, because of the concept of mental health, it is possible that I missed the voices of those who have negative attitudes toward mental illnesses and services. Finally, the participants of this study were all women who identified as mothers, and I missed the voices of fathers who may have different views of their children's mental health after immigration.

Third, building rapport during virtual interviews was challenging, especially with

Arabic speaking participants due to cultural differences. To mitigate this effect, I began the interviews by introducing myself, telling the participants about my immigration journey, and challenges that I faced establishing myself in Canada. Before interviews with Arabic Speaking participants, I looked at the world map to see where their country of origin was situated in relation to Iran. At the beginning of interview with Arabic-speaking participants I told them that I was from Iran and discussed the geographical relationship between their country and Iran.

Implications

In this study, Middle Eastern immigrant caregivers provided insight into changes that should be implemented by Canadian systems to support immigrant children's mental health post-migration. In addition, several suggestions are made for policymakers, mental health promotion programs, the school system, and immigrant services to effectively support immigrant children's mental health after migration. The findings of this study may raise awareness about discriminatory policies and practices within different sectors of society such as the education, employment, and health system.

Parents' suggestions

Believing their children feel lonely and isolated due to post-migration challenges, the caregivers shared a range of practices to support their children's mental health. These included encouraging their children to spend time with friends, attending community programs, or accessing consulting services. Participants who also believed their own mental health post-migration influenced their children also recommended parenting programs and mental health supports. Participants highlighted the importance of connections and relationships for their children's mental wellbeing; therefore, they have

encouraged their children to build friendships, plan activities with their friends, or engage in community events. In addition, due to the high fees associated with mental health services in Canada, more than half of the participants expressed that they would appreciate schools providing counselling services to immigrant children to support them in navigating their feelings after immigration. Finally, to support their children's mental health, some participants relied on counselling services or parenting programs to enhance their emotional capacity and learn about ways to help their children transition into Canada.

Practice

Policies and programs have a critical role in immigrant families' experiences after migration. Interventions that enhance immigrant children's experiences at school and facilitate immigrant families' integration into Canada will support immigrant children's mental health after migration. The next few paragraphs summarize these interventions.

School. School, as one of the first services that immigrant children access in Canada, has an important role in supporting their mental wellbeing. To address the unique needs of immigrant children, trauma-informed practices within the school system have been found to help immigrant children who experience social, emotional, educational, and behavioural disparities after the migration (Jacobson et al., 2021). Trauma-informed practices have three significant factors that can be used to support immigrant children's transition, including an understanding of children's needs, adaption to address their needs, and promoting socialization (Cole et el., 2013). Immigrant children have unique needs after immigration as they face language differences, cultural barriers, racism, caregivers' limited capacity to support their children, and families' financial difficulties. Therefore, teachers need to be aware of the unique needs of these children to better support their social,

emotional, and academic development (Stewart, 2012; Jacobson, 2021).

Further, to address immigrant children's racism and bullying experiences, teachers can raise awareness about immigrant children's language and cultural differences and encourage inter-cultural relationships (Stewart, 2012; Jacobson, 2021). Moreover, the presence of a support person like a counsellor or an English teacher, who is familiar with the child's language and culture, is necessary at school to help children to adapt to Canadian schools, build friendships, practice English, receive support for assignments, and learn to navigate their emotions and feelings resulting from pre- and post-migration challenges (Walker & Zuberi, 2020; Guo et al., 2021).

Employment. Further, providing support to caregivers, whose mental and emotional health has an impact on their children's mental wellbeing, will also improve immigrant children's mental health. Several interventions are suggested to avoid the mental health decline of immigrant caregivers. First, immigrant caregivers' mental health may be improved if they find employment more quickly. This goal may be achieved if the employment sector in Canada adopts a new approach and vision to value pre-migration experiences, training, and certificates (Newbold, 2009; Choi et al., 2014; Salami et al., 2022). Second, high quality, free English classes may also enhance immigrant caregivers' ability to find employment (Hynie, 2018).

