A MIXED-METHOD ANALYSIS OF SENSE OF PLACE AND MENTAL WELLBEING OF VISIBLE MINORITY IMMIGRANTS

By Boadi Agyekum

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AUTHOR: Boadi Agyekum

BA (University of Ghana, 2007)

MA (York University, 2012)

SUPERVISOR: Dr. K. Bruce Newbold

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Abstract

Employing an expanded meaning of the concept of sense of place within Health Geography, this thesis explores the relationship between sense of place and mental wellbeing of immigrants. The concept of sense of place demonstrates the importance of specific places for socioeconomic and health impacts on individuals and groups in their societies. While research has explored immigrants' sense of place, few studies have attempted to explore visible minority's perceptions of place and its influence on wellbeing. Using qualitative and quantitative techniques, this thesis explores the perceptions and experiences of place amongst Ghanaian and Somali immigrants in Hamilton, Ontario, Canada. First, we explore key informants' revelations on immigrants' sense of place and mental wellness in Hamilton, Ontario. Findings provide insight into the role of policies that affect determinants of health amongst immigrants. Second, we examine the effects of self-perceived mental wellness, socioeconomic and demographic variables on sense of place amongst Ghanaian and Somali immigrants living in Hamilton, based on an analysis of a survey questionnaire (n=236). Findings highlight a positive relationship between sense of place and mental wellness. Third, using descriptive and multivariate regression methods, we focus on factors that predict African immigrants' life satisfaction in Canada. We examine sociodemographic, economic and health-related factors that predict life satisfaction amongst African immigrants, specifically Ghanaian and Somali immigrants. We find that immigrant settlement workers and agencies would be better able to meet the needs of immigrants if they are conscious of the factors that would empower immigrants to cope with life stresses. We suggest a reduction of stress

by helping individuals and families identify sources of support, providing jobs, affordable housing, language interpretation and training. Lastly, we explore specific places, religious sites and their relationship to health and wellbeing for immigrants. Specifically, we explore churches and mosques where Ghanaian and Somali immigrants worship. We find that places of worship are significant for physical health, social, emotional, spiritual, mental, and general quality of life amongst immigrants. The thesis is highly relevant in the current Canadian policy context, which includes contribution to the understanding of the determinants of health and integration of immigrants, providing insights into the concepts of sense of place and mental wellbeing, and broadening our understanding of African immigrants' integration. Overall, this thesis develops a better understanding of immigrants' settlement and integration, and further contributes to the broader immigration literature.

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Preface

This thesis comprises four substantive chapters that are either accepted (Chapter 3) or submitted (Chapters 4, 5 and 6). Each individual study design, data collection and analysis, and manuscript preparation were conducted by the lead author. The main chapters in this thesis are:

Chapter 2: Agyekum, B., and Newbold, K. B. Sense of Place and Mental Wellness of Visible Minority Immigrants in Hamilton, ON: Revelations from Key Informants. *Canadian Ethnic Studies* 48 (1): 101-121.

Chapter 3: Agyekum, B., and Newbold, K. B. Sense of Place and Mental Wellness amongst African Immigrants. *Journal of Happiness Studies* (Under Review).

Chapter 4: Agyekum, B., and Newbold, K. B. Determinants of Life Satisfaction amongst African Immigrant in Hamilton, Canada. *Health & Social Care in the Community* (Under Review).

Chapter 5: Agyekum, B., and Newbold, K.B. Religion/Spirituality, Therapeutic Landscape and Immigrant Mental Wellbeing. *Mental Health, Religion & Culture* (Under Review).

Chapter One: Introduction

1.1 Introduction

Canada's demographic composition has changed significantly in the last few decades. Immigrants in Canada constituted approximately 20.6% of the total population in 2011 (Statistics Canada, 2011) and it is projected that by 2025 immigrants will be the only source of population growth in Canada (Hiebert, 2005). Immigrants often cite improvement in quality of life, including employment opportunities, improved living standards and safe political conditions as the main reason for migrating to Canada (Statistics Canada 2014). Nevertheless, the motivation for, and outcomes of, immigration is often challenged by complexities due to very different reasons, different preparedness and different expectations for migrating (Dimitrova et al. 2014). Many of these immigrants will face resettlement challenges given that they are visible minorities and come from countries with cultures and languages different from those in Canada (Ng and Omariba 2010). Ultimately, these differences may pose settlement difficulties in a new destination and are likely to affect the mental wellbeing of immigrants (Ng and Omariba 2010).

As a result, there has been ongoing research amongst both academic and policy makers on immigrant experiences in their new societies including housing (Murdie 2003, employment (Mensah 2010), education (Dei 2005), and health and mental health (Ali 2002; Newbold 2005), with these studies addressing issues of wellbeing and integration of individuals, families and groups. Such studies are critically important to ensure better

conditions and successful integration for Canada's immigrant population. However, studies have not explicitly explored the impact of the physical and social environments on wellbeing and integration amongst immigrants, areas which extend beyond, but also overlap with economic outcomes and health.

In trying to understand the challenges and issues and ultimately success or failure of the adjustment process, the concept of sense of place or individual's perceptions of and relationship to his/her place of residence may provide important and interesting insights. The *Dictionary of Human Geography* (Wylie, 2009, p. 878) defines sense of place as "the attitudes and feelings that individuals and groups hold vis-à-vis the geographical areas in which they live. It further commonly suggests intimate, personal and emotional relationships between self and place". It stresses the emotional bonds with places that are actively and continuously constructed and reconstructed within individual minds, with awareness of the cultural, historical and spatial context (Williams and Stelwart 1998). Because of its multidimensional nature, sense of place is sometimes also referred to as sense of belonging (Kitchen et al. 2012; Hagerty and Williams 1999; Ma, 2003; Choenarom et al. 2005; Bailey and McLaren 2005), sense of community (Bathum and Baumann 2007), community belonging (Ross 2001), and place attachment (Hidalgo and Hernandez 2001).

A number of studies in disciplines other than health geography have applied the concept of sense of place in their research. For instance, its application has been highlighted in religious studies (Casakin 2009; Jensen 2015) and in land-use planning and

resource management in which it is often necessary to account for the senses of place of different stakeholders (Williams and Stewart 1998; Clark and Stein 2003). Also, its quantitative analysis is of interest to the recreational and tourism industries (Bricker and Kerstetter 2002). Lastly, student's sense of place has been observed to influence learning outcomes and assessment measures of place-based Geoscience teaching (Semken et al. 2009).

The concept of sense of place has turned out to be a useful tool for providing a more nuanced picture of immigrants' overall experiences than analyses based on specific studies (e.g., labour market studies, health studies), and, perhaps even more important, for analyzing processes of immigrants neighbourhood perceptions and experiences (Williams and Kitchen 2012; Kitchen et al. 2012). Recent findings suggest that immigrants are more likely to rate their sense of place as low compare to the non-immigrant populations (Williams et al. 2010; Gallina and Williams 2014). In light of empirical investigation of factors contributing to positive sense of place and/or protecting against the impact of negative experiences for immigrants, it is of critical importance to arrive at understandings that can be translated into applicable interventions. We contend that sense of place is an important concept that provides insights into immigrants' holistic experiences of place and wellbeing because of its analysis of place as a central reference point. The next sections describe how each chapter relates and contributes, not only to in-depth understanding of sense of place and wellbeing of immigrants, but also to a multi-method and conceptual approaches of research on immigrants and the basic objectives of this thesis.

1.2 Objectives of this Research

With an increasing number of immigrants settling in smaller and medium-sized cities in Canada, researchers have called for more immigrant studies on second-tier cities (Frideres 2006; Radford 2007; Gallina and Williams 2014). These calls reflect the need and desire to retain immigrants through the provision of desirable conditions and appealing opportunities within immigrants' communities and neigbourhoods (Garcea 2006; CIC 2011; Grubel 2013). One area of research that can offer insight is the concept of sense of place (Williams and Kitchen 2012; Gallina and Williams 2014). Because of the centrality of place in providing meaning for people in many different ways, including settings for family life and employment, identity, feelings of security, and as locales for aesthetic experience (Gesler 1992), the sense of place concept has the potential to explore the various aspects of immigrants' experiences that have bearings on their settlement and integration in a host society.

Indeed, understanding issues of wellbeing and integration of immigrant families are critically important to ensure that we provide a welcoming environment for this growing population in their new destinations. This thesis features contributions across an array of geographic areas with the focus on visible minority immigrants, specifically Ghanaian and Somali immigrants in Hamilton, Ontario. Thus, new approaches and empirical investigations are required to understand immigrants' place making in their new societies. In doing so, the contributions in this thesis address four major objectives:

1.2.1 Objective One

The first objective is to develop new insights regarding concepts of sense of place and mental wellness in health geography, highlighting the personal and social resources that promote a sense of community belonging. This research does not identify causal relationships between sense of place and mental wellness, but rather, sheds light on the services and programs that are likely to promote immigrants' (including refugees) sense of place or community belonging, which is a pre-requisite for positive mental wellness.

1.2.2 Objective Two

The second objective examines sense of place and mental wellness amongst Ghanaian and Somali immigrants in Hamilton, Ontario. This research builds on the first objective by examining the relationships between sense of place, self-perceived mental wellness, and socioeconomic and demographic profiles, including gender, age and length of residence in Canada, family status, education, employment and income.

1.2.3 Objective Three

The third objective examines how life satisfaction varies according to socioeconomic and demographic variables (i.e., age, gender, length of residence, family status, education, employment, income, sense of place), and health related factors, including perceived depression, anxiety, stress, and happiness. The aim is to shed light on factors that influence immigrants' satisfaction in their host societies.

1.2.4 Objective Four

The final objective explores whether places of worship (churches and mosques) are therapeutic places that enable a sense of place for newcomers. By focusing on Ghanaians, a predominately Christian community, and Somalis, who are predominantly Muslim, this research extends existing work on therapeutic landscapes through an analysis of the landscapes of religious places, specifically churches and mosques and their role in the integration of newcomers.

1.3 Organization of the Thesis

The thesis contains seven chapters including the introduction, methodology and conclusion. The four substantive chapters (chapters 3-6) reflect the four objectives noted above, which are broadly related to understanding minority immigrants' sense of place and wellbeing in Hamilton, Canada. Chapter two provides an overview of the methods used in each substantive chapter – a qualitative-driven sequential mixed method approach provides insight into the concept of sense of place and wellbeing. Ethical issues surrounding immigrants' sense of place are also examined.

Chapter three explores key informants' revelations on immigrants' sense of place and mental wellness in Hamilton, Ontario, directed toward processes and programs that challenge belongingness and integration. Grounded in key informant interviews, the thesis underscores the importance of understanding immigrants' sense of community, belonging embedded in socioeconomic conditions, and implications for mental wellness. The results suggest that settlement service providers and other stakeholders adopt a broad

and multifaceted approach that recognizes the importance of addressing immigrants' circumstances in a holistic manner. Findings highlight the role of policies that affect all determinants of health (including mental health) through the integration of public policies into a comprehensive package of health improvement and promotion strategies, and should be incorporated into policies of health and health-related institutions for implementation.

Chapter four examines the effects of self-perceived mental wellness, socioeconomic and demographic variables on sense of place amongst Ghanaian and Somali immigrants living in Hamilton, Ontario. Findings are based on the analysis of survey questionnaires (n=236) of Ghanaian and Somali immigrant adults, with recent (0 – 5 years), mid-term (6 – 10 years), and long-term (more than 10 years) residency in Canada. Findings revealed several significant factors of sense of place and the relationship between sense of place and self-perceived mental wellness, including income, age, employment, citizenship status, marital status, dwelling type and length of residency in Canada. Findings revealed that those who perceived their mental wellness to be 'Excellent/Very good', and who are fully employed with higher income and have been in Canada for longer periods of time were more likely to evaluate their sense of place as 'positive' and vice versa. The findings highlight the need for research to incorporate sense of place into studies on visible minority immigrants and to focus on those factors contributing to place attachment amongst recent immigrants.

Chapter five examines the factors that affect African immigrants' life satisfaction in Canada. Using a combination of descriptive and multivariate regression methods applied on a sample survey (n=236) conducted in Hamilton, Ontario, between June 2014 and January 2015, this chapter investigates socio-demographic, socioeconomic and health-related factors that predict life satisfaction amongst African immigrants, specifically, Ghanaians and Somalis. By doing so, this chapter contributes to the literature on quality of life, which is often cited as the motivating factor for migration. Results of ordered logistic regression models revealed several significant factors associated with life satisfaction: being a Ghanaian; having a residency in Canada of 10 years and above; employed; living in a single/semi-detached house and being in age-categories 25-34, 35-44 and 45-54. The findings suggest that immigrant settlement workers and agencies would be better able to meet the needs of these immigrants if they are conscious of the effects of settlement challenges. Attention should be focused on reducing stress at a systemic level, including helping families identify sources of support, providing jobs, affordable housing, language interpretation and training. At the individual level, empowering immigrants to cope effectively with settlement challenges as they navigate through their new destinations would be worthwhile.

In chapter six, the focus shifts to the experiences of the role of religious places in the reinforcement of health and wellbeing. Attention is paid to how religious places are seen as therapeutic and their impact on the wellbeing of Ghanaian and Somali immigrants in Hamilton, Ontario. The findings emerging from the therapeutic landscape lens underscores the importance of immigrants' religious places and activities in shaping

health in their new destination. The findings indicate that immigrants' places of worship are significant for physical health, social, emotional, spiritual, mental, and general quality of life. Future research employing the therapeutic landscape theory may explore the links between health and place in specific religious places and activities.

Chapter seven concludes with some general comments, limitations and contributions of the thesis to the literature on immigrants' sense of place and wellbeing. This chapter provides insightful areas for re-directing research attention on several areas to understanding immigrants' sense of place and integration.

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Chapter Two: Methodology

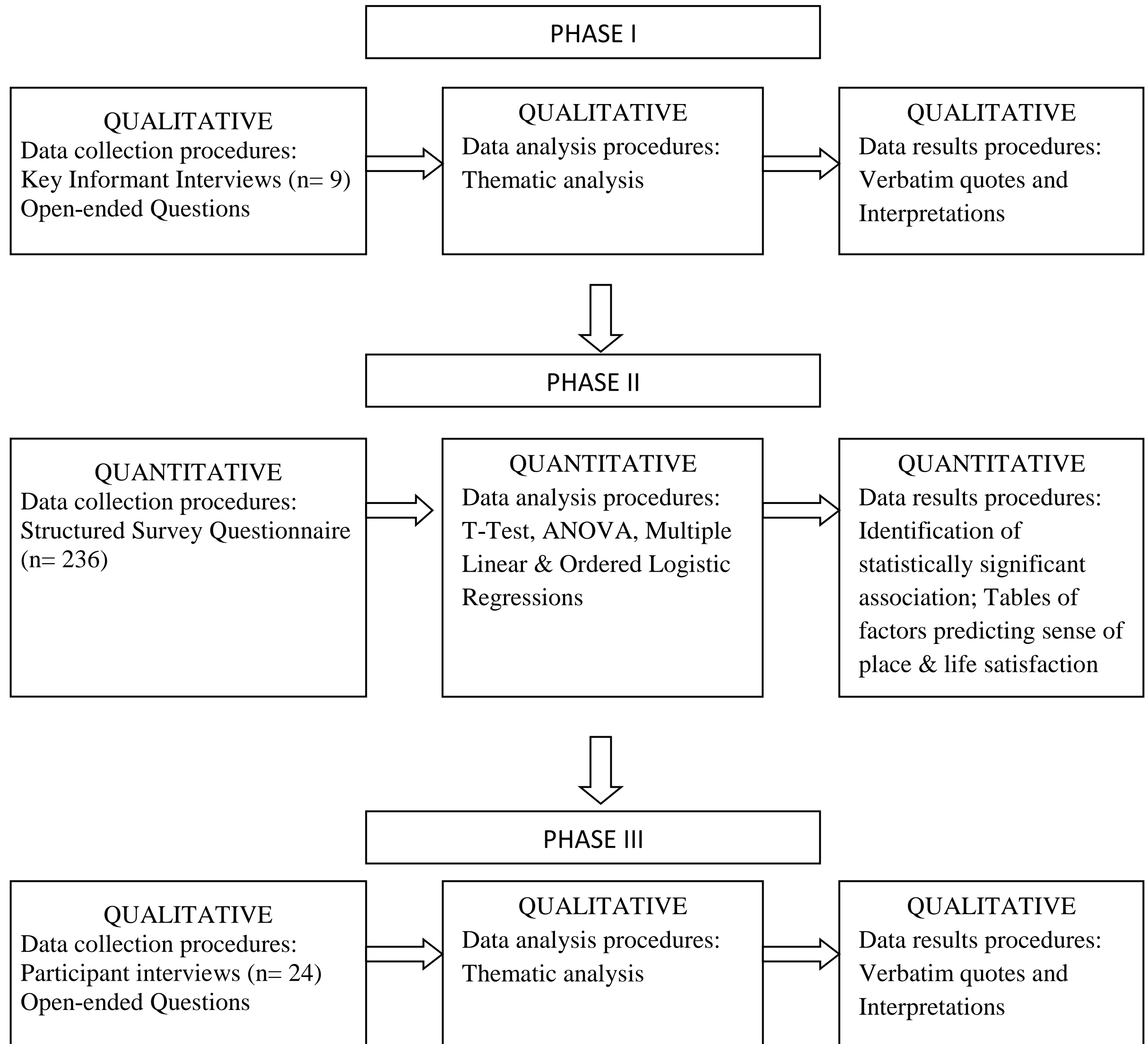
2. 1 Introduction

The research utilizes multiple methods in which a qualitatively-driven sequential mixed method design was applied. Focusing on Ghanaian and Somali immigrants in Hamilton, Ontario, the research started with a qualitative approach grounded in key informant interviews to explore sense of place and mental wellness. The aim was to explore the background for the subsequent methods (survey questionnaire and participant in-depth interviews). Second, a structured survey was used to examine the relationship between sense of place and mental wellness and determinants of life satisfaction. Third, in-depth participant interviews were used to explore the perceived links between religion and health (using the therapeutic landscape lens) of Ghanaian and Somali immigrants. In-depth interviews were used to supplement the survey questionnaire, with the goal of ensuring trustworthiness and confirmability of findings.

The first phase of the project, which relies on key informants' revelations, emphasizes the importance of addressing immigrants' social and economic conditions embedded in their communities or neighbourhoods of residence. This study reiterated the importance of a further study into immigrants' sense of place. The second phase, which focuses on immigrants themselves (as opposed to key informants), uses quantitative techniques (e.g., survey questionnaire, regression models) and builds on the first phase to examine specific factors or conditions that predict immigrants' sense of place and life

satisfaction in immigrants' communities of residence (see Appendix A and B for the survey).

Figure 2.1. Sequential mixed-method design



Factors that significantly predicted sense of place and life satisfaction were identified. However, these studies failed to observe social interactions amongst

individuals and groups, hence the need to explore specific places that immigrants associate with sense of place. In phase three, in-depth interviews were designed to provide perspectives of Ghanaians and Somali groups through understanding the sociocultural activities that promote their sense of belonging in their communities. This revealed the meanings people assign to social phenomenon examined in the survey questionnaire in phase two.

2.2 Ethical Considerations

The study was approved by the McMaster Research Ethics Board, McMaster University, Hamilton, Ontario, Canada. The following ethical considerations were addressed: informed consent was obtained from all participant (written and oral); participation was voluntary; participants were fully informed of the nature of the study and their rights and responsibilities; refusal to participate did not affect the relationship between participants and the investigator; and participants were assured that confidentiality would be provided to the fullest extent such as, including assigning pseudonyms to participants to ensure anonymity. Additionally, procedures developed to ensure confidentiality included having research assistants sign a confidentiality statement agreeing to adhere to the study procedure; storage of questionnaires in locked cabinets in a locked office, accessible only to the investigator; and storage of electronic data on encrypted computers kept in a locked office.

2.3 Key Informant Interviews

The purpose of this approach was to explore key informants' (service providers) views on the personal and social resources that influence sense of place and how those resources might shape mental wellness of visible minorities. Purposive sampling was used to recruit participants for the key informant interviews. In recruiting participants, organizations including churches, mosques, cultural associations, and City of Hamilton organizations in charge of immigration and resettlement services were contacted. With a total of 11 organizations contacted, approximately 81% expressed interest in the study. Organizations that could not directly participate helped in distributing invitations to their workers/service providers through e-mail. In total, nine in-depth interviews were conducted with key informants, including three religious leaders (with all their congregation members being visible minorities), two local group (immigrants' association groups) leaders, one health practitioner and three participants from members of the Hamilton Immigration Partnership Council (HIPC). HIPC includes representatives from the immigrant service provider sector (i.e., health), businesses, unions, government and community-based organizations along with other groups, and aims to create a welcoming community for new immigrants. We recruited a relatively small number of key informants due to the limited number of immigrant resettlement service providers in the city. Participants were between 29 and 56 years of age; four females and five males; seven married, one widowed and one single, and all had completed post-secondary school. In terms of country of origin, the study sample was quite heterogeneous with participants coming from Africa, Asia, South America and Europe. It is important to note

that all key informants were visible minorities themselves who have lived in Hamilton between 11 and 28 years.

Some of the areas explored in the interviews included employment, housing, language training and interpretation, immigration and health. Key informant interviews took place between June 2014 and September 2014. After individual consent was obtained, community service providers and religious leaders participated in individual open-ended interviews (see Table 2.1) in English. All key informant interviews were recorded, except two who requested that the interview not be recorded. In these cases, notes were taken verbatim. The interviews lasted between approximately 60 and 90 minutes and were conducted at locations preferred by the participants, including offices, shops, church/mosque premises and homes.

