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# A Narrative Study of Refugee Women Who Have Experienced Violence in the Context of War

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## *Introduction*

During the past 50 years, the number of immigrants and refugees has increased dramatically. At the time the United Nations High Commission for Refugees was first established in 1951, there were approximately 1.8 million people classified as immigrants or refugees. Today that number is estimated to be 44 million. Although the statistics are highly variable, in availability and quality, it is widely recognized that women constitute more than half of the world's refugee population. The challenges that this group of refugees face are enormous. In the absence of war, women have traditionally assumed the multiple roles of caregiver, nurturer, and protector within their families. However, when war intrudes, women must continue to carry out these roles at a time when they, and often their partners, are suffering the enduring effects of trauma. Collectively, their experiences often leave them physically, psychologically, and spiritually scared. Even though they may be able to escape the war, the traumas continue to haunt them.

Research with Holocaust survivors lends support to the idea that the impact of human atrocity and suffering continues to be felt for generations after the event. According to Krell (1993), children who lived through the Holocaust were forced to learn how to stifle their emotions and embrace silence; doing otherwise meant certain death. As adults, these survivors typically dampen enthusiasm when enthusiastic, and grief when bereaved. Facing survival in an unfamiliar cultural landscape, while isolated from their loved ones and familiar supports and suffering emotional and material depletion, refugee women must still attend to the needs of themselves and their families.

Before their flight, refugee women experience a multitude of horrific pre-migration experiences, including separation from their spouses, children, and other family members; many have either experienced firsthand, or been witnesses to, the torture or killing of family and friends. Rape and other forms of sexual torture have become weapons in modern warfare, and have been used to an alarming degree by those intent upon the destruction and genocide of large portions of humanity. Frequently, such horrific events are carried out in the name of “ethnic cleansing”, or they are justified as a moral imperative. The international community has been slow to respond as a result of resistance to diversity, the sheer horror of it all, and political, social, and economic pressures. Yet, despite the painful integration of war in their lives, there is a growing body of literature suggesting that many refugee women reveal a surprising capacity for resilience. Though vulnerable in many ways, they are the backbone of the refugee community.

The disproportionate burden endured by refugee women, and the unique challenges they face, have received growing attention in recent years. However, theoretical understandings remain sparse and few programs have been developed that are responsive to the needs of these women. The purpose of this research was to investigate the experiences of refugee women who have experienced violence in the context of war before migration to Canada. With the knowledge gained from this study, it was expected that refugee women and their families would be able to suggest recommendations for the provision of culturally meaningful and appropriate health and social services that would take into account the unique circumstances faced.

## *Background*

The present study evolved from an earlier conceptualization of a community-based research project that was to be conducted under the auspices of the Sexual Assault Centre London (SACL). The goal was to investigate the experiences of women who had suffered sexual torture in the context of war. Despite considerable effort and commitment on the part of the research team, the highly sensitive nature of that study made recruitment of participants, of women and service providers, extremely difficult. A small group of us met with individuals at the Centre for Victims of Torture in Toronto in order to discuss this research and the problems we were encountering. As a result of this meeting, we concluded that a study of this nature was unlikely to succeed in its present form. In addition, questions were raised regarding the appropriateness of it being conducted under the auspices of SACL.

Based on the importance of this issue, we were reluctant to abandon it, and decided instead to modify and strengthen the study from its earlier version. By broadening the scope to include women who had endured a range of pre-migration traumatic war experiences, rather than a focus solely on sexual torture as originally planned, it was our hope and belief that we would be able to carry out this project in a realistic and worthwhile manner. Further, we felt that the composition of the research team, which included members of the academic community as well as leaders within the immigrant and refugee community, made us well positioned to conduct this research. Although the Sexual Assault Centre London did not assume a principal role in the revised study, members of SACL continued their involvement with this project and, as an

organization, their support was constant.

The researchers approached women's stories from an interdisciplinary perspective, integrating important insights from the fields of nursing, clinical psychology, social work, anthropology and sociology. In addition, considering the topic of this research and the reasons that motivated the authors' endeavours to conduct such a project, feminist standpoints are imbued within the paper.