The Health System. Immigrant families' mental health will also be improved if they have better access to health services. Immigrants' access to the Canadian health system may be increased if the system's practices became culturally responsive and more diverse health professionals were hired (O'Mahony & Clark, 2018). In addition, immigrant families will benefit from accessible mental health programs like counselling (Hynie, 2018;

Salami et al., 2022). Free and accessible mental health programs offered by providers who know patients' language and are aware of their cultural practices may address this goal (Hynie, 2018; Rezazadeh & Hoover, 2018; Salami et al., 2022). Further, immigrant caregivers may need support to help their children transition to a new environment with new culture, norms, and rules. Therefore, culturally responsive parenting classes may equip the caregivers with strategies to protect their children after the migration (Salami et al., 2019; Brown et al., 2020).

Cultural Community Organizations. Through my research and other relevant studies, it became clear that access to social networks and connections with ethnic communities enhanced immigrant caregivers' mental health. Social networks and relationships with ethnic communities create informational and emotional exchange opportunities that contribute to immigrant families' integration process in Canada, promote their sense of belonging, and address the loneliness they feel after migration. Therefore, more funding for cultural organizations may allow these communities to create more extracurricular activities, informational classes, and cultural celebration events for community members to increase social networking opportunities (Khanlou, 2010).

Future Research. Finally, this study adds to the existing body of knowledge about the impact of caregivers' post-migration experiences on their children's mental health which is an understudied topic. This study gave voices to families to reflect on their own post-migration challenges and widened their perception of the impact of migration on their children's mental health. Likewise, the result of this study deepens my understanding of immigrant families and their children's challenges which inspires my future research studies with this population. Future research may explore the experiences of immigrant

children in schools in Atlantic Canada where the majority of students, teachers, and administrators are White. I am hoping to gain a better understanding of immigrant children's realities in Nova Scotian schools during my doctoral study. There is also a need to investigate how Middle Eastern immigrant families experience changes in gender roles after migration and how those changes impact their children. Finally, with more mental health awareness that has been raised during the COVID-19 pandemic, there is a space to explore how Middle Eastern families' attitudes toward mental health have changed.

Knowledge Mobilization

The knowledge mobilization for this study will occur in a few forms. First, the dissemination includes the defence of the thesis. Also, the summary of the results will be transformed into visual infographics which are suitable for immigrant populations with different levels of English proficiency; the visual infographics will be shared directly with the participants who indicated their interests in the study results. Finally, I intend to publish the results of the study in health promotion journals, immigration-related journals, and presenting at relevant conferences like Metropolis and Canadian Association for Health Services and Policy Research (CAHSPR).

Conclusion

In conclusion, this research suggests that immigrant caregivers from the Middle East believe that their children experience loneliness and isolation after migration. This qualitative study explored the perception of six Middle Eastern immigrant caregivers on their children's mental health post-migration. The three research questions were: how immigrant caregivers conceptualize mental health? How is the immigrant children's mental health post-migration? And what are some caregivers' post-migration experiences that

influence their children's mental health? These caregivers felt that their children's direct experiences with family separation, exposure to racism at school, and parents' marital status change contributed to their loneliness. Further, these participants believed that their children's isolation was increased by their families' limited capacity to access to resources to support their transition into Canada. Nevertheless, the study participants considered social support as an asset to their families' mental health. This research indicates the importance of culturally responsive programs and policies in various government systems like education, health, and employment to support immigrant children's mental health after migration.

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Appendix A

Recruitment Email to Community Organizations

Dear [community organization name],

My name is Nahal Fakhari, and I am a Master of Arts in Health Promotion student at Dalhousie University in the School of Health and Human Performance under the supervision of Dr. Becky Spencer. I am writing to ask for your assistance in recruiting participants to help with a research study exploring immigrant children's mental health from their caregivers' perceptions post-migration. Your organization has been selected as you provide services to newcomer families with children in Atlantic Canada.