1. Can you tell me a bit about your own background? 2. What do we mean by place attachment? 3. What factors do you think contribute to immigrant's attachment to place/neighbourhood? 4. Is sense of place important for immigrants? Why? Can you give specific examples if a positive sense of place might improve mental or physical health? 5. Should sense of place be promoted? Why? 6. What things do you think the city should do to promote immigrants' sense of place (feeling that they are "Hamiltonian")? 7. Does your organization (i.e., religious group) promote sense of place? How does it do this? Do you think it does a good job? 8. What other ways could sense of place be promoted?

Table 2.1: Key Informant Study Interview Guide

2.4 Quantitative Data Collection and Analysis

The data for the study were based on a close-ended questionnaire survey of 236 Ghanaian and Somali immigrants. The main eligibility criterion for participation in the study was to have immigrated to Canada at age eighteen and above. In addition to questions related to socio-demographic (sex, age, education) and socioeconomic profiles (income), the questionnaire contained a validated 16-item sense of place scale established by Williams et al. (2010).

It focused on four areas, namely neighbourhood rootedness; neighbourhood sentiment; neighbours; environment; and health. Each of the four areas included up of four questions (see Appendix B. All sixteen items were collected on a five-point Likert scale and later recorded into numbers between the values of one and five. Values of one represent the most positive responses and values of five represent the most negative responses (Williams et al. 2010). However, three of the questions on environment and health (D7, D8 and D9) were reverse coded because these questions refer to negative influences on sense of place (Williams et al. 2010). Thus, reverse coding was done to ensure consistency with other questions which reflect positive influences on sense of place (Williams et al. 2010). Based on these responses, a sense of place score was calculated for each individual (Williams et al. 2010). Finally, health-related questions, including self-perceived mental wellness, life satisfaction, depression, anxiety, stress and happiness (five-point Likert scale with 1 representing a positive response and 5 a negative response) were collected to explore their relationship with sense of place (see

Appendix C). Some of the survey questionnaires were given out to respondents in a prepaid postage envelope (43 envelopes were given but only 2 were returned after two months, with a return rate of 4.7%), while others were conducted face-to-face in a range of locations, including respondents' places of residence, churches and mosques; and were done in English, Ghanaian *Twi* and Somali *Af Maay* and *Af Maxaatiri* with the help of interpreters. In total, 250 surveys were given out as face-to-face while 234 were returned, representing a response rate of 93.6%. The surveys were conducted between August 2014 and April 2015.

In order to examine whether significant differences exist among the categories in each of the variables, a t-test and one-way analysis of variance (ANOVA) were conducted followed by determination of effect size for each variable. T-test and ANOVA procedures were used to compare the means of categories, with the t-test comparing the means of two populations and the ANOVA test comparing the means of several populations or groups.

Multiple linear regression was used to determine the relationship between sense of place score (dependent variable), length of residence, marital status, age, household income and mental wellness (predictor variables). Other regressors, including gender, education, living arrangements and dwelling type were tested but did not contribute to the model. In order to assign numerical values to categories of the variables, a dummy variable was generated. This in effect enabled us to estimate the contribution of each

category of a variable (e.g., categories of income) in predicting sense of place score in the regression model.

2.5 In-depth Interviews

The goal of these interviews (see Table 2.2 and 2.3) was to understand the link between religious place making and health amongst Ghanaian and Somali immigrants. The focus was on the therapeutic landscape theory that contributes to an understanding of "religious places" as socio-cultural landscapes for promoting mental wellness (i.e., religion as a feature of mental wellness for immigrants). This approach used purposive, convenience sampling to recruit participants from Ghanaian and Somali communities in Hamilton. After obtaining clearance from the McMaster Research Ethics Board and individual consent was obtained, we recruited at Ghanaian churches and Somali mosques through recruitment posters and verbal announcements.

Respondents participated in individual open-ended interviews in English and Ghanaian *Twi*. This was designed to allow for a more open and freer exchange between the interviewer and interviewee (Dunn 2005). The interviews were conducted between July 2015 and November 2015. In accordance with the agreed ethics protocols, and with the participants' consent, interviews were recorded. Interviews lasted between 45 and 60 minutes and were conducted at locations preferred by the participants, including church/mosque premises, homes and shops. Participants who indicated their willingness to participate in the interview at the end of the survey questionnaire were contacted. In total, we recruited 24 participants from the two study groups until a point at which it was

determined that data saturation had been met (Mays and Pope 2000), with no new themes emerging in the interviews. We recruited 12 participants from each of the study groups, including 7 males and 5 females from the Ghanaian community and 4 males and 8 females from the Somali community. A majority of the participants were between the ages of 22 and 54 years old. All participants were attending church or mosque at the time of the interviews. It is important to note that the majority of individuals in these two communities participate in a religious activity. Common themes within and across groups were identified through the coding process and further discussed for importance and meaning with the help of one of the translators who is knowledgeable in qualitative research.

Table 2.2 Participants in-depth interview guide (Background)

1. How long have you lived in Hamilton? When did you come to Canada?
2. What language do you usually use at home or outside home? Do you feel that you are fluent in English?
3. What type of activities do you do with your family/friends?
4. Where is your favourite place in Hamilton? And why?
5. What do you like best about Hamilton?
6. Is religion important in your life? How often do you attend church/mosque? What religious activities do you miss most when you are not with your religious group for some reason?
7. What community/neighbourhood activities are you involved in besides religious activities?
8. Do you think that immigrants (Ghanaians, Somalis, etc) are valued in Hamilton? How is that shown?
9. Do you think that immigrants are involved in community activities or volunteering? Why and How?
10. What made you settle in Hamilton? If you had to do it all over again, would you still choose to settle in Hamilton? If not, where would you settle? Why?
11. Do you have a feeling of belonging in Hamilton?
12. What things do you think the city exactly does to promote immigrants' sense of place (feeling as "Hamiltonian")?
13. What other things could the city do to promote immigrants' sense of place?

Table 2.3 Questions on Therapeutic Landscape

1. Does the church/mosque promote good general health to their members? How can the church or the mosque function to promote good health of their members?
2. How does the church/mosque become healing places for members/people?
3. What does healing in the spiritual context mean?
4. In what ways are the body protected from diseases/illnesses through activities in the mosque/church or through your belief?
5. How does the interaction of people in the church/mosque provide healthy conditions or atmosphere for members?
6. What does the act of singing, dancing or praying together (large or small group) offer to members who engage in it? What about people who do not?
7. Do you feel involved in the church or mosques? Please tell me.
8. How does the layout of the church or mosques influence your spiritual wellbeing?
9. What other things does the church or mosques do to support members' welfare or wellbeing?
10. Do you see the church/mosque as your second home aside where you live?

2.6 Conclusion

This chapter emerged from a mixed-method project, which included open-ended questions with key informants (immigrant settlement service workers) and participants from the two study groups. The quantitative part included structured survey questionnaire with subset of 236 Ghanaian and Somali immigrants in Hamilton, Ontario. The qualitative data analysis informed the quantitative analysis. This approach was designed to gather data and expand on the concept of sense of place and mental wellbeing. The survey focused on socioeconomic and demographic characteristics, sense of place and mental wellbeing. Thus, a qualitative driven-sequential mixed method approach enabled a more comprehensive understanding of sense of place and mental wellbeing. Although this chapter makes an important contribution to mixed-method analysis through the consideration of immigrants' perceptions and experiences of place in a mid-sized city,

further research elsewhere is needed to develop a more comprehensive understanding of sense of place and wellbeing. This chapter concludes that more individual-level, household-level, and multilevel analysis is needed enhance understanding of sense of place and mental wellbeing outcomes.

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Chapter Three: Sense of Place and Mental Wellness of Visible Minority Immigrants in Hamilton, Ontario: Revelations from Key Informants[1]

3.1 Introduction

Like many developed nations, immigrants represent a significant proportion of the total population (approximately 20.6%) of Canada (Statistics Canada 2011). Immigrants go through rigorous health screening to ensure that they are healthy before they are admitted, with immigrants having a relative health advantage over the general population, a common phenomenon known as the 'healthy immigrant effect' (i.e., Ali 2002; McDonald and Kennedy 2004; Newbold and Danforth 2003). However, the health of immigrants has been observed to deteriorate within a few years of arriving in Canada, with the decline in immigrants' physical and mental health said to be the result of pre-migration, migration and post-migration stressors associated with acculturation, barriers to health care, and/or changing diets (Pumariega et al. 2005; Dean and Wilson 2010), suggesting that there are factors within the host society that negatively affect the health of immigrants (McDonald and Kennedy 2004; Newbold 2005; Ali 2002; Ng et al. 2005).

Most research on immigrants' health has focused on post-migration factors of health, presumably due to a lack of data on pre-migration and migration experiences of immigrants. While Canadian scholars have given considerable attention to immigrants' physical and mental health in the context of an increasing number of immigrants from non-traditional source countries and by examining themes such as the 'healthy immigrant

[1] This paper is forthcoming in *Canadian Ethnic Studies* 48 (1), 99 – 120.

effect' and settlement challenges (Newbold 2005; Ng and Omariba 2010; Khanlou 2009), it is only recently that researchers have begun to explore the relationship between sense of place (often referred to as sense of belonging, sense of community, community belonging, and/or place attachment) and its implication on mental wellness amongst immigrants (Williams and Kitchen 2012; Kitchen et al. 2012). Research in these areas have shown that immigrants who rated their sense of place as 'positive' were more likely to say that their physical/mental health was excellent/very good (Williams and Kitchen 2012; Kitchen et al. 2012; Wilson et al. 2004). A recent study in Hamilton, Ontario found that immigrants in general were more likely to rate their sense of place lower than their Canadian-born counterparts (Gallina and Williams 2014). Their study disagrees with a past study in Hamilton on the evaluation of sense of place between immigrants and Canadian-born individuals, which did not show any clear pattern (Williams et al. 2010; Williams and Kitchen 2012), suggesting that greater attention is needed to nurture immigrants' connection with their new home. To be sure, some of the implications of these trends for immigrants' health are commonly alluded to but rarely examined with empirical evidence from the perspective of immigrant resettlement workers and other stakeholders. This study builds on previous studies in Hamilton by identifying resettlement stressors that impede on health, and the personal and social resources that promote a sense of community belonging amongst immigrants in Canada.

The aim of this chapter is to develop new insights regarding concepts of sense of place and mental wellness in health geography, highlighting the personal and social resources that promote a sense of community belonging. This exploratory study is not

meant to identify causal relationships between sense of place and mental wellness, but rather, to shed light on the services and programs that are likely to promote immigrants' (including refugees) sense of place or community belonging, which is a pre-requisite for positive mental wellness.

3.2 Literature Review: Sense of Place and Mental Wellness

Sense of place is a multidimensional and contemporary concept (Lengen and Kistemann 2012) that encapsulates geographical place, social community or environment and is embedded with psychoanalytic meaning (Williams and Kitchen 2012). It is sometimes also referred to as sense of belonging (Kitchen et al. 2012; Hagerty and Williams 1999; Ma 2003; Choenarom et al. 2005; Bailey and McLaren 2005), sense of community (Bathum and Baumann 2007), community belonging (Ross 2001), and place attachment (Hidalgo and Hernandez 2001). The literature that follows will use these terminologies interchangeably.

The Dictionary of Human Geography (2009) defines sense of place as "the attitudes and feelings that individuals and groups hold vis-à-vis the geographical areas in which they live. It further commonly suggests intimate, personal and emotional relationships between self and place" (Wylie 2009, 676). Earlier on, Agnew (1987) and Altman and Low (1992) argued that sense of place emanates from places that develop from emotions related to experience and are composed not only of physical elements, but also of activity, meaning and place attachment. These places are locations (Cresswell 2004) and zones of experiences and meanings (Wilson et al. 2004), which influence how

we think, the course of our life, our consciousness, our social structures, and our health and wellbeing (Lengen and Kistemann 2012). Place is therefore defined as any locality or space that has become imbued with meaning by human experience in it (Tuan 1977).

In recent decades, place has come to be understood to mean different things to different populations. For instance, Williams (1999) noted that people have certain places that they interact in and invest with meanings including peace, relaxation, rejuvenation, restoration and/or some form of physical, mental and/or spiritual healing. Furthermore, Williams (1999) posits that environments that have a strong sense of place can promote the maintenance of health and wellness. Contributing to the link between place and health, Williams noted that a positive sense of place can also create therapeutic landscapes in other locations, most obviously the home, which "without exception is considered to be the 'place' of greatest personal significance in one's life − the central reference point of human existence" (Williams 2002, 145). These environments that promote individuals' and groups' sense of place have also been observed to influence people's physical and mental wellness (Kitchen et al. 2012; Bathum and Baumann 2007) at the individual, intermediate and systemic levels (Ng and Omariba 2010; Khanlou 2009; Wu and Schimmele 2005).

Amongst immigrants, it may be that a positive sense of place encourages mental wellness. Understanding immigrant mental wellness is fundamental to Canada's immigration policy as it relates to general measures of population health. It also adds to our understanding of the costs and benefits of Canada's immigration policy. According to

the World Health Organization (WHO 2007), there is no health without mental health. Mental health therefore refers to a broad array of activities directly or indirectly related to the mental wellbeing component included in the World Health Organization's (WHO) definition of health: "A state of complete physical, mental and social wellbeing and not merely the absence of disease." It is the foundation for wellbeing of individuals, families and communities (WHO 2001). The WHO defines mental health as "… a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO 2007, 1).

Mental health, like physical health, is determined by a number of social, psychological and biological factors known as the determinants of mental health. The WHO's Ottawa Charter for Health Promotion determined that the fundamental conditions and resources for health, including mental health, include peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (WHO 1986). The determinants of mental health are often discussed in terms of risk factors and protective factors. Risk factors increase the probability that a particular individual or group of people will develop a mental disorder; they can also worsen the burden of an existing disorder. Protective factors moderate the impact of stress and reduce the likelihood of mental health problems (Commonwealth Department of Health and Aged Care (CDHAC 2000). Indeed, one protective factor often discussed is the self-selection process where it is the physically and financially sound individuals who have the ability to withstand the rigours that migration entails (Ng et al. 2005; McDonald and Kennedy

2004). On the other hand, the decline in immigrant physical and mental health with increasing years in Canada is said to be the result of pre-migration, migration and post-migration stressors (Pumariega et al. 2005; Dean and Wilson 2010), with the latter suggesting that there is something within the host society that negatively affects the health of immigrants (McDonald and Kennedy 2004; Newbold 2005; Ali 2002; Ng et al. 2005).

Research that has focused on pre-migration stressors often recognizes that immigration itself can be a lengthy and stressful process that can lead to increased risk for emotional disorders in newer immigrants (Pumariega et al. 2005; Stafford et al. 2010). The pre-migration stressors according to Pumariega et al. (2005) include previous traumatic exposure such as terrorism, torture, war, famine and natural disaster; detention in refugee camps for extended periods; illegal immigration, and loss of extended family and kinship networks (Pumariega et al. 2005; Kirmayer et al. 2011; Beiser 2009). The migration stressors are often discussed around exposure to harsh living conditions (e.g., refugee camps), exposure to violence, disruption of family and community networks as well as uncertainty about the outcome of migration (Kamperman et al. 2007; Lindert et al. 2009; Kirmayer et al. 2011). Lastly, research that has focused on characteristics of the host society that influence mental and physical health of immigrants discusses the lack of access to health care, difficulties in language and language learning, concerns about family members left behind and the possibility of reunification, and the acculturation process as the main determinants of immigrant health (McDonald and Kennedy 2004; Newbold 2005; Dean and Wilson 2010; Stafford et al. 2010; Kirmayer et al. 2011).

Following these studies on immigrant mental health, a study by the Centre for Research on Inner City Health (2012) in Toronto found that fewer immigrants received treatment for depression despite similar levels of depression symptoms among immigrants and Canadian-born participants. The study also found that recent immigrants were half as likely to have taken prescription medication for a mental health problem, and non-recent immigrants (those arriving more than 10 years ago) were about 30% less likely compared to Canadian-born participants. In addition, recent immigrants were half as likely to have consulted with a psychiatrist or psychologist.

Considering the nature of this study, the major focus of the literature is on post-migration conditions that influence immigrants' health in general and mental health in particular. Strong evidence shows that some immigrants have a higher incidence of psychotic disorders after migration (Cantor-Grace 2007; Coid et al. 2008; Morgan et al. 2008). Some researchers (McDonald and Kennedy 2004; Newbold 2005; Ng et al. 2005) hypothesize that the decline of health status of immigrants is due to barriers to the use of health services, including gender roles, trust of western medicine, preferential use of traditional health care providers, education and income, language or cultural differences, and a lack of information about and experience with their new health care system. These barriers are seen to worsen immigrants' health status because of relative under-utilization of preventive health services and under-diagnosis and treatment of health problems. An alternative explanation given by McDonald and Kennedy (2004) posits that improved access to and use of health services over time reveals existing but undiagnosed conditions, hence a worsening of health.

Other studies have discussed conditions that influence immigrants' health and mental health under three main factors, namely: individual, intermediate and system influences. For example, studies have identified individual factors that affect mental health as being female, low income, lower education, having children under six years old, marital status (separated/divorced, widowed, never married compared to married/cohabitation) to be significantly related with depression (Wu and Schimmele 2005; Khanlou and Crawford 2006; Guruge and Collins 2008; Mawani 2008). At the intermediate level, family and social support networks (Canadian Association for Community Living 2005) have identified as a protective factor against depression (Wu and Schimmele 2005). Immigrants often leave behind family and friends who provide emotional, informational and cognitive supports that are important in maintaining health. These supports are difficult to access in a new society. Coupled with loneliness and isolation, the lack of support structures contribute to stress and mental health problems (Beiser 2005; Canadian Task Force on Mental Health Issues 1988). It is increasingly noted that in smaller communities, developing social support networks across social sectors and ethno-cultural groups can be useful in a way that provides a sense of belonging and support to newcomers (Reitmanova and Gustafson 2009; Khanlou et al. 2008). In particular, Khanlou et al. (2008) note that underemployment and unemployment are among the most significant stressors for mental health that has been identified by immigrants.

Historically immigrants have been treated as a secondary labour force or "reserve army" (Hakim 1982) and therefore find it difficult to gain relatively better jobs or full

employment (Canadian Task Force on Mental Health Issues 1988; Gastaldo et al. 2005). This experience is often linked to discrimination relating to language, skin colour and undervaluing of foreign credentials (Dean and Wilson 2009). Unemployment is a very stressful experience and is linked with low self-esteem, isolation and family conflicts that can subsequently lead to mental health problems. Continual unemployment may lead to poverty, which is linked with poorer nutrition and lower housing standards, fewer educational opportunities and access to quality health care. Again, an unemployed person may adopt unhealthy coping skills, including smoking, alcohol or drug abuse, which may jeopardize health. Early research has shown that unemployment is associated with poor marital adjustment and communication, separation and divorce as well as physical violence among couples (Dew et al. 1991). Aside from the above factors, it is noted that the transition from a familiar climate and diet add stress to the difficulties that newcomers face in a new environment (Ahmad et al. 2004).

The review has identified a list of community resources and services, including employment, housing, food, education and language, social support and quality health care. These resources, which are necessary for mental health needs, are also noted to be important for promoting immigrants' sense of place (community belonging). Resettlement after migration is strongly affected by the policies, practices and opportunities of the resettlement society and other organizations, including ethnocultural community organizations and religious institutions, which support immigrants in the process of integration (Pumariega et al. 2005; Beiser 2009; Kirmayer et al. 2011). This

process is designed to help immigrants take control of their lives and improve their mental health.

3.3 The study area

Hamilton is a medium-sized city in Ontario about 75 kilometres southwest of Toronto, and it is comprised of six communities: Ancaster, Stoney Creek, Dundas, Flamborough, Glanbrook, and Hamilton. With a population of 519,949 in 2011, the City of Hamilton is ranked 5th largest in the province of Ontario and 10th in Canada (Statistic Canada 2011), with almost 25% of its residents born outside of Canada and 12.3% as visible minorities (City of Hamilton 2005-2010). A comparatively large proportion (approximately 30%) of the foreign-born entered as refugees. In terms of religion, about 344,625 people are Christians, and 19,025 identified as Muslims. Hamilton has been labelled as the 'Steeltown' of Canada. However, the City has undergone major economic changes and is now recognized for its health care and education sectors (Barber 2004; Freeman 2001; Russ 2007), with several large hospitals, clinics, laboratories as well as educational institutions, including McMaster University and Mohawk College. The City had an unemployment rate of 6.0% in July 2013, which was below that of the province of Ontario (7.3%) (Statistics Canada 2013).

Hamilton is a diverse city, home to successful newcomers and immigrants. It provides newcomers a wide variety of living accommodation, including single family homes, high- and low-rise apartments and townhouses (City of Hamilton 2005-2010). Physically divided by the Niagara escarpment which runs east-west through the city,

poverty is most severe in the lower city, and particularly in the downtown core as compared to the western communities of Ancaster and Dundas. While the downtown core has been the traditional entry point for newcomers, large numbers of immigrants have also settled in suburban communities such as Stoney Creek or newer suburbs of Hamilton, including its 'mountain' neighbourhoods.