### *The Refugee Experience: A Historical and Legal Perspective*

In 1951, the Office of the United Nations High Commissioner for Refugees (UNHCR) was established at the Geneva Convention in order to assist the large number of refugees created by the events of World War II. A primary goal of the UNHCR and the subsequent 1967 Protocol Relating to the Status of Refugees was to establish an internationally acceptable and recognizable frame for the definition of a refugee and her or his ensuing treatment by the international community. According to the definition, a refugee is anyone who,

Owing to a well-founded fear of being persecuted for reasons of race, religion or nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable, or owing to such fear, is unwilling to return to that country. (UNHCR, 1988)

The UNHCR has two main functions: to provide refugees with international protection and, at the request of the host government, to assist them towards durable solutions to their problems. In fulfilling its mandate of international protection to refugees, the UNHCR

encourages governments to adhere to the Convention and to international instruments concerning refugees. These include: the granting of asylum, guarantees for the physical safety and well-being of refugees, the establishment of safeguards against the forcible return of refugees to a country where they fear persecution (refoulement), the dissemination of international refugee law, and the legal treatment of refugees as much like nationals of the asylum country as possible (Loescher, 1992).

Despite the international mechanisms that seek to ensure equality of treatment for all refugees, the majority of refugees, three-fourths of whom are women and children, have not achieved guarantees for their protection (Gilad, 1990). Although the 1951 Convention with its 1967 Protocol remains the official definition of a refugee, most of today's refugees do not qualify. The definition is restrictive in its emphasis on the individual, persecution and its stipulated categories of persecution (Gilad).

The Canadian Immigration Act (1976) definition of a refugee is consistent with the Convention definition. Yet, to some degree, the restrictive nature of this definition is recognized and the Canadian Immigration Act has created the category of “designated classes”, enabling some persons to enter Canada under relaxed selection criteria. Many of these people, brought to Canada as either private or government sponsored immigrants would not be able to establish both a subjective fear and concrete evidence of that fear, and thus, not meet the Convention definition of refuge. Three refugee movements are generally recognized: the Indochinese who have fled one of the communist Southeast Asian regimes (Vietnam, Laos, and Cambodia) after April 30, 1975; the self-exiled from Eastern Europe; and political prisoners and oppressed

persons, including those from the nations of El Salvador, Guatemala, Poland, and Chile.

Before the 1990's, the Canadian refugee policy seemed to be biased in favour of refugees from communist countries and against refugees from right-wing dictatorships (Whitaker, 1987). While many Eastern European refugees may have in fact been economic migrants, not fleeing political persecution, they are ideologically “correct” as anti-communists. In contrast, many refugees from the right-wing dictatorships of Central America were perceived as "left-wing radicals" or dismissed as economic migrants, even though they may have been peasants fleeing from the crossfire of bullets. Thus, the designation of refugees as Convention Refugee or Designated Class Refugee has resulted in two unequal classes of refugees. Ironically, the “political prisoners and oppressed persons” designated class is aimed at several right-wing Latin American regimes, but it is extremely dangerous to even approach Canadian authorities in these countries (Gilad, 1990).

Thus, despite the less restrictive Canadian refugee policy, many individuals are unable to meet the criteria for refugee status and prove that they would, in all probability, be persecuted if they returned to their homeland. The vast majority of those who flee do not choose to get into rickety boats and endanger their own lives and those of their children, risk pirate attacks or rape, cross steep snow-covered mountains, or willingly live under burlap tents, behind barbed-wire fences unless they are fleeing for their safety. People who flee do so to escape bombardments, inevitable starvation, and oppressive rulers.

### *The Contemporary Context*

In January 1997, the controversial *Not Just Numbers* report came out followed by the

ambiguous *Building on a Strong Foundation for the Twenty-First Century: New Directions for Immigration and Refugee Policy and Legislation* in January 1998. According to Arat-Koc (2000), the *Not Just Numbers* report is “a product of anti-immigrant, anti-refugee, and racist sentiments” (p.18), especially when it comes to immigrants coming from non-traditional source countries. The author asserts that the recommendations of the report overlook the most disadvantaged group of immigrants and refugees, namely poor women and women of colour.