For my master's thesis, I am leading this research study called, "Child Immigrant Post-Migration Mental Health: A Qualitative Inquiry into Caregivers' Perspectives". The purpose of this study is to explore the perspective of immigrant caregivers in Nova Scotia regarding the impact of their post-migration experiences on their children's mental health. The study is looking for five to eight Middle Eastern non-refugee, immigrant caregivers who:

- Have permanent residency or citizenship status
- Have been in Atlantic Canada for at least three years
- Currently have at least one child under the age of 18
- Whom this child was under the age of eleven when migrated
- Participants need to have English proficiency for day-to-day conversation.

Anyone interested in participating will be asked to take part in an approximately one-hour interview. Participants have the option to choose phone, virtual face-to-face through Microsoft Teams, or in-person interviews. Participants will be asked a series of open-ended

questions about their experiences post-migration and the impact of those experiences on their children's mental health. Participants will be compensated with a $15 honorarium. You or your organization will not be held responsible for the study or any issues that arise as a result of it. You can find the recruitment poster attached to this email. Please share that with your relevant networks.

If you have any further questions, I would be happy to discuss over email or phone.

Thank you for considering,

Nahal Fakhari

Email address: Nahal.Fakhari@dal.ca

Phone number: (902) 489-8942

Appendix B

Recruitment Poster

We are interested in learning about your post-migration experiences and how you believe your experiences influence your children's mental health.

You are invited to participate in an approximately one-hour interview. The interviews will be offered through online platforms like Microsoft Teams, phone, or in-person. As a thank you, you will receive a $15 honorarium.

You are invited to participate if:

- You are a **Middle Eastern, non-refugee immigrant**
- You directly migrated to **Atlantic Canada** and lived there for **at least three years.**
- Your child was **under the age of 11 when migrated** and they are currently **under the age of 18.**
- You have **English proficiency** for day-to-day conversation as the **interviews will be conducted in English.**

If you are interested in participating, you can contact Nahal Fakhari at Nahal.Fakhari@dal.ca ; (902) 489-8942

Appendix C

Example Social Media Post

Along with a short script, the recruitment poster will be shared on social media like lead researcher's twitter account. The lead researcher will also tag twitter accounts like Dal_HAHP, DalGradStudies, DalHealth, ECCRC, and ISANS.

For example, the script that accompanies the social media post could be: Are you a Middle Eastern Caregiver? Would you like to share with us how your child experienced immigration? You are invited to complete an approximately one-hour interview in English and receive a $15 honorarium for your time.

Appendix D

Email Response to Interested Participants

Dear [Participant name],

Thank you for your interest in our study, titled, "Child Immigrant Post-Migration Mental Health: A Qualitative Inquiry into Caregivers' Perspectives." This study is being conducted as part of my master's thesis within the school of Health and Human Performance at Dalhousie University. The purpose of the study is to understand the experiences and mental health of Middle Eastern immigrant children from their caregivers' perspectives. Anyone interested in participating will be asked to take part in an approximately one-hour interview online, over the phone, or in-person (if aligned with Public Health guideline).

The study is looking for five to eight Middle Eastern non-refugee, immigrant caregivers who have permanent residency or citizenship status, currently have at least one child under the age of 18 and migrated when this child was under the age of eleven, and have been in Atlantic provinces for at least five years. You will be asked a series of open-ended questions about your child's mental health post-migration.

<u>Please consider answering the following questions:</u>

1. Are you a caregiver who migrated from the Middle East region?
2. Do you currently hold permanent residency or citizenship status?
3. Do you currently have at least one child under the age of 18?
4. Was your child(ren) under the age of 11 once they migrated?
5. Did you migrate directly to Atlantic Canada and have you lived there for at least three years?

6. The interviews will be conducted in English. Do you have English proficiency for day-to-day conversation?

Please let me know your preferred method of interview.

7. Online? Over the phone? Or in-person (if applicable)?

In the interview session, your responses will be audio-recorded. Please note that you are under no obligation to take part in this study. Choosing to take part or not take part will have no effect on your ability to access services or employment at any organization. I will make sure any information you share will be kept private and confidential. Your name will not be attached to anything you say.