A look at the 2013 health profile of Canada reveals interesting and intriguing facts about the position of Hamilton with respect to the health of its residents. For example, 64.6% and 77.3% of residents in Hamilton reported very good or excellent perceived health and mental health, respectively. In comparison, somewhat smaller proportions were observed at the provincial level (61% and 74.3%). Residents of Hamilton also reported a lower level of perceived life stress (22.5%) than the province of Ontario (24%). Approximately 93.2% of residents in Hamilton identified themselves as satisfied or very satisfied with their life satisfaction compared to 91.5% for Ontario. Finally, 69.8% residents of Hamilton rated their sense of community belonging as positive compared to 67.5% of the province of Ontario (Statistics Canada 2013). As noted by Williams et al. (2010) and Williams and Kitchen (2012), sense of place differs among residents with respect to where they live. For example, they found that residents of the Southwest Mountain are upper middle class and rate their sense of place as positive, whereas those living in the Central and Lower City are comparatively older lower-income people who tend to rate their sense of place more negatively.

3.4 Study design

This exploratory study is one of the first to explore key informants' (service providers) views on the personal and social resources that influence sense of place and how those resources might shape mental wellness of visible minorities in Hamilton (see Table 3.1). Purposive sampling was used to recruit participants for the key informant interviews. In recruiting participants, organizations including churches, mosques, associations, and Hamilton city organizations in charge of immigration and resettlement services were contacted. With a total of eleven organizations contacted, nine (81%) expressed interest in the study. Organizations that could not directly participate helped in distributing invitations to their workers/service providers through e-mail. In total, nine in-depth interviews were conducted with key informants, including three religious leaders (with all of their congregation members being visible minorities), two local group leaders, one health practitioner and three participants from members of the Hamilton Immigration Partnership Council (HIPC). HIPC includes representatives from the immigrant service provider sector (i.e., health), businesses, unions, government and community-based organizations along with other groups, and aims to create a welcoming community for new immigrants.. Because of the limited number of participants, we make no claims about the representativeness or the generalizability of our findings. However, we are confident that our data is credible and trustworthy as this is a comparatively small group from which to draw upon. Moreover, as Guest et al. (2006) observed that saturation occurs with meta-themes emerging as early as six interviews. Participants were between 29 and 56 years of age; four females and five males; seven married, one

widowed and one single; all had completed post-secondary school. In terms of country of origin, the study sample was quite heterogeneous with participants coming from Africa, Asia, South America and Europe. It is important to note that all key informants were visible minorities themselves who have lived in Hamilton between 11 and 28 years.

The aim of the analysis was not to directly measure the relationship between sense of place/community belongingness and mental wellness but rather, to infer from the perspectives of service providers and religious organizations how visible minorities' sense of place is nurtured in their everyday activities and the perceived impacts on their mental wellness. Some of the areas explored in the interviews included employment, housing, language training and interpretation, immigration and health. Key informant interviews took place between June 2014 and September 2014. After individual consent was obtained, community service providers and religious leaders participated in individual open-ended interviews in English. All key informant interviews were recorded, except two who requested that the interview not be recorded. In this case, notes were taken verbatim. The interviews lasted between approximately 60 and 90 minutes and were conducted at locations preferred by the participants, including offices, shops, church/mosque premises and homes.

1. Can you tell me a bit about your own background?
2. What do we mean by place attachment?
3. What factors do you think contribute to immigrant's attachment to place/neighbourhood?
4. Is sense of place important for immigrants? Why?
5 Can you give specific examples if a positive sense of place might improve mental or physical health?
6. Should sense of place be promoted? Why?
7. What things do you think the city should do to promote immigrants' sense of place (feeling that they are "Hamiltonian")?
8. Does your organization (i.e., religious group) promote sense of place? How does it do this? Do you think it does a good job?
9. What other ways could sense of place be promoted?

Table 3.1: Key Informant Study Interview Guide

All interviews were transcribed verbatim. Codes were developed after several readings of the transcripts and then clustered to form themes followed. Naming of categories was reviewed and refined with the help of two colleagues who are knowledgeable in qualitative research. The first step in the analysis was the initial coding of the data, codes were then grouped into themes and categorizing it into sub-headings. The next level involved analyzing codes and re-reading the transcripts to develop pattern codes. In order to maintain confidentiality, different key informants are identified by their major association (i.e., religious leader, service provider, health provider, etc.), with an assigned participant code to distinguish between different respondents in each group.

3.5 Findings

There are a number of similarities with regards to the key informants' revelations on sense of place and how that might shape mental wellness amongst visible minorities. Our findings revealed eight factors that influence sense of place amongst immigrants in

Hamilton: discrimination, education, religion, housing, employment, language, gender and social support network. These factors reinforce the importance of housing, employment and language that we have seen elsewhere in the literature (Williams and Kitchen 2012; Kitchen et al. 2012; Ross 2001). Key informant service providers claim discrimination compromises health and inhibits access to healthcare services. There is a growing research suggesting the effect of discrimination experienced by visible minorities through various mechanisms (e.g., psychosocial stressors, economic deprivation, social exclusion, etc.) (Edge and Newbold 2013; Harris et al. 2006; Taylor and Turner 2002; Nazroo 2003). Of specific importance to this study is the role of education and how religion as a 'home' and as a social support network is tied to employment, housing and health. Educational outcomes amongst the children of immigrants provide a longer-term assessment of the effectiveness of a country's immigration policy. Again, it provides an evaluation of whether immigrant parents' desire for and improvement in their quality of life and that of their offspring has been successful and accomplished. However, key informants revealed the presence of improper placement within the educational system. For example, some youth from refugee camps that have never been to school, are placed in school based on their age rather than the ability to understand what is required of them. This, along with settlement stress experienced by the parents, challenges the process of belonging to a community with its associated effect on mental wellness. In his own words:

> *The other area is the portion of like we have a lot of youth from refugee camps (visible minorities) that have never been in school. And what happens is that when*

they come here and you know what you're 15 years old so you have to be in grade 9. So how is someone that is never been in a school setting going to be in grade 9. And again we see that on a daily basis where they are sitting down. They give them paper and say do this, they don't know how to read in their own language, let alone they going to read here in Canada (Service provider participant #1).

Traditionally, religion has been a unifying force for developing a sense of community for immigrants, and provides a way of balancing their identity with that of the host country's identity. The construction of religious centres as a 'home' for believers helps to promote a sense of belonging and cohesiveness. Indeed, it has been suggested that it is the social aspect of religion, rather than faith or spirituality that leads to life satisfaction (Lima and Putnam 2010). The religious leaders in the study demonstrated the various ways through which religion is tied to housing, employment and other social services needed to promote members' belongingness and wellbeing.

With respect to housing, where new arrivals live was also identified as having a large impact on their wellbeing and functioning:

Most visible minority newcomers live in the downtown core because that's where the rent is cheaper and it's more affordable. Unfortunately, the living conditions are not the greatest; it's atrocious and some of the places you wouldn't even think of living in (Health practitioner participant).

So a lot of visible minorities that come to the country sometimes they turn to be very disadvantaged economically, and socioeconomic disadvantage that limit

where they can live and often times they would confine to a specific government housing and really limits their upward mobility and their interaction with other people, it limits the opportunities, it really limits what they can do (Religious leader participant #2).

As noted by Murdie (2003), appropriate housing establishes conditions for access to other formal and informal supports and networks and thus speeds the integration of immigrants into the host societies. Thus, the lack of appropriate housing as identified by the informants is likely to inhibit visible minorities' sense of belonging, which is vital to general and mental wellness. To help in this respect, all religious groups indicated ways through which they help new members to settle before they find government assisted housing or are able to find their own accommodation:

When we receive newcomers we offer them the 1st, 2nd and 3rd month rents and help them look for something, get them connect with other resources in the community (Religious group leader #2).

In terms of employment, key informants stressed how visible minorities are excluded, directly or indirectly, from job opportunities and key information networks. According to a study by Block and Galabuzi (2011), data show that while racialized Canadians have slightly higher levels of labour market participation, they continue to experience higher levels of unemployment and earn less income. Thus, racial discrimination denies the visible minorities from reaching their full career potential. This

issue has compelled some organizations, including religious bodies, to help remedy the unemployment situation. As one religious leader put it:

> *We do have programs, we are working on a database on employment so that means if somebody comes across employment or job and opportunity positions they would enter that in the system and that would be basically opened for anybody who is basically looking. This is intended to help achieve equality in the workplace so that no person will be denied employment opportunities based on one's physical traits (Religious group leader #1).*

> *I noticed that most men don't want to take part in house chores even if their wives are working full time outside the home. They still expect them to come home from work, cook and perform all other household chores; it was only a week ago that I received a phone call around 2:00 o'clock in the morning that one of my members was attempting to commit suicide. We got there as early as possible. So as… (Religious name withheld), we highlighted sayings from the prophetic from the traditions and the importance of staying both physically and mentally fit (Religious group leader #1).*

Social support and networks are vital to the functioning of religious groups. Most of the religious leaders indicated that members see themselves as a family where they can communicate and interact freely, share, and ask for anything they need. Given the emphasis that most major religions place on human relationships, love and compassion, members' sense of community is nurtured and wellness promoted:

But when it comes to other supplements like food and clothing we help them to stand on their feet. Other areas are bereavements, naming and wedding ceremonies, all other things that members could help (Religious group leader #2).

At the end of the year, we have a banquet, so we all come together and we give some gifts to the people and we have music and enjoy. And then we go to picnic, we play all kinds of games (Religious group leader #3).

Religious key informants identified the need to promote religion in various communities given that religious organizations provide spaces and other services through which a sense of place is nurtured amongst immigrants. Again, it has been observed that places where people have a sense of belonging are also noted for their therapeutic conditions (Williams 1999), including mental health. One religious leader shares his opinion on this:

We discuss the importance of health and one of the best things to do as a [Name withheld] is to highlight sayings from the prophetic traditions from the scholars discusses the importance of health. The discussion they had about 400 years ago is the importance of staying fit, healthy, shape, walking, physically active, all of these things are important (Religious leader participant #1).

When it comes to the benefit of having a sense of place in a community, all participants shared similar experiences. They expressed that belonging to a community is an important need for residents in general, and for immigrants in particular. They think it

is even greater for immigrants because there is a sense of separation from home, from family and friends, from where one is used to living, as most immigrants left their places of origin to start a new life in Canada. Therefore, when immigrants feel that they do not belong, feelings of isolation, separation, social exclusion and increased anxiety are common:

> *If you come to a place and you have no family member, no friend to talk to and explain things for you it hurts. It can lead to sickness because you don't know where and when to go. It brings about anxiety, etc., so I think what bothers many immigrants is anxiety, distress and such like (Service provider participant #1).*

Participants thought that improving language skills is an important motivation to make sure that immigrants get outside of their comfort zone, get involved in community activities, and learn some of the values within the community through programs at clubs or youth centres or through sports clubs. Together, they work to improve immigrants' career success, expand their networks and consequently promote a sense of community belonging:

> *When visible minorities come in, they're faced with a lot of challenges. When I came here I didn't speak the same word of English, and I was not used to the study system; it was very very difficult, but having a community that offers certain assistance and certain levels of transition programs, and transition processes. For example, having an English language class teacher who speaks your language can really help; having an introduction about the school system by*

somebody who has gone through the same experience, come from the same place, which can really make it easy (Service provider participant #2).

Access to social support networks was identified as a prospect in every single key informant interview. All service providers, associational groups, and religious leaders who work with immigrants and newcomers develop programs that would help immigrants connect to others for resources, information, ideas, skills, knowledge as well as other forms of social and human capital. They are of the opinion that immigrants who come to the city, regardless of their status, hold some resources that may be useful to others in the city. Likewise, members of the city also possess resources that are beneficial for newcomers. Thus, it is through active social networking that these reciprocal tendencies can be achieved, which help to promote sense of community belonging amongst individuals and groups, with positive implications on mental wellness:

I think some of the factors that helped me personally were being part of an organization. I was part of this organization (Name withheld) before I started working with them and afterwards, since then, I'm not saying just this organization but just being part of an organization from the beginning in this country, this community, and learning some of the values within the community helped. I think that friends, families, how well they are connected themselves within the community makes a bit difference (Service provider participant #3).

A feeling of belongingness in a community where you live is a two-way street, according to participants. Even though the city works to create an inclusive and

welcoming environment, immigrants are also responsible for making themselves feel welcome:

> *There is a saying that you can take the horse to a river side but you cannot force it to drink, as one participant noted. There are sometimes I find that it's the immigrants also who isolate themselves and say things like…. Oh these guys, these people… and it doesn't help them because they don't allow themselves to integrate into the community, they want to do things it is as if they are transferring their countries of origin to Canada, it doesn't work. It has to be give and take. So I think from the part of immigrants they should also allow themselves to integrate into the community, learn the processes that make this place the way it is (Local group leader participant #1).*

The combination of the stress of trying to make ends meet and the frustration of not being able to speak proficiently and interact freely negatively impact the health of immigrants in general. Studies on visible minority immigrants emphasize how prejudicial and discriminatory treatment within the media, school, labour market and other settings impedes their sense of belonging (Caxaj and Berman 2010; Khanlou et al. 2008) which forms an important part of their health, mental health and positive esteem (Beiser and Hou 2006). Participants indicated a varied number of ways that not belonging to a community or not feeling a part of a community impact their physical and mental wellness:

> *Very frequently, it's when people, when don't feel part of the community that they are living in, whether Hamilton community or a Canadian society at large or ethnic group that they are part of, whatever you may have it highly takes a toll mentally and we know there is impact on mental health like depression and anxiety, that kind of stuff. Often times it also manifest in physical ways so, hmmm, people end up with chronic illness, they become socially isolated and medically declined (Health practitioner participant).*

> *They feel that they are not just outsiders looking inside and that they are part of the community nobody questions them. For instance if they are looking for a doctor and they can just like anybody else within the community goes through the process of getting a doctor it makes them feel well; it makes them feel a part of it if they take the child to school and nobody said because you're this so take your child there it makes them feel that we all belong (Local group leader participant #2).*

Key informants advocate for expanded access to language interpretation services as a means to address the language needs of immigrants whose day-to-day language is not English or French. In terms of health, one initiative within the city is the establishment of the Refuge clinic in 2011 by a group of physicians to address the health gaps that many refugees and immigrants face. The clinic offers primary health care, pediatrics, nutrition specialists, cardiology and a host of other services. An evaluation assessment by refugees and immigrants who access the clinic revealed that the centre is

welcoming and easy for people to navigate compared to other clinics and health centres in the city. Indeed, a welcoming environment throughout the literature has been observed to promote individuals' and groups' sense of belonging and its association on both physical and mental wellness. As one practitioner illustrates,

> *The clinic facilitates language interpretation, people see this place as safe, welcoming, and you are not the 'other' so there is that sense of belonging I think. It is really important, that is other people who look like them, who talk like them, and I think it is important and I think we need to look at diversity and work place (Health practitioner participant).*

3.6 Discussion and Conclusion

This chapter underscores the importance of promoting sense of place amongst visible minorities by attending to the broader structural constraints associated with the wellbeing of immigrants. These key informant revelations reaffirm other literature demonstrating the importance of place on mental wellness for individuals and groups alike (Williams and Kitchen 2012; Kitchen et al. 2012; Wilson et al. 2004). Our analysis of the key informant interviews emphasizes the challenges to belongingness and integration, and consequently physical and mental wellness when conditions necessary for immigrants' inclusion are ignored or poorly promoted in our communities.

Past research in Hamilton has shown that higher socioeconomic status neighbourhoods have a higher evaluation of sense of place and associated mental health. Given that visible minorities reside in poor housing conditions as revealed in this study, it

was hypothesized that they are more likely to suffer from health and mental health-related issues. Adverse outcomes associated with discrimination include poor physical health (e.g., cardiovascular, respiratory), mental health (e.g., anxiety, depression) and risky lifestyle behaviours (e.g., smoking and drinking) (Williams et al. 2003).

The findings revealed that visible minorities face many challenges that affect the process of integration. Some of the areas explored include employment, housing, education, health, language interpretation and training, and the role of religion. These factors are perceived to be important in determining the success of visible minorities' integration and general wellbeing in their host communities.

Visible minorities are more likely to perceive work-related discrimination than their Canadian-born counterparts according to key informants. This is not surprising, given that visible minorities are known to experience greater disadvantage than non-visible minority immigrants in almost all spheres of life, including housing (Murdie 2003), employment (Mensah 2010), education (Dei 2005), and health and mental health (Ali 2002; Newbold 2005).

The findings offer additional insight into the determinants of health and mental wellness as the calls for culturally appropriate care have been increasing (Oxman-Martinez et al. 2001; Carillo et al. 1999; Betancourt et al. 2003). The aim is to enable health and social service providers to reflect on their own and others' cultural beliefs, behaviours and communication strategies to enable practical skills that facilitate quality, non-discriminatory care (Magoon 2005; Reitmanova and Gustafson 2009; Guilfoyle et al.

2008). In Hamilton, Ontario specifically, a strategy employed is the setting up of the Refuge clinic in 2011 to address refugees' health needs by bringing in professionals that share their clients' languages and ethnic backgrounds. This initiative was intended to bridge the health needs gap between visible minority new immigrants and the Canadian population, which is likely to promote visible minorities' sense of belonging and associated wellbeing. Thus, this initiative is in line with the calls for specific programs and strategies to address specific immigrant needs in immigrant receiving communities. It is reasoned that medium to large cities tend to employ 'one-size-fits-all' programs to address immigrants' needs due to cost constraints (Frideres 2006) that may hinder the supply of immigrant services and further place attachment.

It is interesting to note that religious organizations were identified as contributing to the promotion of sense of place and mental wellness of immigrant visible minorities. While it was mainly discussed by religious leaders, it does highlight religion as a potential for promoting sense of place, particularly when it is tied to employment, housing, health and social support network. Religion helps to empower the individual through connecting individuals to the community, and a greater force that might in turn give psychological stability (Oman and Thoresen 2003). Thus, the restorative effects of religion on emotional, cognitive and physical functioning are well illustrated and acknowledged (Giaquinto et al. 2007; Lima and Putnam 2010; Koenig et al. 2012).

The study limitations need to be mentioned. First, this study had a small sample of key informants due to the limited number of immigrant settlement service providers in

Hamilton. Notwithstanding this limitation, the chapter contributes to an improved understanding of the factors that promote immigrants' sense of place and mental wellbeing in medium-sized cities with limited ethno-specific facilities. A second limitation involves the scope of this study, which encompasses all immigrant visible minorities regardless of immigration status (e.g., refugee groups). It is possible that different immigrant groups may have different experiences of sense of place that could be studied by exploring more homogeneous groups of immigrants, given that other research has shown that immigrant experiences and perceptions often vary across immigrant subgroups (Beiser 2005; Ng et al. 2005; Dean and Wilson 2010). Therefore, there is a need to examine the experiences of different immigrant groups.

Third, this study did not directly measure the relationship between visible minorities' sense of place and mental wellness. Rather, it explored key service providers' experiences and perceptions of immigrant visible minorities' sense of community belonging and how that might shape their mental wellness. Thus, examining sense of place and mental wellness of specific immigrant groups is important, and we seek to examine this in future studies.

While we recognize that our study did not identify causal pathways between sense of place and mental wellness, it does provide insight on those significant factors that promote immigrant visible minorities' sense of community belonging and how they may shape their mental wellbeing. Our study has demonstrated the importance of key factors

(e.g., the role of religion) that may be overlooked when considering sense of place and mental wellness.

In conclusion, we emphasize the need for policies and programs that reflect the broader social determinants of health as articulated in the Ottawa Charter for Health Promotion (World Health Organization 1986). The social determinants of health emphasize the social and economic conditions (e.g., income inequality, social exclusion) of individuals and populations that influence belongingness and health (Mikkonen and Raphael 2010). In recognition of the fact that health is a complex phenomenon, it is recommended that a broad and multifaceted approach that recognizes the importance of addressing health in a holistic manner be adopted. This could be achieved by focusing on policies that affect all determinants of health (including mental health) through the integration of public policies into a comprehensive package of health improvement and promotion strategies; and should be incorporated into policies of health and health-related institutions for implementation. A focus on intersectoral approaches that would enhance sense of community belonging amongst immigrants (e.g., social services, language training and interpretation) and across groups categorized by race/ethnicity, gender, and place, and their association with health outcomes, are recommended. Accordingly, this would uncover the extent to which socio-economic conditions influence sense of community belonging, physical and mental health of different populations and provide a lens through which we could improve and reduce health inequalities.

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Chapter Four: Sense of Place and Mental Wellness amongst African Immigrants[2]

4.1 Introduction

Canada's demographic composition has changed significantly in the last few decades. Immigrants in Canada constitute approximately 20.6% of the total population (Statistics Canada, 2011) and it is projected that by 2025 immigrants will be the only source of population growth in Canada (Hiebert, 2005). Many of these immigrants will face resettlement challenges given that they are visible minorities and come from countries with cultures and languages different from those in Canada (Ng and Omariba 2008). Ultimately, these differences may pose settlement difficulties in a new destination and are likely to affect the mental health of immigrants (Ng and Omariba 2008).

Past research on immigrant health has largely focused on differences in health between immigrants and the Canadian-born. Overall, immigrants appear to have a health advantage – a phenomenon known as the healthy immigrant effect (McDonald and Kennedy, 2004; Newbold, 2005). Central to this finding is that the health of immigrants, including their mental health, is significantly better compared to that of Canadian-born population just after arrival, but converges toward that of the Canadian-born with increased length of time in Canada (Ali, 2002; Reitmanova and Gustafson, 2009).