Moreover, the document lacks a gender-based analysis in its recommendations and “fails to acknowledge and address existing bias and discrimination against women in the immigration and refugee system” (ibid. p.18). The expectations and requirements for entry into Canada that are presented in both documents, *Not Just Numbers* and *New Directions*, are extremely high. In particular, only those individuals who have high levels of formal education, are capable of supporting themselves or resettling in twelve months in the case of refugees, speak at least one official language or have the ability to learn it quickly, are relatively young, in excellent health, and exhibit the ability to adapt quickly and successfully to the Canadian culture would be granted entry. Whereas, issues such as emotional trauma, imposed isolation, lack of a supportive social network, sexism, racism and ethnocentrism do not seem to be taken into consideration.

Women and children are among those who would be most adversely affected by these recommendations. It is well known that most women who come from non-traditional source countries have limited access to formal education, foreign language courses, jobs that might provide them with needed skills, and financial resources. Apparently, in order to locate and help these women and their children who are considered the neediest group, Canada Immigration and

Citizenship intends to select them “at locations as close as possible to their home” (*Not Just Numbers*, p.82) as it is very hard for them to reach a Canadian port of entry. Although at first glance, this procedure might appear to be very compassionate and efficient, it is a veiled attempt to keep the “refugee problem” as remotely as possible from Canada. This notion is reinforced by the *Not Just Numbers*’ proposal to offer asylum to these people in “safe third countries” who meet “the relevant human rights standards” (ibid. p.89). Precisely what this statement means remains ambiguous at best.

The fact that women are often victims of rape and domestic violence, while a large number of children suffer malnutrition and a range of other health problems in the refugee camps, is well established. In addition, it is most unlikely that women will be able to meet the above-mentioned criteria as they are usually segregated into traditional gender roles that provide them solely with domestic skills. The likelihood that they are able to speak or learn a foreign language when it is documented that women present the highest rates of illiteracy in many parts of the world is virtually nil. Finally, the *New Directions* recommendation to dissolve the Live-In Caregiver Designated Class, “the one predominantly female immigration stream”, and incorporate it into the Temporarily Highly Skilled Foreign Workers Class seems like another attempt to leave more space to a male-centred flow of human capital (Hyndman, 2000; p.9). These facts make the reports’ recommendations and newly established standards not only controversial, but also unrealistic.

Despite concerns with the current proposals, it is important to acknowledge that several positive initiatives have been undertaken in an effort to include women’s needs and voices in the

international agenda. For example, the UNHCR's initiative to implement the program, *Women at Risk*, in the United States and New Zealand in 1988 and the Canadian Immigration and Refugee Board's decision to adopt the *Guidelines on Women Refugee Claimants Fearing Gender-Related Persecution* in 1993 represent important efforts to acknowledge the lived reality of refugee women. As well, the proposed policy direction that the Family Class criteria be broadened to include persons in common-law and same-sex relationships is commendable. However, as many feminist writers maintain, "more inclusive criteria" are needed that "explicitly recognize women's rights as human rights and incorporate human rights abuses directed at women and children including sexual violence, domestic violence, and sex slavery" (Arat-Koc, 2000:22). In the absence of an explicit recognition of the distinct forms of abuse experienced by women and children, the net effect is a policy that privileges men over women and that, once again, relegates the needs of women to the fringes of the immigration and citizenship legislation.

#### *The Women in This Research and Their Countries of Origin*

Political violence and state terrorism took many hideous forms in Latin America and in the Balkans. Although the motives for oppression varied from one country to another, they also shared several common goals: to disempower and silence the population or specific segments of the population; to maintain and perpetuate the hegemonic societal structures; and to suppress and eliminate the 'personas non grata' and any form of resistance on their part. Therefore, the counter-insurgency wars in Guatemala and El Salvador targeted mostly the rural indigenous population, while in Chile, it was mostly the urban educated civilians that were hunted down by the military. In these countries, "terror was intended to be felt but not named", and "people were

forced to deny their own reality, to swallow their own words” (Summerfield, 1999:119). The outcomes revealed hundreds of thousands of missing (kidnapped), incarcerated, tortured, raped, and/or murdered men, women and children, and entailed numerous waves of refugees fleeing their homes and looking for a safe haven (Farias, 1994). In Guatemala, it was estimated that during the thirty-five year civil war, over 150,000 people died, 50,000 disappeared and one million became refugees (Pyke, 1998:37) of which over 200,000 fled to North America (Farias, 1994:105). In El Salvador, approximately 75,000 people were killed during the war, and about one million people sought refuge in México, Guatemala, Honduras, Panamá, the United States, and Canada (Jenkins, 1991:141). Unfortunately, once they reached a country of asylum or a host country, the refugees bitterly realized that their ordeal was far from being over. The lack of a certain residency status, the lack of access to education, employment and decent housing as well as the lack of social services resulted in deepening their emotional distress and in relegating them to the bottom of the society.