Please let me know if you are interested in taking part or if you have any questions. We can schedule interviews for any time that is convenient for you, including evenings and weekends. As a thank you, you will be given $15.

If you are interested, I will send you a reminder email two days before the interview.

Warm wishes,

Nahal Fakhari

Appendix E

Telephone Response to Interested Participants

Hello [participant name],

Thank you for your interest in our study, titled, “Child Immigrant Post-Migration Mental Health: A Qualitative Inquiry into Caregivers’ Perspectives.” This study is being conducted as part of my master’s thesis within the school of Health and Human Performance at Dalhousie University. The purpose of the study is to understand the experiences and mental health of Middle Eastern immigrant children from their caregivers’ perspectives. Anyone interested in participating will be asked to take part in an approximately one-hour interview online, over the phone, or in-person (if aligned with Public Health guideline).

The study is looking for five to eight Middle Eastern non-refugee, immigrant caregivers who have permanent residency or citizenship status, are from the Middle East region, currently have at least one child under the age of 18 and migrated when this child was under the age of eleven, and have been in Atlantic provinces for at least five years. You will be asked a series of open-ended questions about your child’s mental health post-migration.

Please note that you are under no obligation to take part in this study. Choosing to take part will have no effect on your employment or ability to access any services. The research team will do everything possible to make sure any information you share will be kept private and confidential. Your name will not be attached to anything you say.

Please let me know if you are interested in taking part or if you have any questions. We can schedule interviews for any time that is convenient for you and your family, including evenings and weekends. You will be given $15 for participating.

Does this sound like something you are interested in?

[If no] – No problem at all. Thanks for taking my call.

[If yes] – Wonderful. I'm going to ask you some questions to ensure that you meet the criteria for this study:

1. Are you a caregiver who migrated from the Middle East region?
2. Do you currently hold permanent residency or citizenship status?
3. Do you currently have at least one child under the age of 18?
4. Was your child(ren) under the age of 11 once they migrated?
5. Did you migrate directly to Atlantic Canada and have you lived there for at least three years?
6. The interviews will be conducted in English. Do you have English proficiency for day-to-day conversation?

<u>If the participant met the inclusion criteria:</u>

1. When are you available to complete the interview?
2. Would you like to have the interview Online? Over the phone? Or in-person (if applicable)?

Can I get your email to send you further information about the study? I will call or email you two days before the interview as a reminder.

<u>If the participant did not meet the criteria:</u>

Thank you so much for your time, unfortunately, you do not meet the inclusion criteria for this study even though your experiences are highly valued. Thank you for calling!

Appendix F

Caregivers Verbal Consent Script

Project title: Child Immigrant Post-Migration Mental Health: A Qualitative Inquiry into Caregivers' Perspectives
Lead Researcher: Nahal Fakhari, MA in Health Promotion Candidate, Dalhousie University, nahal.fakhari@dal.ca; (902)489-8942
Other researchers:
Dr. Rebecca Spencer (PhD)
School of Health and Human Performance
Dalhousie University
Becky.spencer@dal.ca
Dr. Karen Gallant (PhD)
School of Health and Human Performance
Dalhousie University
Karen.Gallant@dal.ca
Dr. Jessie-Lee McIsaac (PhD)
Department of Child and Youth Study
Mount Saint Vincent University
Jessie-Lee.McIsaac@msvu.ca

Introduction

You are invited to the research study called, "Child Immigrant Post-Migration Mental Health: A Qualitative Inquiry into Caregivers' Perspectives" under supervision of Dr. Rebecca Spencer, Health Promotion program instructor at Dalhousie University. There will be no impact on your ability to your employment or access to any services organizations if you decide not to participate in the research. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience. You should discuss

any questions you have about this study with Nahal Fakhari. Feel free to ask as many questions as you like and contact her at any time.