In recent years, one area of health geography analysis has been the focus on the relationship between sense of place (also known as sense of belonging or place attachment) and mental health. Research has shown that immigrants who rated their sense

[2] This paper is under review in the *Journal of Happiness Studies*

of place as ‘positive’ were more likely to say that their physical/mental health was excellent/very good (Williams and Kitchen 2012; Kitchen et al. 2012; Wilson et al. 2004). In a recent study in Hamilton, Ontario, Gallina and Williams (2014) found that immigrants in general were more likely to rate their sense of place lower than their Canadian-born counterparts, although their study contradicts other studies which did not show any clear pattern (Williams et al. 2010; Williams and Kitchen 2012). Potentially, these differences could reflect different perceptions of sense of place by origin, race or ethnicity, suggesting that greater attention is needed to understand if sense of place differs by race, and to nurture immigrants’ connection with their new destination. It is hypothesized that strong place attachment may help adaptation and integration into the host country. Thus, we know little about how visible minority immigrants in Canada, especially those from Africa, experience and negotiate place and belonging.

This study is significant because of the dearth of research on Black African immigrants’ sense of place in Canada. Africans make up an increasing proportion of immigrants to Canada (Statistics Canada 2010), and it is projected that the number of African immigrants will double in size in the next two decades (Statistics Canada 2010). Researchers have shown that amongst immigrants, Blacks are the most underprivileged groups in Canada (Este et al. 2012; Reitz 2010; Banerjee 2006) and experience higher rates of discrimination (Ray and Preston 2009). The study is also important given that sense of place remains an integral part of the lives of immigrants, and also has a bearing on their integration and wellbeing. Consequently, the goal of this chapter is to examine sense of place and mental wellness among Ghanaian and Somali immigrants in Hamilton,

Ontario. Specifically, we examine the factors that influence individual and group sense of place. It is significant to understand sense of place from a Black African perspective because they may have specific circumstances that influence their community belonging.

The main objective of this chapter therefore is to examine the relationship between sense of place and self-perceived mental wellness, along with variations by gender, age and length of residence in Canada, family status, education, employment and income. The primary research questions are as follows: (1). Are there differences in the evaluation of sense of place between Ghanaians and Somalis? (2). Does sense of place vary according to gender, age, length of residence, family status, education, employment and income? (3). How does sense of place relate to self- perceived mental wellness amongst immigrant groups? It is worth noting that we are not measuring mental wellness but, rather, sense of place and its implications for mental wellness.

4.2 The Concepts of Sense of Place (SOP) and Mental Wellness

Sense of place is a concept developed as a result of both theoretical (Relph 1976; Tuan 1974; Gesler 1992; Cresswell 2009) and empirical (Manzo 2005; Jorgensen and Stedman 2001; Eyles and Williams 2008) construction of place. Sense of place is defined as a geographic concept "intended to describe the particular ways in which human beings invest their surroundings with meanings." (Hubbard et al. 2004, p. 351). It is a multidimensional concept that is sometimes referred to as sense of belonging (Kitchen et al., 2012; Hagerty and Williams, 1999; Ma, 2003; Choenarom et al., 2005; Bailey and McLaren, 2005), sense of community (Bathum and Baumann, 2007), community

belonging (Ross, 2002), and place attachment (Hidalgo and Hernandez, 2001). Although the literature uses these terms interchangeably, this research focuses on sense of place as the experiences and perceptions that immigrants hold vis-à-vis their communities.

Recognizing that individual perceptions of a place can apply to a wide range of settings, Billig (2005, p.118) suggests three factors that affect sense of place: "sense of place is a multivariate characterization on a particular residential environment, formed by the subjective feelings and patterns of behaviour of its residents and resulting from relations between groups of residents, and from their attitude toward the physical aspects of the neighbourhood environment. Secondly, many social and physical factors will influence the sense of place of the residential environment, and lastly, each residential environment will be characterized by its own unique sense of place." Hence, sense of place is contingent on a combination of individual and contextual (i.e. physical and social) attributes (Williams et al., 2008; Rapoport, 1977; Hiss, 1990: xi).

Sense of place can be "created by the pattern of reactions that a setting stimulates for a person" (Steele 1981, p. 12). Places, therefore, are locations where people can identify themselves and meanings are understood. Places said to have a strong sense of place have a strong identity. Buttimer (1980) used the term 'place identity' to include the most important functional activities that take place in or around the home. She proposed a balance between the home and the surrounding geography as necessary for the maintenance of personal identity and emotional wellbeing.

It is worth noting that the concept of sense of place is difficult to define due to its multidimensional nature (Luginaah et al., 2001; Coulton et al., 2001). Despite this, Williams et al. (2010) developed and validated a multidimensional scale to quantify sense of place. Moreover, the lack of a coherent definition makes it versatile and easily accessible to a range of disciplines beyond geography. For instance, its application in land-use planning and resource management has been highlighted in which it is often necessary to account for the senses of place of different stakeholders (Williams and Stewart, 1998; Clark and Stein, 2003). Also, its quantitative analysis is of interest to the recreational and tourism industries (Bricker & Kerstetter, 2002). Lastly, student's sense of place has been observed to influence learning outcomes and assessment measure of place-based Geoscience teaching (Semken et al., 2009).

The need to have a sense of place is fundamental for immigrants' adaptation in the host country. As pointed out by Lewin (1976), "uncertainty of belongingness" is a challenge faced by all new immigrants. Thus, regardless of their motivation for emigration, immigrants may feel out of place in the beginning. Research has continually shown that a sense of belonging is crucial to feeling positive about oneself, to feeling trust and positive regard from and for others (Chow 2007). In addition, the restorative effects of place on cognitive, emotional and physical functioning are well described and acknowledged (Ulrich 1981; Kaplan and Kaplan 1989; Harting and Staats 2006). Factors such as meaning, value, symbolic landscapes and experiences in a sense of place are seen as sources of health and wellbeing (Williams 1998).

A few studies have examined the health implications of sense of place in immigrant groups (Williams and Kitchen 2012; Kitchen et al. 2012). According to Xu and McDonald (2010), the difficulties in connecting with and adapting to the economic and social institutions of the host may result in poor mental health outcomes, which may affect the evaluation of sense of place. Previous research on sense of place in Hamilton revealed factors including age, income, length of residence and immigrant status as significant predictors of sense of place (Williams et al. 2010). Immigrants were more likely to have a higher sense of place than Canadian-born individuals. Moreover, Williams and Kitchen (2012) found that immigrant status was a factor in evaluating sense of place, with immigrants having lower evaluations of sense of place compared to their Canadian-born counterparts.

Immigrants' previous experiences with the cultural structures of their home countries may influence the development of a sense of place in their new destination. A study in Australia found that participation in traditional cultural activities in the new country provided integrative and protective cultural factors for Chilean and Black South African immigrant in Australia (Sonn 2002). In a related study in the Southwestern United States, Patel et al. (2003) found that Mexicans were more likely to rate their health as poorer and a lower sense of place if they lived in disenfranchised neighbourhoods populated with fewer people of their own culture.

In general, there are mixed findings in the evaluation of sense of place between immigrants and non-immigrants. Notwithstanding the health implications on sense of

place, there is little, if any comparative study by race. Consequently, the focus on two African groups would assist in identifying significant factors that influence their sense of place.

4.3 The study groups: Ghanaians and Somalis

Like many recent immigrant arrivals in Canada, it was only after the introduction of the "points system" in the 1960s and the Immigration Act of 1976 (which incorporated the UN Convention's definition of refugee into Canadian Law) that Ghanaians began to arrive in Canada in significant numbers. Deteriorating economic and political conditions in Ghana, immigration restrictions in Europe and relatively favourable immigration policies in Canada have been cited as the driving forces behind their immigration (Mensah 2010). These immigrants were mostly made up of scholarship students, professionals working in education, health, and social services, and a few political dissidents escaping persecution.

It is estimated that between 1973 and 1976 about 220 Ghanaians entered Canada annually. Although already a small number of arrivals, numbers declined in the early 1980s, with declines attributed to Canadian policy such as the introduction of Bill C-86 (Donkor 200; Firang 2011) or the Ghanaian coup d'état (Gariba 2009), both of which served to reduce the number of entrants.

With the usual cumulative effects of immigration and natural population increase, the Ghanaian population in Canada has increased substantially in recent years. Most Ghanaians are concentrated in Ontario, and specifically the Greater Toronto Area, the

suburban communities of North York, Etobicoke, Scarborough and Brampton. In addition, Ghanaians settled in other Census Metropolitan Areas in Ontario, including Hamilton, primarily because of their need for affordable accommodation and their desire to live close to other Ghanaians (Mensah 2008; Owusu 1999). The majority of Ghanaians speak English (the official language of Ghana), meaning that Ghanaian immigrants face relatively fewer language-related problems in their attempt to settle in Canada.

On the other hand, the Somali Republic became independent in 1960 as a result of the unification between southern and northern Somalilands, which were previously administered by the Italian and British colonial powers respectively. Following independence, Somalis had two successful parliamentary-based civilian administrations from 1960 to 1964, and 1964 to 1968. However, a military regime took power and remained until 1990 when the country was plunged into civil war. Between 1991 and 2000, Somalia had no working government. An interim government was formed in 2000, but it expired in 2003 until a new transitional parliament was instituted in 2004. Currently, Somalia is still an unstable country, with limited control over its territory.

Like Ghanaian immigration, Somali immigration to Canada has also been limited – less than ten persons per annum for several years until the late 1980s (CIC 2005). However, with the relatively flexible refugee policy in Canada at the time, the number of Somali immigrants increased substantially in subsequent years, rising to about 5,456 in 1992 (Mensah 2002). Figures from Citizenship and Immigration Canada indicate that by 1988, Somalia had become the leading African source of refugee claimants in Canada,

corresponding to the military regime that ruled the country through 1990, which was followed by civil war in the 1990s. Thus, because of their traumatic background, many Somali immigrants suffer from psychological problems that are quintessential of torture victims, including depression, anxiety, nightmares, severe headaches, memory loss, and lack of concentration (Kendall 1992).

Unlike many African countries, Somalia does not have either English or French as its official language, with the official languages being Arabic and Somali instead. Most Somalis are Muslims, (Middle East Policy Council 2006), with the majority being Sunni (Abdullahi 2001). According to the 2006 census, the overwhelming majority of Somali immigrants live in Ontario, Quebec and British Columbia. Like their Ghanaian counterparts, considerable number of Somalis can be found in Toronto, Ottawa, Montreal, Vancouver and Hamilton, with few settling in the metropolitan centres of Atlantic Canada.

4.4 Methodology

The data for the present analyses were based on a questionnaire survey administered to Ghanaian and Somali immigrants in Hamilton, Ontario. Hamilton is a medium-sized city located in Ontario with a population of about 520,000 (Statistics Canada 2012b), with an economy focused on services, manufacturing, health, and education (Statistics Canada 2007b). Hamilton is a diverse city with almost 25% of its residents born outside Canada and 12.3% as visible minorities (City of Hamilton 2005-2010). In terms of religion, about 344,625 people are Christians, and 19,025 identified as

Muslims. The City has enjoyed a high level of health status compared to the province of Ontario.

A look at the 2013 health profile of Canada reveals that about 64.6% and 77.3% of residents in Hamilton reported very good or excellent perceived physical health and mental health, respectively. In comparison, somewhat smaller proportions were observed at the provincial level (61% and 74.3%). Residents of Hamilton also reported a slightly lower level of perceived life stress (22.5%) than the province of Ontario (24%). Approximately 93.2% of residents in Hamilton identified themselves as satisfied or very satisfied with their life satisfaction compared to 91.5% for Ontario. Finally, 69.8% residents of Hamilton rated their sense of community belonging as positive compared to 67.5% of the province of Ontario (Statistics Canada 2013).

Hamilton was selected not only because it is home to sizeable numbers of both Ghanaians and Somalis, but because it is also a location that has received a significant amount of attention from scholars at McMaster University looking at sense of place effects (William et al. 2010; William and Kitchen 2012; Gallina and Williams 2014). In addition, the researcher had contacts with individuals and community organizations that helped to facilitate this work. Additionally, with an increasing number of immigrants settling in smaller and medium-sized Canadian cities, researchers have called for more immigrant studies in second-tier cities (Frideres 2006; Radford 2007; Gallina and Williams 2014). Because of lack of a reliable sample-frame with the names of all Ghanaians and Somalis in Hamilton, we relied on a network of churches, mosques,

associational groups and individuals to administer questionnaires to a total of 236 participants.

In addition to questions related to sociodemographic (sex, age, education) and socioeconomic profiles (income), the questionnaire contained a validated 16-item sense of place scale established by Williams et al. (2010). It focuses on four areas, namely neighbourhood rootedness; neighbourhood sentiment; neighbours and, environmental and health (see Table 4.1). Each of the four areas is made up of four questions (see Table 4.2. All sixteen items were collected on a five-point Likert scale and later recorded into numbers between the values of one and five. Values of one represent the most positive responses and values of five represent the most negative responses (Williams et al. 2010). However, three of the questions on environment and health (D7, D8 and D9) were reverse coded because these questions refer to negative influences on sense of place (Williams et al. 2010). Thus, reverse coding was done to ensure consistency with other questions which reflect positive influences on sense of place (Williams et al. 2010). Based on these responses, a sense of place score was calculated for each individual (Williams et al. 2010). Finally, a question on self-perceived mental wellness (five-point Likert scale with 1 representing a positive mental wellness and 5 a negative mental wellness) was collected to explore its relationship with sense of place.

Table 4.1 Sense of place scale: 16-item sense of place scale (Williams et al. 2010)

D1. My neighbourhood means a great deal to me.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D2. There's no other neighbourhood I would rather live.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D3. I feel at home in my neighbourhood.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D4. There are people in my neighbourhood who I think of as close friends.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5(Strongly disagree)
D5. I would like to stay in my neighbourhood as long as my health allows me to do so.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D6. Green space availability in my neighbourhood positively influences my health.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D7. Environmental problems in my neighbourhood (e.g. air pollution, run-down buildings) negatively influence my health.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D8. Social problems in my neighbourhood (e.g. racism, violence) negatively influence my health.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D9. The personal safety of myself and my family in my neighbourhood negatively affects my health.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
How true are the following two statements?
D10. I know many of my neighbours on a first name basis.
1 (Very true) 2 (Fairly true) 3 (Neutral) 4 (Not very true) 5 (Not at all true)
D11. If I were to live somewhere else, it would be difficult to move away from my neighbourhood.
1 (Very true) 2 (Fairly true) 3 (Neutral) 4 (Not very true) 5 (Not at all true)
I would like to ask you several more questions on how you feel about your neighbourhood.
D12. How rooted do you feel in your neighbourhood?
1 (Very rooted) 2 (Fairly rooted) 3 (Neutral) 4 (Not very rooted) 5 (Not at all rooted)
D13. How connected do you feel to your neighbourhood?
1 (Very connected) 2 (Fairly connected) 3 (Neutral) 4 (Not very connected) 5 (Not at all connected)
D14. How much do you like your neighbourhood?
1 (A great deal) 2 (A fair amount) 3 (Neutral) 4 (Not very much) 5 (Not at all)
D15. How often do you participate in social activities with your neighbours (e.g. barbeques, coffee dates, etc.).
1 (All the time) 2 (Often) 3 (Sometimes) 4 (Hardly ever) 5 (Never)
D16. If you had to leave your neighbourhood, how many of your neighbours would you miss?
1 (Many of them) 2 (Some of them) 3 (Neutral) 4 (Hardly any of them) 5 (None of them)

Some of the survey questionnaires were given out to respondents in a prepaid postage envelope. Additionally, the majority of surveys were conducted face-to-face in a range of locations, including respondents' places of residence, churches and mosques; and were done in English, Ghanaian *Twi* and Somali *Af Maay* and *Af Maxaatiri* with the help of interpreters.

Table 4.2 Factors of sense of place

Neigbourhood rootedness	= D2+D12+D5+D11
Neighbourhood sentiment	= D1+D3+D13+D14
Neighbours	= D10+D15+D4+D16
Environment and health	= D6+D7+D8+D9

The surveys were conducted between August 2014 and April 2015. It is important to note that the survey was based on purposive sampling (convenient and self-selection), which might be different than a random sample (every member of the two groups has an equal chance of being selected). Thus, a random sampling would have accurately represented the two study groups, permitting conclusion being drawn about the larger population of the two study groups and other immigrants, as well as other cities.

Table 4.3 shows the mean sense of place scores for all respondents across the two study groups (n= 236, including 133 Ghanaians and 103 Somalis). In order to examine whether significant differences exist among the categories in each of the variables, a t-test and one-way analysis of variance (ANOVA) were conducted followed by determination of effect size for each variable. T-test and ANOVA procedures were used to compare the means of categories, with the t-test comparing the means of two populations and the ANOVA test comparing the means of several populations or groups.

Multiple linear regression was used to determine the relationship between sense of place score (dependent variable), length of residence, marital status, age, household income and mental wellness (predictor variables). Other regressors, including gender, education, living arrangements and dwelling type were tested but did not contribute to the model. In order to assign numerical values to categories of the variables, a dummy variable was generated. This in effect enabled us to estimate the contribution of each category of a variable in predicting sense of place score in the regression model.

4.5 Results

The mean sense of place score and analysis of variance (ANOVA) for each variable are presented, followed by calculation of effect size for variables that showed significant difference in sense of place score, as shown in Table 4.3.

As shown in Table 4.3, the mean sense of place score for the entire sample (n=236) is 56.8, with no significant difference in the scores for Ghanaians (57.6) and Somalis (55.8). For reference, and although not directly comparable, Williams and Kitchen (2012) revealed a sense of place score of 62 (n=1,002) for Hamilton using the same survey methodology. Likewise, there was no significant difference in sense of place by gender. Conversely, there is a significant difference ($p = 0.05$) in sense of place between Canadian citizens and non-citizens, with citizens having a significantly higher sense of place score than non-citizens, although the actual differences in the mean scores between the two groups were moderate (Cohen's d= 0.5) based on Cohen's (1998) conventions for interpreting effect size.

Table 4.3 Mean sense of place score (N= 236)

Variable	Count	Mean SOP Score	Mean difference ANOVA	Effect size Cohen's d/Partia Eta
Entire sample	236	56.8		
Groups				
Ghanaian	133	57.6		
Somali	103	55.8		
Gender				
Female	119	56.1		
Male	117	57.5		
Citizenship status				
Citizen	109	60.3	1-2*	0.54
Non-citizen	126	53.7	2-1*	
Length of residence				
0 -5	118	53.4	1-3*	
0 – 10	55	56.9	2-3*	0.10
Over 10 years	63	63.1	3-1* 3-2*	
Education level				
Less than high sch.	40	57		
High school	48	55		
Some college	49	58		
College/trade	47	57		
University graduate	52	55.9		
Employment status				
Working full-time	78	60.3	1-2* 1-4*	
Working part-time	61	53.4	2-1*	0.07
Retired/homemaker	45	59.4		
Unemployed/student	52	53.2	4-1*	
Household income				
Less than $20,000	80	53	1-4*	
$20,000-$39,000	67	55.9	2-4*	0.11
$40,000-$79,000	57	57.8	3-4*	
$80,000 & above	32	66.4	4-1* 4-2* 4-3*	

*Statistically significant at $p < 0.05$

Table 4.3 (Continued) Mean sense of place score

Variable	Count	Mean SOP Score	Mean difference ANNOVA	Effect size (Cohen's d Partial Eta
Dwelling type				
Single/semi-detached	63	60.3	1-3*	
Row/town/low-rise	52	59.1	2-3*	0.05
High rise apartment	121	54	3-1* 3-2*	
Marital status				
Single never married	68	50.4	1-2* 1-3*	
Married/common law	112	58.9	2-1*	0.11
Separate/divorce/widowed	56	60.4	3-1*	
Living arrangement				
Unattached living alone	42	52.7	1-3*	
Unattached living with other	66	55.1		0.04
Couple living with children	81	59.2	3-1*	
Couple living alone/ no kids	47	58.7		
Age category				
18-24	29	48.2	1-3* 1-4* 1-5* 1-6*	
25-34	56	54.5	2-5* 2-6*	
35-49	59	56.3	3-1* 3-5* 3-6*	
45-54	47	56.7	4-1* 4-6*	0.17
55-64	31	64.1	5-1* 5-2* 5-3*	
65 & above	14	69.9	6-1* 6-2* 6-3* 6-4*	
Self-perceived mental health				
Excellent/very good	117	59.9	1-2* 1-3*	
Good	71	53.9	2-1*	0.06
Fair/poor	48	53.5	3-1*	

* Statistically significant at $P < 0.05$

Significant differences in sense of place ratings were found in terms of length of residence in Canada, with long-term residents (living in Canada for over 10 years) having significantly higher sense of place scores as compared to more recent arrivals (0-5 years and 6-10 years). The magnitude of the difference in the mean scores and the effect size

was moderate (partial eta squared = 0.102). In terms of employment status, significant differences were found with "Working full-time" people having a higher sense of place score (60.3) than "Working part-time" (53.4) and "Unemployed/student/disability/maternity leave" groups (53.2). However, there was no significant difference between the "Working full-time" group (60.3) and those who are "Retired/homemaker" (59.4). The magnitude of the difference in the mean scores and the effect size was moderate (partial eta squared = 0.07) with a statistical power of 0.95. Again, significant differences were found across household income categories, with those who earn "$80,000 and above" having a higher sense of place score than lower income categories. The actual differences in means was moderate (partial eta squared = 0.112) with a statistical power 0.99. Respondents' dwelling type was also found to be significant (p= 0.05) with those who lived in "Single/semi-detached" having a higher sense of place score (60.3) than those who lived in "High rise apartments" (54.0). In addition, residents in "Row/town/low rise apartments" (59.1) had a higher sense of place than those in "High rise apartments". However, there was no statistically significant difference between those who lived in "Single/semi-detached" and those who lived in "Row/town/low rise apartments". The effect size was small (partial eta squared = 0.05) with enough statistical power equal to 0.95. Two related factors were significant: respondents' marital status and living arrangement with people. Marital status was found to be significant with people who are "Separate/divorce/widowed" having a significantly greater sense of place score (60.4) than those who are "Single/never married" (50.4) and also a significant difference between those "Married/common law" (58.9) and those who are "Single/never married.