In the Balkans, where the aftermath of war is still visible, the atrocities reached their highest intensity in Bosnia and Kosovo where the Muslim population was ““cleansed” by the Serbian army with the sole purpose of obtaining ethnic purification and unilateral power over the land. Bosnia recorded the highest number of victims as the killing often occurred in conjunction with the raping of the victims. Thus, in Bosnia, the act of rape became a monstrous form of ethnic cleansing which affected about 56,000 to 60,000 women (Morokvasic, 1998:81) and war violence led to the suffering of 65,000 children only in Sarajevo (Malone, 1996:320, footnote 6). According to Morokvasic (1998), as a result of war.

Women clearly emerged as victims, either indirectly on the receiving end of everyday violence, economic disaster and political chaos in the states at war, or as direct victims of the warring parties, killed, raped, and forced into prostitution as refugees and displaced persons (p.76).

*Upon Arrival In a New Country: Facing a New Set of Challenges*

To add to the trauma of their past, refugees are usually poor and are cut off from any sources of social support when they arrive in a country of asylum. The desperation that prompted their decisions to leave, coupled with lengthy delays that invariably preceded the numerous hearings to determine their eligibility for refugee status, generated new sources of stress. Once refugee status is granted, these newcomers confront additional barriers. Beside the practical problems such as being unable to speak the language, limited job opportunities, difficulties accessing health services, and so forth, many refugees are stigmatized as unwanted, displaced persons. Attitudes and behaviours indicative of racial intolerance are not uncommon (Beiser, 1988). Although Canada has achieved a reputation as a humanitarian nation, a number of studies reveal that a substantial and growing proportion of the population displays a “morbid dislike of foreigners” (ibid., p.12). A report released by the Canada Employment and Immigration Commission (CEIC) in 1985 demonstrated that a great number of Canadians exhibit racist and xenophobic attitudes (ibid.). While no research has identified a causal link between discrimination and health, it is difficult to imagine that the relentless experience of rejection does not jeopardize one's health and sense of well-being.

Refugees and refugee movements traditionally have been regarded as localized, nonrecurring, and isolated flows. This inaccurate perspective has resulted in a failure to develop comprehensive programs to assist refugee women and their families. Instead, efforts to respond to the problems confronted by each group have been undertaken on an ad hoc basis. As one of the three cities in Ontario that has been designated by the Federal Government as a receiving centre for refugees, London has become increasingly diverse. Each year hundreds of newcomers arrive and are offered some orientation to Canadian ways before they set out to rebuild their lives in this community. For many who fled their homes and countries without legal status or time to prepare, this task is particularly difficult. Although many of these women may not have identified themselves as survivors of war trauma, they all have endured at least some form of pre-migration exposure to war, either as witnesses or as direct recipients.

Despite the reality that the majority of the world's refugees are women, most of the programs and services available have been developed, implemented, and administered by men. The current research is intended to be a first step toward the design of programs and policies that are responsive to, and respectful of, the needs and concerns of refugee and immigrant women.

### *Review of the Literature*

In this literature review, research that is relevant to an understanding of the experiences of refugee women from databases in the fields on nursing, sociology, anthropology and psychology, is examined. Because much of what is currently known and understood regarding the responses of refugee women to wartime trauma is derived from research using the concept of post-traumatic stress disorder (PTSD), the review will include a brief analysis of this 'disorder'

and thoughts about its relevance for an understanding of the lives of refugee women.

*Pre-migration Experiences.* Before coming to Canada, women are exposed to a range of pre-migration atrocities. These may include directly or indirectly experiencing pain, torture, rape, or killing of loved ones. For example, during the war in Bosnia, many women knew that their husbands were being beaten and tortured while imprisoned in concentration camps; they saw the aftermath; the physical and emotional scars, and were deeply traumatized, and forever changed by these events (White-Earnshaw & Misgeld, 1996).