Study purpose and outline

Immigrants experience a variety of barriers and challenges that influence their mental health post-migration. With the increase in immigration rate from the Middle East to Canada and the gap in research about immigrant children's mental health this study the will explore the perspective of immigrant caregivers in Atlantic Canada regarding the impact of their post-migration experiences on their children's mental health.

Who is participating in this study?

Five to eight participants will be recruited to participate in this study. You can take part in this study if:

1. You are a Middle Eastern non-refugee immigrant holding permanent residency or Canadian citizenship.
2. You currently have at least one child under the age of 18.
3. This child was under the age of 11 when migrated.
4. You directly migrated to Atlantic Canada and lived there for at least three years.

What you will be asked to do?

The total amount of participating in this study is around 90 minutes as actual participation could approximately be one hour, but scheduling and reviewing the informed consent document may take extra time. For your interview session, you had the option to choose between phone-interview, virtual face-to-face interview, and in-person interview. During your interview, you will be asked to share your post-migration experiences and its

impacts on your child's mental health. The definition of mental health for this study is broad, and can include emotional, mental, spiritual, cultural, and social wellbeing. You do not need to have any mental health challenges, psychological diagnoses, or disorders to take part in this study. You can choose to skip any question in your interview and are free to stop participating at any time. With your permission, the interview session will be audio-record. All interviews will be transcribed verbatim.

What are benefits and risks of participating in this study?

This study will create opportunities for you to reflect on your post-migration experiences and to bring greater community awareness. The main risk of participating is that you may experience some discomfort while recalling your post-migration experiences and your child's mental health. Also, despite all the efforts made to protect confidentiality and privacy there is still a small risk of being identified.

How will you be compensated for your time?

A $15 dollar honorarium will be emailed to you at the end of your interview. If you chose to have an in-person interview and required a metro transit ticket to and/or from your interview, this will be provided to you.

How will your name or identifying information be used?

Your name will not be published in any study findings, and only myself (Nahal Fakhari) and my supervisor, Dr. Becky Spencer, will have access to the study data. All names and identifying information will be removed from the study and pseudonyms will be assigned to present your quotes and stories in presentations or publications. No information about your participation in this research will be disclosed to anyone unless compelled to do so

by law, such as in the unlikely event that child abuse is suspected, and the researchers are required to contact authorities

How will the information be stored?

Once the study is over your data will be kept for five years before being physically destroyed. During this time hard copies of form of your mailing address-if you choose physical compensation- will be stored in a locked cabinet at supervisor's office which will be destroyed immediately after you receive the compensation. All other electronic files like information collected during the interviews, will be stored on OneDrive folder shared between the lead researcher and the supervisor and will be destroyed after five years.

If you decide to stop participating

You may withdraw from the project at any time without any consequences. If you prefer you can also request to remove all your information from the study up to one week after your interview session. After that time, it will become impossible for us to remove it because it will already be part of our analysis.

Conflict of interest

Because of small community of immigrants in Halifax, and the study inclusion criteria being specific, it is possible that lead researcher, as she is an immigrant herself, may know some of the participants from her own community (Iranian community) or other immigrant communities. Even though the research team recognize this as a strength to have an insider perspective this may raise concern. To mitigate this, the potential participants will know the name of the lead researcher during the recruitment phase and

will see her face or voice during the data collection. Therefore, the participants have the choice to not begin or continue their participation.

What if you had any additional questions?

If you had any additional question, you can contact me (Nahal) at (902)489-8942 nahal.fakhari@dal.ca. If you preferred to talk to my supervisor, you can also contact Dr. Becky Spencer at Becky.Spencer@dal.ca. If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-3423, or email: ethics@dal.ca

How do you provide consent for your participation?

"If you are interested in participating in this project, you can provide your verbal consent and I will document your consent for future reference."

Agreement page

"By providing your verbal consent, you agree to fully participate in this project by doing the following activities:

- Attend an approximately one-hour interview session Yes/No
- Have your thoughts and ideas audio-recorded for the project. Yes/No

Remember, your participation is completely voluntary. Providing your verbal consent means that you have understood this information and that you want to be in the research project.