Nevertheless, there is no statistically significant difference between those who are "Separate/divorce/widowed" and those who are "Married/common law". Here, the effect size is moderate (partial eta squared = 0.107) with a statistical power of 0.99. With respect to living arrangement, "Couple living with children" had a significantly higher sense of place score than "Unattached individuals living alone", but no significant difference with "Couple living alone/lone-parents with no kids living with them" and "Unattached individuals living with others". The magnitude of the difference in the mean scores and the effect size was small (partial eta squared =0.04) with a statistical power of 0.75. Age was a significant factor in predicting respondents' sense of place. People aged "65 and greater had a significantly greater sense of place score (69.9) than lower age groups (i.e., ages 18 – 24, 25 – 34, 35 – 44 and 45 – 54) with the exception of those aged 55 – 65. The magnitude of the difference in the mean scores and the effect size was very large (partial eta squared = 0.17). Finally, with respect to self-perceived mental wellness, respondents who evaluated their self-perceived mental wellness as "Excellent/Very good" had a significant higher sense of place score (59.9) than those who evaluated their mental wellness as "Good" (53.9) or "Fair/Poor" (53.5). The effect size was moderate (partial eta squared = 0.06) with a statistical power equal to 0.93.

Multiple regression analysis (Table 4.4) was used to evaluate the correlates of sense of place, with correlates including respondents' length of residence, marital status, age, income, citizenship status and self-perceived mental wellness. Preliminary analyses were performed to ensure there was no violation of the assumptions of normality,

linearity and multicollinearity. A significant regression equation was found [F (15, 220) = 5.760, P < 0 .001], with an $R^2 = 23.30$.

Table 4.4 Multiple linear regression model, sense of place (n= 236)

$R^2 = 23.30$ %
F (15, 220) = 5.76

Variable	Coefficient	95% CI
Constant	46.62	40.360 – 52.87
Length of residence in Canada (ref = 0-5years)		
1. 6 – 10 years	0 .432	-4.463 – 5.33
2. Over 10 years	1.14	-5.046 – 7.32
Marital status (ref = Single/never married)		
1. Married/common law	4.00*	-0.089 – 8.10
2. Separate/divorce/widowed	4.91**	0 .040 – 9.78
Age (ref = 18-24 years)		
1. 25 – 34	3.77	-1.631 – 9.16
2. 35 – 44	3.12	-2.637 – 8.88
3. 45 – 54	1.99	-4.477 – 8.45
4. 55 – 64	8.21**	1.003 – 15.41
5. 65 and above	14.37**	5.150 – 23.59
Annual household income (ref = Less than $20,000)		
1. $20,000 - $39,000	-0.01	-3.800 – 3.79
2. $40,000 - $79,000	1.20	-2.851 – 5.26
3. $80,000 and above	7.75**	2.436 – 13.07
Self-perceived mental wellness (ref = Fair/Poor)		
1. Good	3.03*	-.316 – 6.37
2. Excellent/ Very good	4.84**	0.782 – 8.89
Citizenship status (ref = citizen)		
1. Non-citizen	-0.90	-5.825 – 4.02

** Statistically significant at $p < 0.05$; *Close to statistically significant at $p < 0.05$

Findings suggest several positive correlates of sense of place. First, respondents who are “separated/divorce/widowed” are more likely to report a higher sense of place than individuals who are “single/never married”, which is the reference group. However, there is no statistically significant difference in sense of place score between those who are married and the reference group. Second, age has a strong positive effect on sense of place, with respondents aged 55-64 and 65+ more likely to report a higher level of sense of place as compared to the reference group (i.e., age 18-24). Third, income also has a positive effect on sense of place, with individuals reporting a yearly household income greater than $80,000 having a higher sense of place than individuals whose annual household income is less than $20,000 (the reference group). Fourth, mental wellness was associated with sense of place. Respondents who rated their mental wellness as “Excellent/Very good” had a higher sense of place than those who rated their mental wellness as “Fair/Poor” (the reference group). Neither length of residence nor citizenship status was statistically significant in predicting sense of place scores.

4.6 Discussion

The aim of this study was to examine the relationship between sense of place, self-perceived mental wellness and other socioeconomic factors amongst Ghanaian and Somali immigrants in Hamilton, Ontario. Using a validated sense of place scale (Williams et al. 2010), a number of interesting findings have surfaced, many of which are reinforced empirically by our analysis. First, no statistically significant difference in the evaluation of sense of place was observed between Ghanaian and Somali immigrants.

This finding is not surprising since about 50% of the study populations are recent immigrants (0 – 5 years) who may have insufficient support from families and friends and who are physically far away. They are separated from familiar neighbourhoods and social environments that support the assertion that unfamiliarity creates 'placelessness' (Rowles and Bernard 2013). Further, as Bauman (2011) argues, the more immigrants feel threatened or feel uncertain about life chances, the more appealing the cultural options of their home country appear to them, and vice versa. Given that immigrant groups with small populations are more likely to feel threatened and uncertain about life chances than those with large populations, the finding that Ghanaian and Somali immigrants have similar perceptions and experiences in the evaluation of sense of place is understandable. In addition, it is found that immigrant communities often struggle with internal inequalities related to race, ethnicity and religion that can lead to mistrust unlike non-immigrant communities (Reitmanova and Gustafson 2009). However, sense of place was found to be higher in those who are Canadian citizens than those who are non-citizens, suggesting that citizenship does confer a sense of permanence to immigrants. The reverse is also plausible: that only those who feel a sense of belonging become Canadian citizens.

Other factors that have been observed to influence sense of place are consistent with the literature (Williams and Kitchen 2012). For example, education did not impact sense of place. However, employment, which directly relates to education, did have an impact on sense of place. Specifically, those 'working full-time' and 'retired and homemakers' had a much higher sense of place compared to those "working part-time' and the 'unemployed/student/disability/maternity leave'. Having a sufficient income went

hand-in-hand with being gainfully employed. People who had less than $20,000 were less likely to evaluate their sense of place as high compared to those who earned $80,000 and above. It is possible that those in higher income categories may have the ability to relocate if they are unhappy with their current living arrangements. Billig (2005) suggests that many social and physical factors will influence the sense of place of the residential environment, and as Buttimer (1980) noted, a balance between the home and the surrounding geography is necessary for the maintenance of personal identity and emotional wellbeing. Closely related to employment and income is the dwelling type, with individuals living in a single or semi-detached dwelling having a higher sense of place than those who live in high rise apartments.

Regarding marital status and living arrangements, the study found that the 'widowed/separated/divorced' had a higher sense of place followed by the 'married/common law' and the 'single/never married'. Also, 'couples living with children' were found to have a higher sense of place compared to the 'unattached individual living alone'. It may be that individuals who experience the end of a marriage relocate to a preferred place, while individuals who live alone are more socially isolated. Also, it is reasoned that families with children (even if separated, divorced and widowed) are found to have a higher sense of community belonging than are those who are not married and without children (see Nasar and Julian 1995; Robinson and Wilkinson 1995). Concerning why single/never married and unattached individual have a lower sense of place, Williams and Kitchen (2012) speculated that issues related to work life demands and everyday activities in an industrial community might have influenced the views of

the ‘single/never married people. Thus, this group is more likely to connect to other places other than their neighbourhoods or homes. As Buttimer (1980) again noted, places said to have a strong sense of place have a strong identity as this group is more likely to identify itself with other place settings than the neighbourhood environment.

It is interesting to note that age was the single most significant factor in predicting sense of place. Thus the importance of age is reflected in the significant difference observed in length of residence. With age ‘65 and above’ having a significantly higher sense of place than those in the younger age groups, it highlights age as a potential explanation of sense of place and points to the need for studies to take into consideration not only immigrants’ length of residency but also differences in sense of place across age groups. With respect to length of residency, the study found that those who have been in the country for longer time (usually over 10 years) are more likely to rate their sense of place as higher compared to recent immigrants (between 0 to 5 years). A possible explanation is that sense of place has a temporal dimension and as people age and/or spend more time in their neighbourhoods, a lifetime of memories and experiences will develop a sense of meaning and attachment to particular places (Golant 2003; Williams and Kitchen 2012; Rowles and Bernard 2013).

When looking at the relationship between sense of place and self-perceived mental wellness, it was found that those who rated their mental wellness as ‘Excellent/very good’ were likely to evaluate their sense of place as high compared to those who rated their mental wellness as ‘Good’ or ‘Fair/poor’. The analysis revealed that

income and employment were strongly associated with self-perceived mental wellness. In addition, it is important to note that relatively few respondents rated their self-perceived mental wellness as 'Fair' or 'Poor'. It is possible that social desirability bias, which refers to the underreporting of undesirable behaviours or experiences (Klesges et al. 2004; Hebert et al. 2008), may have influenced the reporting of self-perceived mental wellness.

4.7 Conclusion

Sense of place is an important concept that can be used to assess immigrants' integration and settlement. While much of the current research conducted on sense of place is useful, it mainly constitutes comparisons between immigrants and the Canadian-born populations. Current research overlooks specific research of visible minority's sense of place. This article expands previous research regarding sense of place, specifically, African immigrants in Hamilton, Ontario. Our results show significant factors of sense of place; the relationship between sense of place and self-perceived mental wellness, including income, age, employment, citizenship status, marital status, dwelling type and length of residency in Canada.

Of course, there are limitations to the study. First, our study was based on purposive sampling and was limited to Ghanaian and Somali immigrants in Hamilton, Ontario and therefore may not generalize to other locations or to immigrants from other cultural backgrounds. A second limitation is that the study does not distinguish between immigrant groups (i.e., family class versus refugee). It is possible that different immigrant groups may have different experiences of sense of place that could be studied

by exploring more homogeneous groups of immigrants. Third, our sample consisted of adults of age 18 and above and, as with any cross-sectional design, the directionality of the observed association cannot be determined. Our aim has been to contribute to an expanded conversation about sense of place in Canada, rather than to answer question definitely. We suggest similar research be pursued in other small and medium-sized cities in Canada.

Despite these limitations, we point to two areas where future research would be worthwhile. First, we suggest that future research use qualitative techniques to tease out the personal experiences and perceptions of place making amongst immigrants, an agenda that we pursue in future chapters. Second, it would be worthwhile to examine how African immigrants in small and medium-sized cities with limited ethno-racial resources (i.e., benefits derived from an ethnic and/or racial group for being a member) compare to their counterparts in large cities like Toronto where access to ethno-racial resources may be relatively greater, enabling explanation of how the urban landscape shapes immigrants' perceptions and experiences of place.

Given results of this work, we recommend exploring ways to address inequalities between and within immigrant communities, along with the conditions that determine wellness and general quality of life of immigrants, particularly individuals who are low income and unemployed. Such programs should be geared toward promoting and helping qualified visible minority immigrants realize their full potential in the labour market. We recognize that the neigbourhood structure and service providers can modify individual

sense of place. Research may examine how neigbourhood form and design influence people's perceptions. In addition, work could consider how access to recreational facilities, parks and other social networking facilities alters sense of place. Given that neighbourhoods' physical characteristics influence perceptions of place, provision of such facilities may help reduce the greater feelings of isolation and related mental and physical health issues.

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Chapter Five: Determinants of Life Satisfaction amongst African Immigrants in Hamilton, Canada[3]

5.1 Introduction

According to the most recent national census in 2011, immigrants accounted for 20.6% of the Canadian population, the highest proportion amongst the G8 countries. Between 2006 and 2011, over one million immigrants entered Canada (Statistics Canada 2011), with arrivals often citing improvement in quality of life as the main reason for migrating to Canada. As Ward (1996) noted, immigration and a different cultural background raises questions of psychological and sociological adaptation, along with belonging and acceptance. In addition to factors such as lower income, unemployment and underemployment, lower education, and poorer health; being an ethnic minority immigrant adds life challenges and discrimination that can lower general quality of life (Statistics Canada 2003; CIC 2010). Consequently, visible minority members who feel out of place or discriminated against are likely to be less satisfied with their life in the country of residence. Researchers have found relatively low life satisfaction amongst ethnic and racial minorities (Michalos and Zumbo 2001; Verkuyten 2008; Ullman and Tatar 2011). Ultimately, this may affect their ability and willingness to identity with the broader community and impact their general quality of life.

This chapter examines the life satisfaction of Ghanaian and Somali immigrants in Hamilton, Ontario. With a population of just over 500,000, Hamilton is a medium-sized

[3] This paper is under review in *Health & Social Care in the Community*

city in Ontario about 75 kilometres southwest of Toronto. It is comprised of six communities, including the original City of Hamilton, and five more suburban communities that were amalgamated with the original city in 2001, including Ancaster, Stoney Creek, Dundas, Flamborough, and Glanbrook. Hamilton is a diverse city with almost 25% of its residents born outside Canada and 12.3% as visible minorities (City of Hamilton 2005-2010). The city provides newcomers a wide variety of living accommodations, including single family homes, high and low-rise apartments and townhouses (City of Hamilton 2005-2010). Physically divided by the Niagara escarpment which runs east-west through the city, poverty is most severe in the lower, older parts of the city, and particularly in the downtown core as compared to the western communities of Ancaster and Dundas. While the downtown core has been the traditional entry point for newcomers, large numbers of immigrants have also settled in suburban communities such as Stoney Creek or the newer suburbs of Hamilton, including its 'mountain' neighbourhoods. The 2013 health profile of Canada reveals that about 64.6% and 77.3% of residents in Hamilton reported very good or excellent perceived health and mental health, respectively. In comparison, somewhat smaller proportions were observed at the provincial level (61% and 74.3%). Residents of Hamilton also reported a lower level of perceived life stress (22.5%) than the province of Ontario (24%). About 93.2% of residents in Hamilton identified themselves as satisfied or very satisfied with their life, compared to 91.5% for Ontario. In addition, 69.8% residents of Hamilton rated their sense of community belonging as positive compared to 67.5% of the province of Ontario (Statistics Canada 2013).

We argue that African immigrants' general quality of life could be understood by analyzing their perceived life satisfaction. Our work contributes to this by examining perceived life satisfaction; analyzing the socio-demographic, socio-economic and health related factors that contribute to life satisfaction. Given that immigrants to Canada often cite improvements in quality of life as the motivation for migration (Statistics Canada 2014), evaluations of perceived life satisfaction are important tests, as they provide immigrants' own assessments of quality of life in Canada. In so doing, this chapter answers the main research question: Does life satisfaction vary according to age, gender, length of residence, family status, education, employment, income, sense of place, and health related factors, including perceived depression, anxiety and stress? The impetus for this research has been the dearth of research on life satisfaction amongst Black African immigrants in Canada.

5.2 Background: African Immigration and Life Satisfaction

In recent years, there have been an increasing number of immigrants from African countries to Canada, and the African population is growing considerably faster than the total population (Statistics Canada 2007). Despite different cultural backgrounds that immigrants bring to their new societies, they bring with them resources, habits, and experiences from their home country (i.e., sources of human capital) that can be harnessed for substantial economic returns for the host country (Constant and Zimmermann 2013). For example, in 2001, Statistics Canada's report shows that 7.3% of people aged 15 and over who reported having African origins had either a Master's

Degree or an earned doctorate, versus 4.8% of all Canadians in this age range (Statistics Canada 2007). However, research has shown that members of the African community in Canada are slightly less likely to be employed than the rest of the population (Ornstein 2006; Statistics Canada 2007; Mensah 2010). Additionally, a look at identity formation in Canada reveals that amongst immigrants, the Black population has the lowest rate of responding that they either 'strongly agree' or 'agree' they view themselves as citizens of their province or region (75.7%) compared to 89.9% of Caucasians, 91.2% of East Asians, 93.9% of South Asians and 90.5% of the Arab population. Possible explanations for these differences have been highlighted to include discrimination and racism that undermine trust and attachment to Canadian society (Statistics Canada 2003; CIC 2010). It is also important to note that there are a number of reasons why individuals immigrate to Canada. As Citizenship and Immigration Canada (CIC 2010) noted, refugees are likely to have different reasons than other immigrant entry groups, with refugees likely having a different sense of attachment to Canada. In the last decade, refugees from Africa, including Ethiopia, Sudan, Democratic Republic of Congo and Somalia were among the top 10 source countries for refugees selected under the Resettlement Program (CIC 2007).

Research on African immigrants to Canada has focused mainly on economic questions, including examining themes such as labour market outcomes (Creese and Wiebe 2012; Mensah 2010) and health (Fenta et al. 2004; Simich et al. 2006; Simich 2008). However, these studies have not explored the general quality of life amongst these immigrants, a concept which extends beyond, but also overlaps with, economic outcomes

and health. The current study examines how immigrants perceive their communities of residence and the satisfaction they derive from these places based on evaluations of their lives. This literature on migration and satisfaction outcomes has the potential to fill some of the gaps in existing paradigms in immigrant studies.

The term “Life Satisfaction” is defined as an individual’s subjective appraisal of life, composed of cognitive and affective components (Diener et al. 1999; Edwards and Lopez, 2006). Many factors predict the life satisfaction of immigrants in a host society. McCullough et al. (2000) and Neto (2001) found that the life events experienced in the immigration and settlement process may have a substantial impact on immigrant’s life satisfaction.

Migration, either voluntary or forced, is a further sociocultural phenomenon shown to affect life satisfaction (Karin 2010). Immigrants’ everyday activity is linked to adaptation and belonging. Amongst immigrants, it may be that a positive sense of place encourages life satisfaction. Experiences and perceptions of ethnic discrimination may have negative consequences for the way minority members feel about their lives and may also affect their identity with the host community. Researchers have found relatively low life satisfaction amongst ethnic and racial minority groups (Verkuyten 2008; Michalos and Zumbo 2001; Ullman and Tatar 2001). Several factors contribute to the life satisfaction of immigrants in a host society. Ward and Masgoret (2004), for example, identified factors as more cultural inclusiveness, greater language proficiency, more contacts with host nationals, a positive attitude in the host community toward immigrants,

more social support, and less discrimination. In addition, socio-demographic predictors of life satisfaction include sex, income, social support and education (Pinqart and Sorensen 2001). Elsewhere in France, Neto (2002) observed that social adaptation difficulties were negatively correlated with life satisfaction amongst Portuguese immigrants.

There is evidence of the negative relationship between perceived ethnic discrimination and life satisfaction (Ward 2006; Verkuyten 2008; CIC 2010). For example, in their study amongst 7000 immigrants in 13 countries, Vedder et al. (2006) found that perceived discrimination was negatively associated with psychological adaptation, including general life satisfaction.

Life satisfaction is contingent on a number of factors, including social, physical and personal affects. It has been argued that the social conditions surrounding a person may consist of the social interactions, relationships and social activities that a person partakes (Sirgy and Cornwell 2002). The level of one's attachment to a community influences their levels of satisfaction (Aiello et al. 2010). Fear of crime and feelings of personal safety are predictors of one's satisfaction. Thus, people who perceive their community as unsafe are less likely to be satisfied (Aiello et al. 2010; Grillo et al. 2010; James et al. 2009). Also, satisfaction with community services, including emergency services, business services, shopping centres and religious services have been observed to influence one's life satisfaction (Sirgy and Cornwell 2002; Potter and Cantarero 2006). These factors have been found to increase a person's attachment to the community, consequently leading to a satisfaction with one's community (Uzzell et al. 2002;

Braubach 2007). In terms of personal factors, it has been observed that an individual can develop an attachment to place through economic and temporal ties (i.e. length of residence) to the community of residence (Aiello et al. 2010; James et al 2009). Other factors associated with life satisfaction are ethnicity (Lu, 1999; Hur and Morrow 2008, Long & Perkins 2007), high socioeconomic status (Billig 2005; Jorgensen et al. 2010; James 2008), marital status (Lu, 1999), age (James 2008; Chapman & Lombard 2006), education (Chapman and Lombard 2006) and gender (Aiello et al. 2010; Perez et al. 2001).

The migration literature suggests that the conditions of immigrants' places of origin may account for the difference in life satisfaction amongst different immigrant populations. In the United States, for example, Bartram (2011) observed lower levels of life satisfaction amongst immigrants who came from poorer nations than among those from wealthier nations. The study found that immigrants from Europe and Canada do not differ significantly from the American-born counterparts, although those from Asia, Latin America and Africa report significantly lower levels of life satisfaction. We expect that structural discrimination in areas, including income, education, employment and housing may affect life satisfaction in the country of residence.

Notwithstanding a number of studies, there is a dearth of empirical research specific to life satisfaction in medium-sized cities amongst African immigrants in Canada. This study examines African immigrants' own self-assessment of their needs and perceptions of factors influencing satisfaction outcomes in their host communities.