Before arriving in Canada, a large number of women refugees, had spent months even years in temporary refugee camps set up by the UNHCR in their own countries, or in neighbouring countries such as Honduras, México, Macedonia, and so forth. Although, in these camps, women were safe from the violence associated with war, they were often abused by their male partners, raped, and experienced lack of food, adequate health care, isolation and severe emotional trauma (Wali,1998). Most refugees were exposed to what Martín-Baró (1994) called “limit situation”, which referred to those politically repressive events when the individual faced life-threatening situations. Commenting on Martín-Baró’s psychological construct, Aron (1992) points out that the “‘limit’ [situation] appears when life hovers at the abyss, in a world controlled by the forces of destruction” (p.174) and it emphasizes “the potentiating properties of the life-and-death crisis” (ibid.). Martín-Baró envisioned the “limit situation” as a therapeutic technique that would assist those individuals who went through situations of extreme violence. Strongly believing that mental health represents “a matter of the basic character of human relations” (p.109), he cogently demonstrated that mental disorders penetrated not only the psyche of the

individual but also her relationships with the others, thus contaminating the entire community.

Post-traumatic stress (PTS) constitutes one of the most dramatic and the most common mental health problems displayed by the majority of refugees. In their study of the patterns of psychological distress among Salvadoran women refugees, Bowen et al. (1992) found that more than 50% of the participants exhibited a wide range of PTS symptoms such as

Recurrent and intrusive recollections, dreams, or intense experience of feelings associated with the event, persistent numbing of responsiveness and avoidance of stimuli associated with the trauma, and increased arousal including sleep difficulties and exaggerated startle response (ibid.:268).

Forty-one percent met the DSM-III-R diagnostic criteria for PTSD. The results have led the researchers to believe that “there may be a high incidence of PTSD among the general population in El Salvador, with particularly traumatic effects on women” (p.271). In the case of the women refugees in the host countries, PTSD may be exacerbated by “long-standing conditions of social illegitimacy, powerlessness and violence” (Farias, 1991:179). When the stress of alienation is coupled with family disruption, unemployment, poor language skills, and lack of social support, women’s lives become governed by emotional distress and “a sense of personal disarray” (p.186).

*Sexual Torture, Assault and Rape in Warfare.* The occurrence of rape and sexual violence against women is evident in times of peace and war, and is one manifestation of gender power imbalances. During warfare, the brutality of rape is escalated by the fact that “in the eyes of the rapist, the woman is the enemy” (Nikolic- Ristanovic, 2000, p.48). According to Nikolic-Ristanovic (2000), the act of rape is a way to devalue the opponent’s manhood because they were unable to protect “their women”. The use of rape in warfare has been clearly documented

in studies of refugees from the Balkans (Nikolic-Ristanovic, 2000).

Aron, Corne, Fursland and Zelwer (1991) discussed the socio-political context of sexual abuse with Guatemalan and Salvadoran refugee women by distinctly delineating the differences between institutionalized (wartime) and non-institutionalized (peacetime) sexual assault. In State terrorism, sexual violence and rape are gender specific and they are performed with the sole purpose of annihilating the political opposition “through a counterinsurgency program of psychological warfare” (p.38). Rape becomes an act of normalcy towards obtaining social control on behalf of a collective goal. The assailants are not punished because “all instances of rape may be considered politically motivated” (ibid.). In fact, they are all licensed’ to rape, and “no suspicion needs to be present for a woman to be targeted” (p.39). By establishing the psycho-socio-political framework of the gender-specific forms of torture and sexual violence, the authors examine the impact of institutionalized rape upon Guatemalan and Salvadoran refugee women and offer a valid explanation of their pre-trauma, trauma and post-trauma experiences with special focus on PTSD. Particularly, they emphasize that refugee women often avoid speaking about sexual torture and rape for fear of losing the minimal support they might have, not being believed or, ironically, that they might be blamed. The authors also stress the fact that more effective intervention and treatment plans must be put in place upon the refugee woman’s arrival in a host country in order to understand “the way in which the individual’s pre-trauma life was affected by the environment of state terrorism in which she lived, and the way exile and lack of immigration status affect her post-trauma recovery”(p.45).