- Do you provide your permission to use your direct quotes? Yes/No
- Do you provide verbal consent to participate in this study? Yes/No

Provision of Results

The lead researcher, Nahal Fakhari, can provide you with a short summary of the study findings when it is finished.

- Are you interested in receiving a summary of the study's results? Yes/No

(If yes, ask for email or other contact information suitable to deliver updates).

In addition, hard copies of the study report will be delivered to community organizations in case some participants could not access the study report through their emails.

Appendix G

Informed Consent Tracking Sheet

DALHOUSIE UNIVERSITY

Participant Name	I explained the study and read the script explaining the consent process.	Did the participant provide verbal consent?	Date and time verbal consent was obtained.	Contact information for summary of results (if applicable)
Example: Jane Doe	*Yes*	*Yes*	*2021-04-01*	*jane.doe@msvu.ca*

Appendix H

Interview Guide

Thank you for giving me your consent, I will now start the audio-recording.

In this interview session I will ask some questions about your experiences post-migration that might have influenced yours and your child's mental health. I understand that you may have more than one child; During the interview I am referring to the ones that were under the age of 11 when they migrated. That said, I understand that sometimes it is not easy to separate your children's experiences, and that is okay. Feel free to speak about whatever you are comfortable sharing. During the interview session, you do not have to answer any questions that make you feel uncomfortable.

Before we start the interview, I would like to tell you a little bit about myself. So, my name is Nahal, and I migrated from Iran 10 years ago with my family. Then, I got married and sponsored my husband to move to Canada. Currently, I am a student, and my husband works at the hospital, we have both experienced positive and negative aspects of migration and settlement firsthand. My previous education is in child development which inspired me to do this research about immigrant children's health.

1. Could you tell me a little bit about yourself and your immigration story?
    - Potential probing questions:
        a) Which country in the Middle East are you from?
        b) What is your immigration status in Canada?
        c) How long have you been migrated, and in which city and province are you located?
        d) How old are you?

e) How many children do you have? What are their ages?

f) How old was/were your child(ren) when they migrated?

g) What is your first language? How do you perceive your English language ability?

2. How do you consider your overall health and wellbeing after immigration?
    - Potential probing question
        a) How might your health have changed over time in Canada, if it has?
3. What are some things that have impacted your overall health after migration?
    - Potential probing questions:
        a) Could you tell me about your family experience in finding employment?
        b) Can you tell me a little bit about your friends and families here in Canada, and how that is different from home?
        c) Could you also tell me a little bit about your experiences accessing health services in your province?
4. How do you consider your child's overall health and wellbeing after immigration?
    - Potential probing questions
        a) How might this differ if your child was growing up in their home country?
        b) What are some things that might have influenced your child's overall health post-migration?
5. According to the World Health Organization, mental health is defined as "a state of well-being in which every individual realizes his or her own potential, can cope with

the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." How do you define mental health according to your culture?

6. Can you tell me a little bit about your mental health after immigration?
    - Potential probing questions
        a) Thinking about the experiences that you shared previously, what has influenced your mental health following immigration?
7. How do you see your child's mental health after immigration?
    - Potential probing questions
        a) What has influenced your child's mental health following immigration?
8. How might your post migration experiences influence your child's mental health?
9. Are you aware of programs and services to support your mental health?
    - Potential probing questions
        a) Are you aware of programs and services to support the mental health of your child?
10. What programs, services, or supports could promote your and your child's mental health?

Appendix I

Participant Honorarium Form

Does the participant confirm that they have received the sum of a $15 from Dalhousie University for participating in the Child Immigrant Post-Migration Mental Health: A Qualitative Inquiry into Caregivers' Perspectives?