5.3 Data and Methods

The data for the present analyses were based on a closed-ended questionnaire survey of 236 Ghanaian and Somali immigrants in Hamilton, Ontario. The main eligibility criterion for participation in the study was to have immigrated to Canada at age eighteen and above. The primary outcome variable for this study is life satisfaction, assessed using a six-point scale, ranging from 1(Extremely/very satisfied) to 6 (Extremely/very dissatisfied). In addition to questions related to socio-demographic (sex, age, education), socioeconomic (income) and health-related (happiness levels, depression levels) variables, the questionnaire contained a validated 16-item sense of place scale (often referred to as community belonging) established by Williams et al. (2010). It focuses on four areas, namely neighbourhood rootedness; neighbourhood sentiment; neighbours and, environmental and health. Each of the four areas is made up of four questions. All sixteen items were collected on a five-point scale and later recorded into numbers between the values of one and five. Values of one represent the most positive responses and values of five represent the most negative responses (Williams et al. 2010). For comparative purposes, most socioeconomic and demographic survey items were derived from the World Values survey (see Abdallah et al. 2008; World Values Survey Association 2013). The World Values survey has demonstrated how economic development and rising social tolerance have increased the extent to which people perceive that they have free choice, which in turn has led to higher levels of satisfaction around the world (Inglehart et al. 2007). The findings provide information for policy makers seeking to build civil society and democratic institutions around the world. Some

of the survey questionnaires were given out to respondents in a prepaid postage envelope (43 envelopes were given but only 2 were returned for a period of two months, with a return rate of 4.7%), while the majority were conducted face-to-face in a range of locations, including respondents' places of residence, churches and mosques; and were done in English, Ghanaian *Twi* and Somali *Af Maay* and *Af Maxaatiri* with the help of interpreters. In total, 250 surveys were given out as face-to-face while 234 were returned, representing a response rate of 93.6%.

Data were cleaned, analyzed and summarized to produce descriptive statistics about the participants (see Table 5.1, n=236, including 133 Ghanaians and 103 Somalis). The description shows the frequency and percentage for each variable. Additionally, cross-tabulation was run for the study groups (Ghanaian and Somali). Layers were added using a number of socio-economic and demographic variables including education, employment, household income, dwelling type and length of residence. Next, we undertook a series of ordered logistic models to evaluate the correlates of life satisfaction. In the regression model (Table 5.2), the effect of immigrant origin (Ghanaian and Somali), gender, age, length of residence, marital status, citizenship status, educational level, employment status, income, dwelling type, living arrangement with people, and sense of place were entered as factors. All factor variables were dummy-coded. Life satisfaction was re-coded into different variables with 1 representing "Extremely/Very satisfied", 2 representing "Generally satisfied" and 3 representing "Generally/Very dissatisfied".

5.4 Results

Table 5.1 Descriptive statistics socio-demographic & economic variables (N=236)

Variable	Count	Ghanaian	Somali	P < 0.05
Life satisfaction				
Extremely/very satisfied	81	58.1	42.7	
Generally satisfied	142	39.4	53.4	**0.02**
Generally dissatisfied	13	2.5	3.9	
Gender				
Female	119	51.9	48.5	0.61
Male	117	48.1	51.5	
Length of residence				
0-10	173	52	48	**0.03**
Over 10 years	63	68.3	31.7	
Education level				
Less than high sch.	40	12.8	22.3	
High school	48	12.8	30.1	
Some college	49	22.6	18.4	**0.00**
College/trade	47	18.8	21.4	
University graduate	52	33.1	7.8	
Employment status				
Employed	139	69.9	38.1	
Retired/homemaker	45	48.9	51.1	0.12
Unemployed/student	52	56.4	43.6	
Household income				
Less than $20,000	80	27.1	42.7	
$20,000-$39,000	67	24.1	34	**0.00**
$40,000-$79,000	57	27.1	20.4	
$80,000 & above	32	21.8	2.9	
Sense of place				
Low	127	51.9	56.3	
Average	69	27.8	31.1	0.30
High	40	20.3	12.6	

Bold indicates statistically significant ($P < 0.05$) between the two groups

Table 5.1 (Continued)

Variable	Count	Ghanaian	Somali	P < 0.05
Dwelling type				
Single/semi-detached	63	33.8	17.5	
Row/town/low-rise	52	23.3	20.4	**0.01**
High rise apartment	121	42.9	62.1	
Marital status				
Single never married	68	24.8	34	
Married/common law	112	54.9	37.9	**0.03**
Separate/divorce/widowed	56	20.3	28.2	
Living arrangement				
Unattached living alone	42	16.5	19.4	
Unattached living with other	66	22.6	35	0.11
Couple living with children	81	39.1	28.2	
Couple living alone/ no kids	47	21.8	17.5	
Age category				
18-24	29	10.5	14.6	
25-34	56	24.8	22.3	
35-49	59	27.1	22.3	
45-54	47	18	22.3	0.62
55-64	31	12	14.6	
65 & above	14	7.5	3.9	
Self-perceived mental health				
Excellent/very good	117	54.1	43.7	
Good	71	27.8	33	0.27
Fair/poor	48	18	23.3	
Levels of anxiety				
Very anxious	68	54.4	45.6	
Little bit anxious	64	56.2	43.8	0.91
No, not at all	104	57.7	42.3	
Levels of stress				
More than usual	70	58.6	41.4	
Some but normal	80	62.5	37.5	0.19
A little bit	86	48.8	51.2	
Levels of depression				
Very depressed	93	61.3	38.7	0.22
Little to no depressed	143	53.1	46.9	

Bold indicates statistically significant ($P < 0.05$) between the two groups

Next, health-related variables were introduced into the model using the following independent variables: perceived stress, perceived mental wellness, levels of anxiety, levels of depression and levels of happiness. All independent variables were dummy-coded. Odds ratios and confidence intervals were calculated. Odds ratios greater than 1 indicate that the associations of the independent variable with 'life satisfaction is positive, while those less than 1 indicates that the association of the independent variable with life satisfaction is negative. Odds ratios close to 1 indicate that changes in the independent variable are not associated with life satisfaction.

Table 5.1 presents bivariate descriptive statistics for all the variables used in the regression. The analyses yielded a number of significant results. First, 58.1% of Ghanaians rated their life satisfaction as extremely/very satisfied, while 42.7% of Somali's rated their life satisfaction in the same way. A slightly larger proportion of Ghanaians (6.8%) rated their life satisfaction as extremely/very dissatisfied, compared to just 3.9% of Somalis. Ghanaians were also more likely to have a university level education (33.1%) as compared to Somalis (7.8%). Equal shares (12.8%) of Ghanaians (12.8%) reported 'less than high school' and 'high school diploma', respectively, compared to 22.3% and 30.1% for Somalis (95% CI). Ghanaians were also more likely to be engaged in full-time employment (39.1%) as compared to Somalis (25.2%), and were less likely to be unemployed (6.8% versus 17.5% for Ghanaians and Somalis, respectively). In terms of household income, different levels emerged again. While 27% of Ghanaians reported household incomes below $20,000, and 21.8% reported incomes greater than $80,000, 42.7% of Somalis reported an income below $20,000 and just

2.9% reported an income greater than 80,000 (significant at the 95% CI). Dwelling type also differed between the two groups, with nearly a quarter of Ghanaian respondents reporting that they lived in a single detached home versus just 4.9% of Somalis. Somalis were also more likely to live in a high rise apartment (62.1%), while just 42.9% of Ghanaians lived in similar accommodation.

With a reported difference in life satisfaction between Ghanaians and Somalis, Table 5.2 displays the findings of the ordered logistic regression. The pseudo r-squared is 0.277, indicating that the selected predictors account for approximately 28% of the variance in the outcome variable 'life satisfaction'. Several significant factors were associated with life satisfaction: being a Ghanaian (OR= 4.12, 95% CI: 1.94, 8.73) versus being a Somalian; having a residency in Canada over 10 years (OR= 1.22, CI: 1.47, 9.16) versus length of residence from zero to ten years; being employed (OR= 2.39, CI: 1.93, 6.15) versus unemployed/student/disability; and living in a single/semi-detached house (OR= 3.04, CI: 1.10, 8.38) versus living in a high rise apartment. It appears three age-categories positively correlate with life satisfaction. Individuals in age-categories 25-34, 35-44 and 45-54 (OR= 3.63, CI: 1.01, 13.03; OR= 4.77, CI: 1.23, 18.54; OR= 5.77, CI: 1.31, 25.44) are 3.6, 4.8 and 5.8 respectively more likely to say they are satisfied with their lives compared to those in the age-category 18-24 (Reference group).

Table 5.2 Ordered logistic regression model, Life satisfaction (N=236)

Log likelihood = -141.96
Prob > chi2 = 0.0000
Pseudo R^2 = 28.0% (rounded up? ok)

Variable	Odds ratio	95% CI
Study group (ref = Somali)		
Ghanaian	4.12**	1.95-8.73
Gender (ref = Male)		
Female	0.87	0.46-1.65
Length of residence (ref =0 – 10years)		
Over 10 years	1.22*	1.47-9.16
Education level (ref = Less than high school)		
High school diploma	0.83	0.27-2.52
Some college/university	0.26	0.08-0.86
College/trade diploma or cert	0.70	0.23-2.14
University graduate	0.60	0.19-1.93
Employment status (ref = Unemployed/student)		
Employed	2.39*	1.93-6.15
Retired/homemaker	1.39	0.35-2.99
Household income (ref = <$20,000)		
$20,000 - $39,000	0.74	0.29-1.86
$40,000 - $79,000	0.87	0.33-2.30
$80,000 & above	0.12	0.03-0.53
Dwelling type (ref = High rise apt)		
Single/semi-detached	3.04*	1.10-8.38
Row/town/low-rise	0.90	0.41-2.25
Marital status (ref = Single/never married)		
Married/common law	0.38	0.12-1.26
Separate/divorce/widowed	0.40	0.12-1.34
Living arrangement (ref = Unattached adult living alone)		
Unattached adult living with others	0.43	0.13-1.42
Couple living with children	0.85	0.20-3.64
Couple living alone without children	0.77	0.212.88

**Statistically significant at $P < 0.01$; statistically significant at $P < 0.05$

Table 5.2 (Continued) Ordered logistic regression model, Life Satisfaction (N=236)

Log likelihood = - 141.96
Prob > chi2 = 0.0000
Pseudo R^2 = 28.0%

Variable	**Odds ratio**	**95% CI**
Age category (ref = 18 – 24)		
25 – 34	**3.63***	1.01-13.03
35 – 44	**4.77***	1.23-18.54
45 – 54	**5.78***	1.31-25.44
55 and above	3.38	0.63-18.24
Sense of place (ref= low)		
Average	0.71	0.31-1.62
High	0.66	0.23-1.92
Levels of depression (Ref = Extremely/Very depressed)		
Little or never depressed	0.10	0.42-1.92
***Levels of anxiety (Ref = Extremely/very an*xious)**		
A little bit anxious	0.93	0.35-2.49
No, not at all	0.93	0.30-1.89
Levels of stress (Ref = More than usual)		
Some but normal	1.08	0.44-2.65
A little bit	0.91	0.31-2.64
Levels of happiness (None of the time)		
Almost all the time	0.12	0.04-0.37
A good bit of time	0.26	0.08-0.83
Some of the time	0.34	0.09-1.26
Mental wellness (Fair/Poor)		
Excellent/very good	0.22	0.07-0.69
Good	0.60	0.21-1.68

**Statistically significant at $P < 0.01$; statistically significant at $P < 0.05$

No significant difference was observed between the reference group and individuals aged 55 and over. Finally, there were no significant effects for gender, education, and income on life satisfaction.

5.5 Discussion

The purpose of this exploratory study was to examine how socioeconomic, demographic and health-related factors shape visible minority immigrants' life satisfaction in a mid-sized city in Canada. Our findings reveal differences in the evaluation of life satisfaction between the two study groups. In particular, results reveal that Ghanaian immigrants were more satisfied with life in Canada than Somali immigrants. The lower levels of satisfaction amongst Somali respondents may be explained by having lower socioeconomic status (e.g., income levels, see table 5.1) as revealed by the bivariate analysis. This is likely to affect their feelings of living in Canada negatively. This finding is consistent with the results of Sam et al. (2006), who found that socioeconomic adjustment is an important factor for immigrant and minority groups to feel at home and to be satisfied with their life. Other studies have cited factors associated with settlement problems, including inadequate official language proficiency, affordable housing, and employment (Opoku-Dapaah 1995; Murdie 2003; Mensah and Williams 2013). These problems have likely worsened in recent years, given the rise of Islamaphobia in the post-9/11 era (Mensah and Williams 2014). Further research should explore the reasons behind these observed differences.

Consistent with previous research, this study suggests that higher evaluations of life satisfaction are more common amongst people with longer length of residence in host communities (Verkuyten and Nekuee 1999; Verkuyten 2008). One potential explanation for this finding may lie in the acculturative process after migration as immigrants familiarize themselves in their new destinations. The process of acculturation has an important influence on an individual's adjustment and well-being (Garcia Coll and Marks 2011), which may predict life satisfaction. It is interesting to note that a significant predictor of life satisfaction was observed amongst those who have been in Canada for ten years or more years, likely reflecting the development of memories and experiences that promote sense of meaning and attachment to particular places (Golant 2003; Charkhchian and Daneshpour 2010; Rowles and Bernard 2013). Several studies have also shown correlates between length of residence and satisfaction (see Hur and Marrow-Jones 2008; Fleury-Bahi et al. 2008). Thus, length of residence contributes to the feeling of comfort and bonding to a place, which may affect the positive image of a place, safety, security and positive connection with neighbours (Ujang 2012; Goldar and Daneshpour 2015). Existing research has relatively limited information on length of residence and life satisfaction, which is an important area for further study.

Employment has been found to be one of the domains that can contribute to life satisfaction (Michalos and Zumbo 2001). There are a number of possible explanations as to why those 'working full-time' have higher life satisfaction than the 'retired/home' and the 'unemployed/student' that this study revealed. Research suggests that employment and having a quality job that matches employee's priorities and preferences contribute to

quality of life and life satisfaction of workers (James and Spiro 2006). In general, high quality jobs support people's financial, social, physical, and emotional well-being (Silverman et al. 2000; Fernandez-Ballesteros et al. 2001; Johnson and Krueger 2006). Another possible explanation is that those 'working full-time' may have resources to engage in other activities that would promote their well-being and life satisfaction. Research has shown that lower life satisfaction amongst some immigrant groups may reflect unobserved factors such as sacrifices made for migration (e.g., family separation, or perceived drop in status due to shift in their reference group (Statistics Canada 2014). These explanations suggest that external factors are important to immigrants' life satisfaction and are potential topics for future research.

Socioeconomic status is reflected in the significant differences that have been observed in dwelling types with people in single/semi-detached housing more likely to evaluate their life satisfaction higher than those who rent (e.g., those in low and high rise apartments). It may be explained that those in single/semi-detached dwellings may have the means to be able to afford good housing at a preferred location, which is likely to contribute to life satisfaction and overall quality of life. This finding underscores the importance of housing in the evaluation of quality of life and by extension life satisfaction. As noted by Murdie (2003), appropriate housing establishes conditions for access to other formal and informal supports and networks, and speeds up the integration of immigrants in the host societies. Consequently, this is likely to impact on other spheres of immigrants' lives, including their sense of place. Thus, more attention could be focused on how the housing characteristics may influence attachments to place.

The insignificance of sense of place (community belonging) on life satisfaction does not necessarily mean that place does not matter. Rather, it may indicate a diminished sense of community belonging for immigrants whose goal is to seek better life conditions for themselves and their offspring. Nevertheless, studies have consistently shown positive effects of sense of place on health and life satisfaction (Benejam 2006; Hur and Morrow-Jones 2008; Williams and Kitchen 2012) and as important aspects of an individual identity (DeMiglio and Williams 2008).

Lastly, age was significantly related to life satisfaction. The differences between individuals in age-categories and in terms of length of residence in the host society may have influenced the differences in the evaluation of life satisfaction (Pan et al. 2008; Singh et al. 2011; Moztarzadeh and O'Rourke 2015). In spite of positive relationships between age and life satisfaction, this study found that life satisfaction was greatest amongst respondents aged 25-54. For older adults (55+), their life satisfaction was no different than the reference group (18-25). Consistent with a study in Australia, Foroughi et al. (2001) observed that Iranian-Australians who migrated at an older age reported lower subjective quality of life, which may suggest negative effects of migration on older immigrants. Thus, declining physical health with advancing age may affect the emotional health and well-being of immigrants, which, in turn, influences the way life satisfaction is rated.

5.6 Conclusion

Our study underscores the importance of life satisfaction amongst African immigrants. This study has demonstrated that Somali immigrants have lower life satisfaction than Ghanaian immigrants. Additionally, the findings suggest that length of residence, employment status, housing type and age of immigrants contribute to important differences in the evaluation of life satisfaction amongst immigrant groups in Canada. The chapter contributes to the study of quality of life of visible minority immigrants in several ways. First, it examines life satisfaction of African immigrants, a growing immigrant group in Canada that is projected to double in size in the next two decades. Second, this chapter focuses on Ghanaian and Somali immigrants, whose quality of life has received relatively little attention but who have also been identified as under privileged (Ornstein 2006). Third, this chapter disentangles the various socio-demographic, socio-economic, and health-related factors that significantly affect life satisfaction, aspects of quality of life bearing on integration and wellbeing.

It is important to note that conditions of host communities are important to immigrants' life satisfaction. The lower life satisfaction observed for Somali immigrants may reflect integration difficulties relative to socioeconomic adjustment, including official language proficiency. The results also highlight the role ethnic identity may play in the evaluation of life satisfaction by immigrants. Immigrant settlement workers and agencies would be better able to meet the needs of these immigrants if they are conscious of the effects of settlement challenges. Attention should be focused on reducing stress at

a systemic level, including helping families identify sources of support, providing jobs, affordable housing, language interpretation and training. At the individual level, empowering immigrants to cope effectively with settlement challenges as they navigate through their new destinations would be worthwhile.

This study is unique because of our singular focus on African immigrants in a second-tier city. As respondents were recruited in Hamilton, Ontario only; generalizability to other African immigrants living elsewhere in Canada or other countries is limited. Increasing the number of African immigrant groups studied from a variety of medium-sized cities (replication) might help to increase the generalizability of the results of future studies. Future studies could also focus on other visible minority immigrants in other cities to further understand the ways that minority position affects life satisfaction. Additionally, nations-of-origin specific research is also required to more fully understand factors affecting life satisfaction in different communities.

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Chapter Six: Religion/Spirituality, Therapeutic Landscape and Immigrant Mental Wellbeing[4]

6.1 Introduction

Immigration and the integration of newcomers continue to be of interest in Canada and elsewhere, reflecting the need and desire to retain immigrants through the provision of desirable conditions and appealing opportunities within immigrants' communities and neighbourhoods (Garcea 2006; CIC 2011b; Grubel 2013). As the source of immigrants to Canada has shifted from Europe to arrivals from Asia, Latin America, the Caribbean, and Africa, these newer sources have produced considerable changes in the religious profile of Canada, with growing numbers of Muslim, Buddhist, Hindu, and Sikh populations (Reitz et al. 2009). The concentration of religious groups has had a profound impact on neighbourhoods, towns and cities with the establishment of temples and mosques. In recent years, there has been growing evidence showing a positive relationship between religion/spirituality and health (Giaquinto et al. 2007; Koenig 2012; Williams 2013). Religious sites may constitute elements of the physical, social and symbolic environment (Gesler 1996) that are perceived to have healing capabilities.

However, there is still ambiguity in the mechanisms through which religious sites positively and/or negatively influences physical, social and mental health. Additionally, while there has been substantial research on the link between religion and wellbeing (Park et al. 2012; Koenig 2012; Koenig et al. 2012), we know little about how minority

[4] This paper is under review in *Mental Health, Religion & Culture*

immigrants in Canada, particularly those from Africa, maintain and reinforce their religious practices, given that religious places of worship are potentially key centres for health, socialization, employment and ultimately successful integration. One of the geographic concepts that have been applied to explore the link between place (religious sites) and health is the therapeutic landscape concept (Gesler 1992), a concept that provides a geographic perspective on the healing capabilities of religious sites amongst immigrants in their new homes, and is applied in this chapter.

While the concept of therapeutic landscape has been applied in many areas and scales in recent years (see, for example, Wilson 2003; Gastaldo et al. 2004; Williams 2013), little attention has been focused on the role of places of worship. The purpose of this chapter is therefore to explore whether religious places of worship (churches and mosques) are therapeutic places for immigrants and build sense of place. That is, the extent to which these places are seen by members as having healing capabilities. By focusing on Ghanaian and Somali immigrants living in Hamilton, Ontario, we extend existing work on therapeutic landscapes through an analysis of the landscapes of religious places, specifically churches and mosques and their role in the integration of newcomers. This research is unique as it places much more emphasis on the physical, social, symbolic and spiritual aspects of religious places of worship but more importantly, it examines the significance of the church and mosque for the health of Ghanaian and Somali immigrants in Hamilton. Exploring the capabilities of religious places will help to deepen the theoretical basis of therapeutic landscapes and the extent to which they shape health.

6.2 Churches and Mosques as therapeutic landscapes

Ghanaians, a predominately Christian community, and Somalis, who are predominantly Muslim, are among the largest Black African communities in Canada (Mensah and Williams 2014). For both groups, religion is an integral part of their lives. More broadly, religious place making amongst immigrants has a bearing on their wellbeing and integration. Health geographers have become increasingly interested in the subjective meanings attached to places, examining the links between their physical, material, spiritual and symbolic significance and the 'development and maintenance of the health of populations' (Williams 2002, p.148).