Similarly, Nikolic-Ristanovic (2000) addresses the differences between rape that occurs

in peace versus rape in wartime. Wartime rape is characterized by a greater number of perpetrators who will rape each victim several times, severely beating them before and afterwards. Often, women are forced to witness the torture and murder of others. In wartime, “women’s bodies become a battlefield where men communicate their rage to other men, because women’s bodies have been the implicit political battlefields all along”(p.63). Nikolic-Ristanovic also describes the multiple dimensions of rape by bringing supportive evidence: rape as revenge against men (and women), rape as an instrument of expulsion and ethnic cleansing, hidden rape under the form of forced concubinage and prostitution, and rape as sexual blackmail and humiliation. It is well-known that sexual and physical abuse goes hand in hand and is used to disempower and paralyze women’s volition to resist or to punish them for being on the wrong side in the case of women in inter-ethnic marriages.

In the Balkans, rape was perpetrated as a form of ethnic cleansing (Nikolic-Ristanovic, 2000), while in Latin America, rape represented a form of ideological cleansing of the body politic. As many feminists have observed, rape is “an attack on the body politic, and not just the physical body” (Crowley, 2000:95). Under these circumstances, rape takes the proportions of a political act performed in the name of a political group, and sexual violence represents a form of persecution. In the extremist dictatorial/military regimes, rape besides being a weapon of war and a vehicle of sexual terrorism, is also a way to reinforce the male hegemony, gender inequality, and serves to keep women entrenched in secular archetypes: virgins, whores, mothers, wives, daughters and sisters. Ultimately, the scope of the act of rape resides in perpetuating patriarchal dichotomies: male-female, machismo-marianismo, war (masculine)-

peace (feminine), violent-passive, aggressive-submissive, domatory-subordinated, superior-inferior, strong-weak, oppressor-oppressed, perpetrator-victim.

Ensuring a group's sovereignty and continuity by mutilating, decimating, and consequently "cleansing" the other, has far-ranging echoes throughout human history. In Bosnia, "national identity... was, on a grand scale, constructed over woman's body" (Kestic, 2000:33). In Chile, Guatemala and El Salvador where many women chose to resist and fight against the military dictatorship, the ultra-nationalist political repression included torture and rape as main tools to punish the woman "for daring to stray away from her secondary identity and her home" and "to malign [her] marital fidelity" (Matthews, 2000, pp. 97-8, 100). Moreover, in Latin America, where "a machista" conception of women's place remained intact, women were doubly tortured: for being women and for being revolutionaries; their elimination became a matter of "national security" (Dandavatti, 1996:28).

Hague (1997) notes that gender and nationalism constitute two of the most well known war components, which led, in the case of Bosnia, to "genocidal rape" (p.51) and to sexual torture and political repression in Chile, Guatemala, and El Salvador. Further, in all these countries, rape became a deviously planned "military strategy" (Knezevic, 1993, p.12). The ultimate goal was to intimidate and to force women and their families to leave their homeland (*The Human Rights Watch*, 1995), or to make them 'break out', provide information and turn in their husbands/sons/*compañeros*. Sexual torture, whether it was performed in concentration camps or in prisons, in public or in private, became a form of ritual abuse that targeted the exclusion of the other and the reproduction of the authoritarian, patriarchal societal structures.

In fact, according to Giles (1999), the very concept of war and the way women's bodies were treated in the context of war were "part of a patriarchal structure of privilege and control" which unfortunately was not inherent only in war zones, but it, rather, reflected "the social and ideological relations in homes" (p.89).

The shortcomings and deficiencies of the international human rights laws and their failure to adequately protect women's rights have been repeatedly addressed by numerous feminist human rights advocates (Copelon, 1995, 1999; Malone, 1996; Pratt & Fletcher, 1994). Feminist activists are constantly making efforts to compel the International Tribunal to recognize gender as a "category of persecution" and to admit that rape *is* a tool of torture purposefully used against women in order to maintain male supremacy, power and control (Copelon, 1995, p.206). Copelon (1995) asserts that "gender violence" has been condoned for a much longer time, and recognizing rape as a war crime and an atrocious form of violence, not just a criminal offence, is a fundamental step for women in achieving equal human rights (p. 208). In recent years, feminists have begun to lobby for the inclusion and definition of rape as a form of torture in the Tribunal Statute under the Geneva Conventions and in the United Nations Torture Convention more explicitly. To date, rape has been mostly implied or too broadly presented in the legislation, which, according to Copelon, stems from a sexist mentality (Copelon, 1999:337-9). Also, massive efforts are channelled toward distinctly and explicitly inserting rape and other forms of gender-based violence in the Tribunal Statute under Grave Breaches (Articles 2), Violations of the Laws and Customs of War (Article 3), and Genocide (Article 4) (Malone, 1996; Pratt & Fletcher, 1994). The only article in the Statute that explicitly identifies rape as a crime is

Crimes Against Humanity (Article 5) (ibid.). Clearly, the devastating physical and psychological consequences of the act of rape as torture and violence against women need to be included in the legislation and appropriate measures need to be taken.