Study?" *(choose Yes or No based on the participant's response)*

_____ Yes No

Name of participant

_____ _____

Name of Researcher Signature of Researcher

(please print)

Appendix J

Additional Resources

Canadian Mental Health Association

A nation-wide voluntary organization promoting the mental health of all and supporting the resilience and recovery of people experiencing mental illness.

Halifax/Dartmouth Branch (902) 455-5445

www.cmhahaldart.ca

Feed NS Help Line

24-hour help line from Feed Nova Scotia

1-877-521-1188

Immigrant Services Association of Nova Scotia (ISANS)

ISANS recognizes the key role of immigrants in Canadian society. We work with newcomers to help them build a future in Canada. We provide a wide range of services to immigrants, from refugee resettlement to professional programs, from family counselling to English in the Workplace.

(902) 423-3607

Kid's Help Phone (24-hour)

1-800-668-6868

YMCA of Greater Halifax/Dartmouth Centre for Immigrant Programs

(902) 457-9622

The YMCA provides newcomer children, youth, and their families with a variety of programs and outreach services. Our approach is to deliver community-based support that is inclusive and welcoming. We also provide on-site services for students at several

partner schools. Our YMCA Centre for Immigrant Programs helps newcomers to Canada settle into their new communities while also supporting the community in understanding the issues and barriers they face.

Dartmouth Family Centre

(902) 464-8234

Dartmouth Family Centre offers programs and services which support families with children aged prenatal to age six. its main activities include:

* prenatal and post-natal support

* child development programs

* programs for parents and children together

* parenting support programs and supports for families take place at the Centre, at outreach locations and in individual's homes.

Fairview United Family Resource Centre (Fairview Family Centre)

(902) 443-9569

Some of our programs include advocacy and referrals, health and wellness programs, youth programs, pre-school programs, one on one adult skill development opportunities, health and safety programs, community meals, pre-k program, parenting programs and support and many community partnerships. Please see under programs and services for a more detailed list.

Chebucto Family Centre (Home of the Guardian Angel)

(902) 479-3031

Chebucto Family Centre provides free services and supports to families and community members. These include but are not limited to: advocacy and support, health and wellness

programs, prenatal and parenting classes, our Volunteer Doula Program, children and youth programming, family play times and operating as a Family Home Day Care Agency.

Bayers/Westwood Family Support Centre

(902) 454-9444 or (902) 454-0762

Offers in-home support to families with children covering topics such as managing behaviour, building relationships in the family, managing a budget, and moving through a divorce.

Mulgrave Park Caring and Learning Centre

(902) 453-5089

The purpose of the Mulgrave Park Caring and Learning Centre is to provide services and programs to promote healthy interactions between children and their parents, other caregivers and members of the community.

Parents and Children Together Resource Centre (PACT)

(902) 434-8952

Parents and Children Together actively contributes to the well-being of families through programs, workshops and activities offered to parents, expectant parents, caregivers and their children.

North End Parent Resource Centre

(902) 492-0133 or (902) 492-0263

The Resource Centre offers a safe place to meet community members, a supportive environment for personal growth and development, and many programs and activities that are planned and organized together by the community and staff. Our programs empower

families to meet their life goals and overcome the challenges of living with poverty and the pressures that come with living in a marginalized community.

Nova Scotia Early Childhood Development Intervention Services

1-844-292-6730

NSECDIS offers child development, family support & capacity building, transition support, and case coordination & partnership.

CMAS (CNC, Care for Newcomer Children)

https://cmascanada.ca/

CMAS is Canada's leading organization that focuses on caring for immigrant and refugee children. We take a great deal of pride in sharing our expertise with immigrant serving organizations and other organizations in the child care field.

Appendix K

Reminder Email

Dear [PARTICIPANT NAME],

Please note that you are scheduled to complete an interview via [Teams/phone/in-person] on [DATE] at [TIME] to talk about your perception of your child's mental health after migration.

If you can no longer attend and need to reschedule, please contact the lead researcher.

Sincerely,

Nahal Fakhari

Email address: nahal.fakhari@dal.ca

Phone number: (902) 489-8942