The relationship between religious place making and mental wellness essentially follows from the conceptual perspective of Therapeutic Landscapes (i.e., Gesler 1996; Williams 1999) and provides an explanation of the subjective meanings of places, exploring the links between the physical, spiritual, material and symbolic meanings and the 'development and maintenance of the health of populations' (Williams 2002, p.148). First introduced by Gesler (1992), the concept of therapeutic landscape describes the ways in which people have traditionally sought healing powers in certain places. The concept acts "as a geographic metaphor for aiding in the understanding of how the healing process works itself out in places (or situations, locales, settings, milieus)" (Gesler 1992, p.743). Even though the concept of therapeutic landscape was initially associated with particular physical or symbolic aspects of places, including baths (Gesler 1998) and shrines (Gesler 1996), the healing qualities of everyday landscapes, such as

homes and beaches, have also been recognized (Williams 2007). For example, using the therapeutic landscapes concept, Wilson (2003) explored the relationship between the land (Mother Earth) and health amongst First Nations peoples in Canada. More recently, Williams (2013) utilized the concept of therapeutic landscapes to explore the healing outcomes via cyber pilgrimage sites. The application of the therapeutic landscape concept in various religious settings has provided insights, including physical, mental and spiritual healing (Dobbs 1997; Williams 2010; Williams 2013).

The concept of therapeutic landscape may provide a useful tool for explaining the interconnections between integration, religion and health of immigrants by providing a framework for understanding the dynamics between place and health outcomes. Situating this theory in the contexts of the "church" and the "mosque" and following the "case of material, real-world religious/spiritual pilgrimages as conducive to healing" (Williams 2013, p.1), this framework provides a way to understand the 'church and mosque' (for Ghanaians and Somalis, respectively) as therapeutic landscapes. Similarly, Leonard et al. (2005) determined that religion continues to delineate and structure the personal and community identities of many new immigrants. It is found that religious sites provide not only a place of worship in their native language but are also a source of familiar ethnic foods, community information, psychological and instrumental support for newcomers who need health care, housing, and jobs (Stodghill and Bower 2002). Additionally, these places provide "stability and security" (Brown and Perkins, 1992), serve as "anchors" (Marcus 1992), and become "symbolic life lines" (Hummon 1989) and "field of care" (Relph 1976). In a study exploring religiosity, social support and life satisfaction among

elderly Korean immigrants in New York, Park et al. (2012) found that greater religiosity correlates with greater life satisfaction and that social support particularly explained the positive relationship between religious place making and life satisfaction.

Focusing on religious places shows the centrality of place for achieving physical, emotional, mental and spiritual healing. The restorative effects of religion/spirituality on emotional, cognitive and physical functioning are well illustrated and acknowledged (Hughes et al. 2004; Yoshimoto et al. 2006; Giaquinto et al. 2007; Koenig et al. 2012). The therapeutic landscape concept distinguishes places, situations, locales, settings and milieus as constituting physical, social and symbolic environments that play important roles in achieving an 'enduring reputation for achieving physical, mental, and spiritual healing' (Gesler 1993, p.171). Research has also demonstrated the importance of the place in which the interaction occurs (Gesler 1992). Thus, religious places such as churches and mosques provide avenues for people to interact with each other, promoting trust and solidarity between and among members. Additionally, it is widely known that positive interaction among people is likely to result in a positive sense of place or place attachment, which in turn, leads to positive health outcomes. Consequently, a landscape in which people exploit their collective efficacy to achieve healthy outcomes has been recognized as a type of therapeutic landscape (Cattell et al. 2008). With regard to mental health, Koenig et al. (2012) recorded that religion and spirituality (R/S) promotes positive emotions and helps neutralize negative emotions, assuming that it serves as both a life-enhancing factor and as a coping resource. Religion/spirituality helps to empower the individual through connecting him or her to a community, and to a greater force, that

might in turn give psychological stability (Oman and Thoresen 2003). Also, support via religious places has provided both expressive and instrumental resources such as economic assistance, employment information as well as spiritual support (Zuckerman 2000; Costen 1993; Mensah 2009). Religious places also provide opportunities for status and prestige often unavailable in the larger society (Lincoln and Mamiya 1990; Hannerz 1969) as well as political leadership (Sernett 1985; Wilmore 1994).

As an ongoing concept, Wilson (2003, p.85) emphasized how research has overlooked the everyday geographies of therapeutic landscapes and further cautioned researchers to explore other (non-physical) aspects of therapeutic landscapes; 'in particular those that do not exist solely on the ground but are embedded within the belief and value systems of different cultural groups'. At the public level, followers of various religions have created their own sacred places, religious institutions, organizations, support services, and transnational linkages (Ebaugh and Chafetz 2000; Mazumdar and Mazumdar 2005; Leonard et al. 2005). At the private level, religious activities have persistently influenced gender roles, mate selection, and family lives, and are used by some to maintain or "re-negotiate these relationships" (Carnes and Yang 2004, p.3).

As noted, religion/spirituality has not only been examined in wide variety of disciplines, but also in many spheres of life including: religion and place making (Mazumdar and Mazumdar 2009), religion and life satisfaction (Park et al. 2012), religion and employment/financial resources (Zuckerman 2000; Mensah 2009; Costen 1993), religion and physical health (Koenig et al. 2012), religion and mental health

(Ardelt 2003; Koenig et al. 2012), and religion and migration (Hagan & Ebaugh 2003; Reitz et al. 2009). Despite the plethora of studies, there is a dearth of empirical research specific to immigrants' religious sites and the exploration of the various therapeutic landscape concept themes. This is likely to shed light on whether religious sites operate as therapeutic landscapes associated with healing.

6.3 Methods

This chapter is based on in-depth interview data collected as part of a mixed-method approach to understand sense of place and mental wellness amongst Ghanaian and Somali immigrants in Hamilton, Ontario. With a total population of 519,949, the City of Hamilton is ranked 5th largest in the province of Ontario and 10th in Canada (Statistics Canada 2011), with almost 25% of its residents born outside of Canada and visible minorities representing12.3% of its population (City of Hamilton 2005-2010). In terms of religion, about 344,625 (66.2% of the total population) people identify as Christians and 19,025 (3.7%) are Muslims.

We focus here on the therapeutic landscape concept that contributes to an understanding of "religious places" as socio-cultural landscapes for building a sense of place and promoting mental wellness (i.e., religion as a feature of mental wellness for immigrants). It is important to note that the study did not intend to directly measure the relationship between religion and mental wellness. Rather, it explored how places of worship and religious activities are viewed as 'healing' and how they shape members' general quality of life, including both mental and physical health. Purposive, convenient

sampling was used to recruit participants from Ghanaian and Somali communities in Hamilton. After obtaining clearance from an institutional ethics board, we advertised at three Ghanaian churches and two mosques where Somalis worship through recruitment posters and verbal announcements. Two churches are located in the central core and one in the suburban mountain. With respect to the mosques, one is located in the central core of the city while the other is in the suburban mountain.

Individuals participated in open-ended, one-on-one interviews in English, Ghanaian *Twi,* and Somali *Af Maxaatiri* with the help of translators where needed. The interviews were conducted between July 2015 and November 2015. In accordance with the agreed ethics protocols, and with the participants' consent, interviews were recorded. The university ethics guidelines were followed and approved by the University Research Ethics Board at the author's institution. The interviews lasted between approximately 45 and 60 minutes and were conducted at locations preferred by the participants, including churches, mosques, homes and shops. Recruitment was based on responses to the quantitative survey described in earlier chapters, with participants asked at the end of the survey to indicate their willingness to participate in in-depth interviews. Because of the limited number of participants needed, only 24 were contacted initially to take part in the in-depth interviews. Seven of those invited did not respond and later two declined after accepting to participate because of some inconvenience. An additional nine were later invited and recruited. In total, 24 participants were recruited from the two study groups, with 12 participants recruited from each. Seven males and five females from the Ghanaian community participated, with four males and eight females from the Somali

community. Participants ranged in age from 22 to 54 years old. All participants were regularly attending church or mosque (i.e., weekly) at the time of the interviews. Common themes within and across groups were identified through the coding process and further discussed for importance and meaning with the help of one of the translators who is knowledgeable in qualitative research.

6.4 Findings

The interviews revealed common themes irrespective of religious affiliation, making the church or mosque more than just a physical space in which people interact. Our findings revealed four therapeutic themes associated with participants' religious places of worship: physical, social, symbolic and spiritual/emotional wellbeing. Verbatim quotes from the interviews are illustrated to show participants' experiences and perceptions of religious sites and their effects on health.

The physical space provides a place where people can meet and/or participate in activities related to worship and their community. Believers have access to the physical space which is considered 'sacred' and contains other symbolic elements. For Christians the songs and hymns sung during worship make members feel as they are actually present with God. Participants explained how religious sites operate as spaces for healing, as places where God dwells, and provide avenues for active participation in certain rituals such as praying, dancing, and worship:

> *It's a healing place for members; it's a sacred place for Allah. Hmm, you know sometimes people stay at home and the only opportunity they have is to go the*

mosque, a lot of people from other places come and interact. This is another way of healing because you get to mingle with people, worship, have fun, chat, and all those things (Male, Muslim).

Yes, I would say so, totally, it is healing place. Based on some of the testimonies I have heard from people at church, like most people come and say they used to have health issues or this or that but when they sign up for church group activities such as prayer groups they got people to talk to and all that and help them both physically and spiritually and mentally and all that so based on what I have heard from people I will say, yeah, it is a healing place. (Male, Christian).

The physical landscape and other structures of religious sites also provide members a sense of place, giving them the hope that they would be healed if they live as devout members of God. This finding is consistent with Williams' (1999) assertion that the concept of therapeutic landscape includes environments that have a strong sense of place and promote maintenance of health and wellness.

With respect to the social therapeutic landscape theme, participants reiterated the importance of religious sites as not only providing members avenues to interact with God through prayers and worship but also sites where members have the opportunity to interact with each other, share ideas, views, information and socialize with other members. Thus, social and physical spaces are closely intertwined, forming a strong attachment where the physical space provides avenue for people to interact with each other. Participants expressed how religious sites offer them the opportunity to interact:

Through group meetings we get to interact, we get news and information from friends about jobs, cheap accommodations and stuffs; it helps to settle and feel part of a family especially for single newcomers. Loneliness is bad. If you're alone you always have headache. Also it helps to share problems by advice – it helps prevent excessive pressure. Interaction helps people to forget about their problems in that particular moment. It is a welcoming environment for everyone (Male, Muslim).

At church sometimes they show movies about Jesus and other Christian movies. It's really nice. In the Easter time, they showed a movie on Jesus' death and His resurrection. This helps us to come together to believe in Him and hope that He is capable of doing anything we ask (Female, Christian).

There are several social resources in religious sites (Church and Mosque) that are considered therapeutic. These sites offer social activities including interaction, praying together and worshipping that provide opportunity for socialization. There are various sub-groups with few people which make it easy for further interaction. Again, these places offer some members the opportunity to undertake certain rituals such as washing of feet, lighting of candles, manipulation of rosary, tasbih and taking of communion or participate in other religious activities.

As the above quotes suggest, increased loneliness is a negative mental health outcome attributed to lack of interaction amongst people. Proximity to family varied among participants as many of them were students and young adults who have

immigrated without their immediate families. Consequently, the church or mosque performs family functions and a place where members can interact with one another.

A related idea to the social therapeutic landscape theme is that God's means of providing welfare to people can be found in religious sites. Religious sites are avenues for social welfare of members through the provision of material needs including ethnic foods, clothing and finances:

> *If you are in need they provide you foodstuff and groceries. If someone is bereaved they give you $2000 for the funeral arrangement; if a newcomer comes, we help him/her to settle down by giving him/her some foods and clothing and other help that he/she might need. They also have a group that helps newcomers to find jobs and affordable housing. (Male, Christian).*

> *In my church, we have potluck in the last Sunday of every month where everyone brings food to share, eat and chat. It is doing these times that you get to see variety of local foods (Female, Christian).*

A third theme that emerged from the analysis emphasizes religious sites as symbols of faith. According to participants, symbols such as the baptistery, rosary, or tasbih reflect the various ways they express faith. Specific symbols have been used by various religious groups to set psychological healing process (cleansing). Amongst Christians and Muslims, new converts are encouraged to simply utter a sincere declaration of faith. Accepting this faith destroys all sins, which come before it. This process means an individual's record is clean, which is similar to a 'literal rebirth'. To

clarify, some participants explain how these symbols are used to purify and guide a person to become a member:

> *In the church, we have a baptistery where new members are baptized in the name of the Father, Son, and the Holy Spirit. Prior to baptism, you have to accept Jesus as your personal savior and believe in Him (Male, Christian).*

> *To become a Muslim, you need to recite 'the Shahada' [a short oral declaration of faith]. "I bear witness that nothing deserves to be worshipped except Allah, and I bear witness that Muhammad is the Messenger of Allah." (Female, Muslim).*

Dealing with the spiritual or emotional therapeutic landscape theme, the church and/or the mosque can be interpreted as creating 'healthy spaces', which contribute to spiritual and mental wellbeing of members through its activities. Participants reiterated the notions of spiritual strength as necessary to health:

> *Sometimes praying, keeping quiet and having your quiet time also enables you to be introspective, it goes really down into yourself and think about a whole lot of issues that you think you can talk with your God that you think you cannot to talk anybody but talking to God is also a way of staying healthy. (Female, Christian).*

> *Singing as a group heals from emotional stress, trauma, and brings joy in your heart; if you follow the song with all your soul, heart and mind, it heals you*

mentally and psychologically. It gives you joy; it's a form of healing. (Male, Christian).

If I have a problem, I go to the mosque, pray, recite some verses in the Quran. If you follow the verses that you read, to me it's like getting treatment from a doctor. It's healing (Male, Muslim).

Activities such as praying, singing and meditating allow individuals to connect spiritually with their God, allowing members to pursue at the same time physical and spiritual connections to religious sites that are important for emotional and mental wellbeing.

6.5 Discussion and Conclusion

This chapter foregrounds the importance of religious places as therapeutic landscapes in shaping health. Religious sites and activities impact members' lives through multiple pathways, including physical, social, emotional, spiritual, and mental wellbeing through everyday activities in these 'healthy spaces'. In addition, a further area of concern for participants is related to material wellbeing, including access to food items, clothing and finances. These findings echo other literature by demonstrating that religious places and practices are significant for health, mental wellness and general quality of life amongst immigrants (Hagan and Ebaugh 2003; Mensah 2009; Koenig et al. 2012). Our analysis of the interviews, emerging from the therapeutic landscape lens underscores the importance of immigrants' places of worship in their new destinations.

Religious involvement and perception of mental wellness are similar in both Ghanaian and Somali groups in Hamilton, Ontario. They expressed a common belief in religious places of worship as ‘sacred’ and ‘healthy’ spaces. The findings of this study via the therapeutic landscape lens support the contention that religious sites are sources of healing for members. As Dyck and Dosa (2007) observed, religious observance/prayer depicts migrant women’s constitution of healthy space. Similarly, scholars have noted that visiting actual pilgrimage sites is a popular spiritual activity that promotes health and well-being (Nolan and Nolan 1992; Gesler 1996; Foley 2010). Almost all participants felt that their stresses were released as a result of attending church or mosque. This finding is consistent with researchers who have found an association between religion, mental health and wellbeing (Ardelt 2003; Yoshimoto et al. 2006; Koenig et al. 2012).

As Malloch (1989) suggested, good health and healing requires that an individual live in harmony with others, their community and the spirit worlds. The results of this exploratory research provide important insight into the effects of interactions amongst members of religious groups on health. As noted by Laws and Radford (1998), places, which may include religious sites, are centres of social relations and practices that operate amongst different people. Consequently, these social relations shape both the experience of place and an individual’s sense of self that are both central to health. Elsewhere, positive emotions are thought to build enduring resources, which leads to positive experiences and a sense of wellbeing (Fredrickson and Joiner 2002), providing stability and security (Brown and Perkins 1992). Additionally, increases in sense of security when members are surrounded by people with similar identities (Popay et al. 2003) promote

social cohesion. This is consistent with other studies that have documented how social cohesion influences health by enhancing the mutual exchange of resources and information (Wilkinson 1997; Kearns and Forrest 2000) and promoting collective efficacy, the extent to which members believe in their ability to mutually solve problems (Sampson et al. 1999; Mensah 2009).

The literature on therapeutic landscapes highlights the importance of symbols and symbolic landscapes in shaping health (Gesler 1996; Scarpaci 1999; Kearns and Barnett 1999). As noted by Wagner (1975), and Daniels and Cosgrove (1988), the cultural landscape can be viewed as a product of symbolic action; it structures, or represents cultural images. Specific symbols, including the baptistery in Christian churches, are directly associated with the religion, and often have spiritual powers or roles themselves. The function of the baptistery is, for example, multifaceted: it is used for prayer and to cleanse the believer from sins. Similarly, in the mosque there is a fountain, its water both a welcome respite and important for ablution (ritual cleansing). Another important symbol in the mosques is the 'Mihrab', a niche in the wall that indicates the direction of Mecca, toward which all Muslims pray. This finding corroborates with the assertion that landscapes are imbued with special symbols that allow the observation of particular rituals in relation to them (Jordan 2003). These symbols enable socialization into a particular material context. Therefore, landscapes are social documents, providing and sustaining social meaning; as a means to control and mystify (Cosgrove 1987); and are associated with sense of place.

Dealing with the spiritual or emotional therapeutic landscape theme, it is important to recognize that religious sites represent more than just a physical location of healing; there must also be a spiritual connection. The belief that religious sites are alive with spirits lends itself to positive mental and emotional health. Participants believe that places of worship are alive and contain spirits. Thus, these sites are dwellings of the Supreme Being that must be kept holy. Individuals are connected spiritually to both God and religious sites through activities such as prayer, worship and recitals that help to maintain health. These places provide individuals a way of meditating and moving into the spiritual realm, thus gaining full concentration on a particular situation. Even though the importance of spirituality for health is poorly understood (Morrison 1990), in recent times, the spiritual healing ability of specific places has been acknowledged (see Williams 1999; Wilson 2003; Williams 2013).

This exploratory study employing the therapeutic landscape concept contributes needed empirical evidence for the debate on the link between religious place making and health. Recognizing landscapes as 'symbolic, as expressions of cultural values, social behaviour, and individual actions worked upon particular localities over as span of time' (Meinig 1979, p.6), this study has demonstrated the importance of immigrants' religious places of worship in shaping physical, social, emotional/and or spiritual, and mental wellbeing. In sum, by adopting a therapeutic landscape framework, we are able to discern how religious places are most importantly seen as therapeutic places. Considering the complex way in which religious places function as therapeutic places, more research is needed to disentangle these complexities. Therapeutic landscape concept provides

insight into immigrants' experience of place and health promotion; and further illustrates the centrality of place in analysis of the complex intersection of migration, religion and health. Further research is needed to gain insight into the mechanisms through which gender roles shape the relationship between religious sites and health. Additionally, research employing the therapeutic landscape concept may explore the links between health and place in specific religious places and activities.

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Chapter Seven: Conclusions

7.1 Introduction

Immigrants in Canada constitute approximately 20.6% of the total population in 2011 (Statistics Canada 2011). Representing a wide variety of socioeconomic, cultural and linguistic backgrounds, immigrants often face multiple challenges attempting to integrate into the Canadian society, including accessibility to health, the labour market and discrimination (Newbold 2005; Ray and Preston 2009; Mensah 2010). Immigrants, particularly those from Africa are increasing in numbers and face a variety of settlement challenges.. In light of potential implications of immigration for individuals and groups, this is an important area of research for policy implications. The breadth of the chapters in this thesis help to understand the processes toward integrating immigrants, including policy practices and initiatives aimed at retaining immigrants that need to be incorporated as part of the settlement process. The contributions presented in this thesis highlight the ways that compositional and contextual characteristics shape the wellbeing of immigrant groups in their host societies.

This thesis examined sense of place and subjective wellbeing of Ghanaian and Somali immigrants in Hamilton, Canada. The first substantive chapter (Chapter 3) explored key informants' revelations on immigrants' sense of place and mental wellness in Hamilton explored how their perception and experiences of place might shape their mental wellbeing. Findings revealed eight factors that influence sense of place amongst immigrants in Hamilton: discrimination, education, religion, housing, employment,

language, gender and social support network. These factors reinforce the importance of housing, employment and language that we have seen elsewhere in the literature (Williams and Kitchen 2012; Kitchen et al. 2012; Ross 2001). This chapter further stresses the importance of promoting sense of place amongst immigrants by attending to the broader structural constraints associated with the wellbeing of immigrants. It is interesting to note that religious organizations were identified as contributing to the promotion of sense of place and mental wellness of immigrants, particularly when it is tied to employment, housing, health and social support network. These key informant revelations reaffirm other literature demonstrating the importance of place on mental wellness for individuals and groups alike (Williams and Kitchen 2012; Kitchen et al. 2012; Wilson et al. 2004). The chapter concludes by suggesting that immigrant service providers focus on policies that affect all determinants of health (including mental health) and be incorporated into policies of health and health-related institutions.