*Post-migration Resettlement.* Many researchers have described the multiple losses refugees face following migration to a new country. Prominent among these are the loss of homeland, loss of family members, loss of language and loss of culture and its values (Forbes Martin, 1992). Refugee women, in particular, “are continually faced with social, cultural, and economic adjustments and cross-cultural clashes” (Parvanta, 1992:124). In order to deal with these problems, they learn “how to barter values - to delineate the parameters and comfort zones for this exchange and evaluate the worth and the quality of the values being bartered” (ibid.).

Resettlement is considered an extremely stressful experience for women who are separated from their families as their identity is attached to their role in the family. In Fox, Cowell and Montgomery (1994), Asian refugee women were studied to understand the impact of disruption of family ties on resettlement. Other researchers noted that it is the conditions in the host countries of resettlement that greatly affect its success (Beiser, 1999).

Similar to the refugees in camps, resettled refugees may (re)experience depression, anxiety, intrusive thoughts, disassociation or psychic numbing, hyper-alertness, and sleeping and eating disorders. Many refugees suffer from “escape trauma”, which refers to “the scars left from the experience of fleeing one’s country to escape from persecution” (Friedman & Jaranson, 1994, p.70). According to Friedman, escape trauma can have serious effects on women’s psyche as it can trigger “severe depression, anger, hostility, nightmares, insomnia, and waking

memories” (p.71). It is documented that separation and war memories can cause more emotional stress than the problems of resettlement. Relying on extensive research of the migrant experiences of the Kurdish women, Ahlberg (2000) reported that the mental problems and the stress among refugees stem mostly from their imposed acculturation, especially in the cases of those refugees whose values are totally different from those of the host country, and from their interactions with the host communities (ibid.). Consequently, women develop post-traumatic stress disorder (PTSD), which, if prolonged, untreated and combined with sexual and domestic violence, can degenerate into *disorder of extreme stress not otherwise specified* (DESNOS) (Ahlberg, 2000).

PTSD seems to be the most common diagnosis given to refugees who experienced trauma. As already presented above, a great number of studies are dedicated to various refugee groups who showed symptoms of PTSD. However, Friedman and Jaranson (1994) question “the validity and usefulness of the PTSD construct” (p.216) with respect to refugees from non-Western countries. This assertion is based on Friedman’s and Jaranson’s clinical experience and research that suggests that PTSD represents a diagnostic established on Western individuals who experienced trauma and was then adapted to refugees coming from non-Western countries. While they admit that all individuals display some similar symptoms, they also emphasize that “ethno cultural differences in the expression of traumatic stress may not conform to DSM-III-R diagnostic criteria for PTSD” (p.215). Therefore, ethnocentricity and narrowness of the PTSD model might deepen the gaps existing in the clinical phenomenology of PTSD which will hinder the clinicians from accurately understanding, assessing and treating the refugees’ psycho-

somatic problems.

Although the process of adjustment varies from one culture to another and from one individual to another, the mental health of the refugee goes through a number of phases during this process. The resettlement stress is inherent in the acculturation process. Beiser (1999) developed a “disillusionment model” in order to measure the refugees’ level of depression during resettlement. According to Beiser, the model is comprised of three phases: the first one represents “the euphoria of arrival” when the refugees display good mental health; the second phase represents “a phase of disillusionment and nostalgia for the past” when the refugees mental health is in serious decline; and the third phase represents the stage where the refugees reach an acceptable level of adaptation and “their mental health approximates that of their hosts” (Beiser, 1999:58). An important point made by Beiser refers to “the way in which people psychologically handle time which seriously impacts their mental health, particularly during stressful experiences like flight and resettlement” (p.64). He stresses that due to their gender roles in the family, women are more prone to become marginalized and depressed than men. In addition, cultural grievance, the loss of the home country and of family members provides refugees with a constant sense of grief and guilt that can delay the adaptation process. The lack of a responsive social network and empathetic therapists could trigger serious mental disorders.