Chapter 4 expanded on the previous chapter by examining sense of place and mental wellness of Ghanaian and Somali immigrants. Employing quantitative techniques, results show significant factors associated with the relationship between sense of place and self-perceived mental wellness, including income, age, employment, citizenship status, marital status, dwelling type and length of residency in Canada. These factors that have been observed to influence sense of place are consistent with the literature (Williams and Kitchen 2012; Kitchen et al. 2012; Gallina and Williams 2014), with findings suggesting the need for research to incorporate sense of place into studies

on visible minority immigrants and to focus on those factors contributing to place attachment amongst recent immigrants.

Chapter 5 examined the factors that affect African immigrants' life satisfaction in Canada. Using a combination of descriptive and multivariate regression methods applied on a sample survey (n=236), this chapter investigated socio-demographic, socioeconomic and health-related factors that predict life satisfaction amongst African immigrants, specifically, Ghanaians and Somalis. Results revealed several significant factors associated with life satisfaction: being a Ghanaian; having a residency in Canada of 10 years and above; employed; living in a single/semi-detached house; and being in age-categories 25-34, 35-44 and 45-54. The chapter emphasizes the importance of factors that affect an individual's adjustment and well-being (Garcia Coll and Marks 2011), which may predict life satisfaction; suggesting that attention should be focused on reducing stress at a systemic level, including helping families identify sources of support, providing jobs, affordable housing, language interpretation and training. At the individual level, empowering immigrants to cope effectively with settlement challenges as they navigate through their new destinations would be worthwhile.

The last substantive chapter (Chapter 6) used qualitative in-depth interviews to explore the relationship between religious sites and mental wellbeing via the therapeutic landscape lens of Ghanaian and Somali immigrants in Hamilton. Results revealed that places of worship are significant for physical health, social, emotional, spiritual, mental, and general quality of life amongst immigrants. Once again, this finding endorses the

claim that religious places play an important role in shaping the geographies of contemporary cultural spaces. In addition, by using religious sites to explore the link between place identity and health, the results augment research on healthy places in health geography – a line of inquiry that is generating new connections between religious practices and wellbeing (Inoue 2000; Williams 2010; Williams 2013).

This thesis emphasizes the multiple ways in which wellbeing is tied to everyday spaces, which problematizes a conceptualization of religious places of worship as static, clearly bounded spaces. These are spaces mainly for worship. What are equivalent options for individuals who spend their time outside religious spaces, but perhaps, religious and take part in worship? This research suggests that we extend our understanding further by exploring everyday religious places of worship among individuals and groups.

Whereas this thesis discuses experiences of immigrants, much of the focus has been on African immigrants, with only the first substantive chapter devoted to immigrants in general. This imbalance is perhaps not surprising because it deals with Black Africans – a group that has received the scantiest research attention on immigration and settlement in Canada (Mensah and Williams 2014). Consequently, the welfare of African immigrants is seen as having important consequences for Canada. In spite of the complexities in conceptualization and methodological underpinnings, the substantive chapters of this thesis point to some convergences in research findings in the broader area of sense of place and wellbeing of immigrant groups. The convergence underscores the

processes of individuals' and groups' adaptation and integration in their host societies. Many of the chapters of this thesis have underscored the importance of context. For example, chapter four, which demonstrates the link between religious sites and health, including socialization of people, is a clear instance of the importance of the context in immigrants' settlement.

7.2 Limitations

Prior to discussing the major contributions of the thesis, there are a few limitations that need to be discussed. First, the thesis focuses on only a single second-tier city and has relatively a small sample size; generalizability to other immigrants living elsewhere in Canada or in other countries is limited. Second, the work focused on religious groups and religious places rather than on other public spaces of interaction, although there is a vibrant literature on the latter in health geography, public health and several social sciences (Wakefield and McMullan 2005; Wilton and DeVerteuil 2006; Wolch et al. 2014). As Hoseini and Mokhtari (2013) noted, public spaces are not only places for gathering and interaction but also for people to live and share their activities and memories with others, and are hence vital grounds for creating a sense of place. Importantly, however, the church figures prominently amongst Ghanaians, and the mosque is just as important for Somalis, with a majority of both groups participating in religion.

Third, the scope of this study encompasses all immigrants regardless of immigration status (e.g. refugee groups, economic immigrants, family reunification

immigrants). Although most Ghanaians entered as family or economic immigrants and most Somalis entered as refugees, and as such the individual groups are largely homogenous, it is possible that the different arrival status may result in different experiences of sense of place because of different acculturative experiences that could be studied by exploring more homogeneous groups of immigrants. Given that other research has shown that immigrant health, experiences, and perceptions often vary across immigrant subgroups (Beiser 2005; Ng et al. 2005; Dean and Wilson 2010), there is a need to examine the experiences of different immigrant groups. Lastly, sense of place or an attachment to a place is developed over time and is accompanied by a number of changes. Immigrants undergo a number of changes at all levels in acquiring the cultural values of host societies. These changes can best be understood in longitudinal studies. However, none of the substantive chapters discussed in this thesis takes a longitudinal approach. The results of this thesis provide insight into the ongoing debate about the nature of relationship between place and health.

7.3 Contributions to the Literature

The study enhances the understanding of the determinants of health and integration amongst visible minority immigrants, particularly African immigrants. In particular, the study provides insight into concepts such as sense of place, mental wellness, life satisfaction and religion, which hitherto have been studied as separate themes in their settlement and integration. Empirically, it utilizes both qualitative and quantitative methods to explore quality of life via religious place making of Ghanaian

and Somali immigrants and thereby broadens our understanding of African immigrants' integration in Canadian society. Situating the study in Hamilton, Ontario is also important: Hamilton is a diverse city with almost 25% of its residents born outside Canada and 12.3% as visible minorities (City of Hamilton 2005-2010). It is home to a sizeable number of both Ghanaian and Somali immigrants. With an increasing number of immigrants settling in smaller and medium-sized Canadian cities, this study has contributed and answered the call for more studies in second-tier cities (Frideres 2006; Radford 2007; Gallina and Williams 2014).

7.4 Recommendations for Future Research

Findings in this research portray implications for intervention on immigrants, which may influence their adjustment in Canada. Thus, providing adequate support for immigrants through resources available in their communities and neighbourhoods is an essential step in helping this increasing population to mitigate the challenges they face. The finding that social support via community organizations and religious sites protect against stressors also provides important information for policy makers. Putting strong support networks in place for newcomer immigrants is likely to be a particularly effective form of settlement assistance. Such measures could include developing networks of friends through groups, clubs, community services and religious engagements, depending on the immigrant population since different lenses of acculturation are required to appropriately ensure the acculturative experience. A crucial topic of further study could be the influence of gender roles in the experiences of place and wellbeing.

With increasing research interests, sense of place research needs to go beyond the simple comparative approach and focus on more cross-comparative involving three or more ethnic groups in three or more communities of settlement. This is likely to reveal the multitude of factors that may influence immigrants' sense of place and wellbeing.

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Appendices

Appendix A: Survey Questionnaire on Socio-demographic and Economic Variables

<table>
<tr><td colspan="7">G. Demographics</td></tr>
<tr><td colspan="7">Now I am going to ask you a few questions about yourself. Please be assured again that your answers are confidential and will not be reported in any way that could be traced back to you.</td></tr>
<tr><td colspan="2">Gender</td><td colspan="2">1 Female</td><td colspan="3">2 Male</td></tr>
<tr><td colspan="7">Age</td></tr>
<tr><td colspan="7">G1. Please stop me when I come to the age category that you fit into:</td></tr>
<tr><td>18-24
1</td><td>25-34
2</td><td>35-44
3</td><td>45-54
4</td><td>55-64
5</td><td>65-74
6</td><td>75 and over
7</td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7"></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><td colspan="7">G2. How long have you lived in Canada?</td></tr>
<tr><td>Less than 1 year
1</td><td>1-5 years
2</td><td>6-10 years
3</td><td>Over 10 years
4</td><td>Refused to answer
99</td><td colspan="2"></td></tr>
<tr><td colspan="7"></td></tr>
<tr><td colspan="7">G3. Are you a Canadian Citizen?</td></tr>
<tr><td>Yes
1</td><td>No
2</td><td colspan="2"></td><td colspan="3"></td></tr>
<tr><td colspan="7">Marital Status</td></tr>
<tr><td colspan="7">G4. What is your marital status?</td></tr>
<tr><td colspan="2">Single/never married
1</td><td colspan="2">Married, common law, or living with a partner
2</td><td colspan="3">Separated/Divorced
3</td></tr>
<tr><td colspan="2">Widowed
4</td><td colspan="2">Refused
99</td><td colspan="3"></td></tr>
<tr><td colspan="7">G5. Which of the following best describes your current living arrangement with people:</td></tr>
<tr><td colspan="2">Unattached individual adult living alone
1</td><td colspan="2">Unattached individual adult living with others (e.g., kids, etc.)
2</td><td colspan="3">Couple living with children (children of any age)
3</td></tr>
<tr><td colspan="2">Couple living alone
4</td><td colspan="2">Lone-parent with no kids living with them
5</td><td colspan="3">Other
6</td></tr>
</table>

Appendix A (Continued): Survey Questionnaire on Socio-demographic and Economic Variables

Education		
G6. What is your current level of education?		
Less than high school 1	High school diploma 2	Some college or university 3
College or trade school diploma or certificate 4	University graduate 5	Refused to answer 99
Employment		
G7. During the past 12 months were you mainly….? Check the one that best categorizes you??		
Working full time 1	Working part-time 2	Unemployed 3
Retired 4	Homemaker/caregiver 5	Student 6
On disability/maternity leave 7	Refused 99	
Income		
G8. What is your total, annual household income before taxes?		
Less than $20,000 1	$20,000-$39,999 2	$40,000-$59,999 3
$60,000-$79,999 4	$80,000-$99,999 5	$100,000 or more 6
Refused to answer/Don't Know 99		
Housing		
G9. What type of dwelling do you live in?		
Single detached home 1	Semi-detached 2	Row/Townhouse 3
Low rise apartment (less than 5 stories) 3	High rise apartment (5 or more stories) 4	Other 5
Don't Know 99		

G10a.How many children do you have? Please indicate………….. G10b. How many children **under age 18** do you have living with you?					
None 0	One 1	Two 2	Three 3	4 or more 4	Refused 99

Appendix B: Sense of place scale: 16-item sense of place scale (Williams et al. 2010)

D1. My neighbourhood means a great deal to me.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D2. There's no other neighbourhood I would rather live.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D3. I feel at home in my neighbourhood.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D4. There are people in my neighbourhood who I think of as close friends.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5(Strongly disagree)
D5. I would like to stay in my neighbourhood as long as my health allows me to do so.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D6. Green space availability in my neighbourhood positively influences my health.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D7. Environmental problems in my neighbourhood (e.g. air pollution, run-down buildings) negatively influence my health.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D8. Social problems in my neighbourhood (e.g. racism, violence) negatively influence my health.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
D9. The personal safety of myself and my family in my neighbourhood negatively affects my health.
1 (Strongly agree) 2 (Agree) 3 (Neutral) 4 (Disagree) 5 (Strongly disagree)
How true are the following two statements?
D10. I know many of my neighbours on a first name basis.
1 (Very true) 2 (Fairly true) 3 (Neutral) 4 (Not very true) 5 (Not at all true)
D11. If I were to live somewhere else, it would be difficult to move away from my neighbourhood.
1 (Very true) 2 (Fairly true) 3 (Neutral) 4 (Not very true) 5 (Not at all true)
I would like to ask you several more questions on how you feel about your neighbourhood.
D12. How rooted do you feel in your neighbourhood?
1 (Very rooted) 2 (Fairly rooted) 3 (Neutral) 4 (Not very rooted) 5 (Not at all rooted)
D13. How connected do you feel to your neighbourhood?
1 (Very connected) 2 (Fairly connected) 3 (Neutral) 4 (Not very connected) 5 (Not at all connected)
D14. How much do you like your neighbourhood?
1 (A great deal) 2 (A fair amount) 3 (Neutral) 4 (Not very much) 5 (Not at all)
D15. How often do you participate in social activities with your neighbours (e.g. barbeques, coffee dates, etc.).
1 (All the time) 2 (Often) 3 (Sometimes) 4 (Hardly ever) 5 (Never)
D16. If you had to leave your neighbourhood, how many of your neighbours would you miss?
1 (Many of them) 2 (Some of them) 3 (Neutral) 4 (Hardly any of them) 5 (None of them)

Appendix C: The mental wellness inventory

1. How happy, satisfied, or pleased have you been with your personal life during the past month? **(Tick one)**
   1( ) Extremely happy, could not have been more satisfied or pleased
   2( ) Very happy most of the time
   3( ) Generally, satisfied, pleased
   4( ) Sometimes fairly satisfied, sometimes fairly unhappy
   5( ) Generally dissatisfied, unhappy
   6( ) Very dissatisfied, unhappy most of the time
2. How much of the time have you felt lonely during the past month? **(Tick one)**
   1( ) All of the time 4( ) Some of the time
   2( ) Most of the time 5( ) A little of the time
   3( ) A good bit of the time 6( ) None of the time
3. How often did you become nervous when faced with excitement or unexpected situations during the past month? **(Tick one)**
   1( ) Always 3( ) Sometimes
   2( ) Very often 5( ) A little of the time
   3( ) Fairly often 6( ) Never
4. During the past month, how much of the time have you felt that the future looks hopeful and promising? **(Tick one)**
   1( ) All of the time 4( ) Some of the time
   2( ) Most of the time 5( ) A little of the time
   3( ) A good bit of the time 6( ) None of the time
5. How much of the time, during the past month, has your daily life been full of things that were interesting to you? **(Tick one)**
   1( ) All of the time 4( ) Some of the time
   2( ) Most of the time 5( ) A little of the time
   3( ) A good bit of time 6( ) None of the time
6. How much of the time, during the past month, did you feel relaxed and from tension? **(Tick one)**
   1( ) All of the time 4( ) Some of the time
   2( ) Most of the time 5( ) A little of the time
   3( ) A good bit of time 6( ) None of the time
7. During the past month, how much of the time have you generally enjoyed the things you do? **(Tick one)**
   1( ) All of the time 4( ) Some of the time
   2( ) Most of the time 5( ) A little of the time
   3( ) A good bit of time 6( ) None of the time

Appendix C (Continued): The mental wellness inventory

8.During the past month, have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or of your memory? **(Tick one)**

1( ) No, not at all
2( ) Maybe a little
3( ) Yes, but not enough to be concerned or worried about
4( ) Yes, and I have been a little concerned
5( ) Yes, and I am quite concerned
6( ) Yes, I am very much concerned about it

9. Did you feel depressed during the past month? **(Tick one)**

1( ) Yes, to the point that I did not care about anything for days at a time
2( ) Yes, very depressed almost every day
3( ) Yes, quite depressed several times
4( ) Yes, a little depressed now and then
5( ) No, never felt depressed at all

10. During the past month, how much of the time have you felt loved and wanted? **(Tick one)**

1( ) All of the time 4( ) Some of the time
2( ) Most of the time 5( ) A little of the time
3( ) A good bit of time 6( ) None of the time

11. How much of the time, during the past month, have you been a very nervous person? **(Tick one)**

1( ) All of the time 4( ) Some of the time
2( ) Most of the time 5( ) A little of the time
3( ) A good bit of time 6( ) None of the time

12. When you have got up in the morning, this past month, about how often did you expect to have an interesting day? **(Tick one)**

1( ) Always 4( ) Some of the time
2( ) Very often 5( ) Almost never
3( ) Fairly often 6( ) Never

13. During the past month, how much of the time have you felt tense or "easily upset"? **(Tick one)**

1( ) All of the time 4( ) Some of the time
2( ) Most of the time 5( ) A little of the time
3( ) A good bit of time 6( ) None of the time

14. During the past month, have you been in firm control of your behaviour, thoughts, emotions or feelings? **(Tick one)**

1( ) Yes, very definitely 4( ) No, not too well
2( ) Yes, for the most part 5( ) No, and I am somewhat disturbed
3( ) Yes, I guess so 6( ) No, and I am very disturbed

Appendix C (Continued): The mental wellness inventory

15. During the past month, how often did your hands shake when you tried to do something because you were worried or nervous? **(Tick one)**
    1( ) Always 4( ) Sometimes
    2( ) Very often 5( ) Almost never
    3( ) Fairly often 6( ) Never
16. During the past month, how did you feel that you had nothing to look forward to? **(Tick one)**
    1( ) Always 4( )Sometimes
    2( ) Very often 5( ) Almost never
    3( ) Fairly often 6( ) Never
17. How much of the time, during the past month, have you felt calm and peaceful? **(Tick one)**
    1( ) All of the time 4( ) Some of the time
    2( ) Most of the time 5( ) A little of the time
    3( ) A good bit of time 6( ) None of the time
18. How much of the time, during the past month, have you felt calm? **(Tick one)**
    1( ) All of the time 4( ) Some of the time
    2( ) Most of the time 5( ) A little of the time
    3( ) A good bit of time 6( ) None of the time
19. How much of the time, during the past month, have you felt unhappy and depressed? **(Tick one)**
    1( ) All of the time 4( ) Some of the time
    2( ) Most of the time 5( ) A little of the time
    3( ) A good bit of time 6( ) None of the time
20. How often have you felt like crying, during the past month? **(Tick one)**
    1( ) Always 4( )Sometimes
    2( ) Very often 5( ) Almost never
    3( ) Fairly often 6( ) Never
21. How much of the time, during the month, were you able to relax without difficulty? **(Tick one)**
    1( ) All of the time 4( ) Some of the time
    2( ) Most of the time 5( ) A little of the time
    3( ) A good bit of time 6( ) None of the time
22. How much of the time, during the past month, did you feel that your love relationships, loving and being loved, were full and complete? **(Tick one)**
    1( ) All of the time 4( ) Some of the time
    2( ) Most of the time 5( ) A little of the time
    3( ) A good bit of time 6( ) None of the time

Appendix C (Continued): The mental wellness inventory

23. How often, during the past month, did you feel that nothing turned out for you the way you wanted it to? **(Tick one)**
    1( ) Always
    4( ) Sometimes
    2( ) Very often
    5( ) Almost never
    3( ) Fairly often
    6( ) Never
24. How much have you been bothered with loss of appetite, during the past month? **(Tick one)**
    1( ) Extremely so, to the point where I could not take care of things
    2( ) Very much bothered
    3( ) Bothered quite a bit by nerves
    4( ) Bothered some, enough to notice
    5( ) Bothered just a little by nerves
    6( ) Not bothered at all by this
25. During the past month, how much of the time has living been a wonderful adventure for you? **(Tick one)**
    1( ) All of the time
    4( ) Some of the time
    2( ) Most of the time
    5( ) A little of the time
    3( ) A good bit of time
    6( ) None of the time
26. How often, during past month, have you felt so sorrowful that nothing could cheer you up? **(Tick one)**
    1( ) Always
    4( ) Sometimes
    2( ) Very often
    5( ) Almost never
    3( ) Fairly often
    6( ) Never
27. During the past month, how much of the time have you felt impatient, uneasy, or annoyed? **(Tick one)**
    1( ) All of the time
    4( ) Some of the time
    2( ) Most of the time
    5( ) A little of the time
    3( ) A good bit of time
    6( ) None of the time
28. During the past month, how much of the time have you been moody or brooded about things? **(Tick one)**
    1( ) All of the time
    4( ) Some of the time
    2( ) Most of the time
    5( ) A little of the time
    3( ) A good bit of time
    6( ) None of the time
29. How much of the time, during the past month, have you felt cheerful, optimistic? **(Tick one)**
    1( ) All of the time
    4( ) Some of the time
    2( ) Most of the time
    5( ) A little of the time
    3( ) A good bit of time
    6( ) None of the time

30. During the past month, how often did you get distressed, upset or flustered? **(Tick one)**
    1( ) Always
    2( ) Very often
    3( ) Fairly often
    4( ) Sometimes
    5( ) Almost never
    6( ) Never

31. During the past month, have you been anxious or worried? **(Tick one)**
    1( ) Yes, extremely to the point of being sick or almost sick
    2( ) Yes, very much so
    3( ) Yes, quite a bit
    4( ) Yes, some, enough to bother me
    5( ) Yes, a little bit

32. During the past month, how much of the time were you a happy person? **(Tick one)**
    1( ) All of the time
    2( ) Most of the time
    3( ) A good bit of time
    4( ) Some of the time
    5( ) A little of the time
    6( ) None of the time

33. How often during the past month did you find yourself trying to calm down? **(Tick one)**
    1( ) Always
    2( ) Very often
    3( ) Fairly often
    4( ) Sometimes
    5( ) Almost never
    6( ) Never

34. During the past month, how much of the time have you been feeling less positive? **(Tick one)**
    1( ) All of the time
    2( ) Most of the time
    3( ) A good bit of time
    4( ) Some of the time
    5( ) A little of the time
    6( ) None of the time

35. How often, during the past month, have you been waking up feeling fresh and rested? **(Tick one)**
    1( ) Always, every day
    2( ) Almost every day
    3( ) Most days
    4( ) Some days, but usually not
    5( ) Hardly ever
    6( ) Never wake up feeling rested

36. During the past month, have you been under or felt you were under any strain, stress or pressure? **(Tick one)**
    1( ) Yes, almost more than I could stand or bear
    2( ) Yes, quite a bit of pressure
    3( ) Yes, some more than usual
    4( ) Yes, some, but about normal
    5( ) Yes, a little bit
    6( ) No, not at all

Appendix C (Continued): The mental wellness inventory

37. In general, would you say your mental wellness is?
    1( ) Excellent
    2( ) Very good
    3( ) Good
    4( ) Fair
    5( ) Poor
    6( ) Don't know