Unfortunately, barriers to successful adjustment are inherent in the settlement process. Two major categories of barriers have been identified: the societal barriers and the individual ones. The societal barriers include primarily racial, sexual and cultural discrimination. Depending on their legal status (i.e., undocumented refugees), more obstacles can elicit and

seriously affect their functioning in the new society. Culture shock and the dramatic shift from being part of the majority to becoming a minority contribute to women's isolation and their feelings of displacement considerably. At the same time, the language barrier constitutes another significant impediment to societal adjustment for refugee women and represents one of the main deterrents to finding employment. In addition, the lack of language ability can be as harmful as any physical or mental disability for newcomers of all ages. Moreover, if the women refugees suffer from PTSD, it is very likely that they will experience memory and concentration problems, which can be long-lasting and, therefore, make it very difficult for them to acquire new language skills.

Unemployment and underemployment represent two other major stressors that impede the refugee's adaptation (Beiser, 1999). It is largely recognized that even if they reach certain levels of prosperity in the new country, refugees often do not acquire the social and cultural status they had back home before their displacement commenced. Often, they will "push" their children to reach the level of respect and dignity the parents enjoyed in the home countries. Other refugees, instead, especially women, experience a dramatic shift in their roles in the family and the society. They become more involved in the community, enter the labour force after being homemakers for years, and cease to be entrenched in traditional gender roles. Although this shift usually generates adversity from their partners, it also liberates them from the male domination they encountered in their countries of origin.

### *Research Questions*

Four major questions were addressed in this qualitative study:

1. What experiences of pre-migration trauma have immigrant and refugee women in London undergone before arrival in Canada?
2. How do pre-migration experiences influence current everyday life among refugee and immigrant women?
3. What do refugee and immigrant women perceive as helpful, or not helpful, in their interactions with service providers?
4. What barriers do they encounter in their efforts to integrate into Canadian society in such a way that allows them to preserve their cultural values and integrity?

### *Findings*

Nine women participated in this study: three from Bosnia, three from Guatemala, two from El Salvador and one who lived in Chile. The participant from Chile had a particular status in the study. Although she is French-Canadian, and not a refugee, she was in Chile during the coup in 1973 and was actively involved in the student movement and other revolutionary actions.

Education levels varied. One woman had not completed high school, while most had university degrees at the undergraduate or graduate levels. The French-Canadian participant was a graduate student in political sciences who had gone to Chile to gather data for her thesis. All had respected professions before arrival in Canada. Included were two teachers, one doctor, one psychologist, one clerk, one nurse, and one artist. None of the refugee women were able to practice their professions in Canada as their academic credentials and professional experiences

were not recognized or validated. A few women decided to go back to school, after years of seclusion and marginalization, and received new degrees in order to live and offer their children better lives. Others, after being underemployed and holding low-paying jobs for years, managed to achieve what they considered a respectable lifestyle. Some of them are still trying to achieve a level of social acceptance and to find their own place within Canadian society.

The semi-structured interview guide consisted of open-ended questions regarding aspects of the women's lives before, during, and after migration to Canada. The interviews were conducted by two of the authors in both English and Spanish. The Spanish interviews were translated and transcribed verbatim. The women described traumatic experiences that included both direct and indirect exposure. Direct exposure consisted of violence experienced first hand whereas indirect exposure consisted of knowing violence and torture was going on around them most often to their loved ones. It was evident that the women's experiences of pain and suffering were shared equally, regardless of whom the trauma was directed at. For these women, life would never be the same. In this presentation of findings, all names are pseudonyms.

#### *Violence of War in the Lives of Women*

Many of the women experienced violence in the form of physical, sexual, emotional and/or verbal threats. Many stated that they knew women who had been raped or they, themselves, were sexually abused. One woman described an incident that occurred in Guatemala when she was 15 in which soldiers physically and sexually terrified her:

They yelled at me and forced me out of the shower. They did not allow me to get dressed and with the butt of their bayonets were pushing me. They made me give them a tour of the house as they ransacked it and then took me naked out of the house to the front and back yard... I yelled at the maid to ask for help, but she

fled. The neighbours closed their doors and I felt so scared and infinitesimal. I was almost 16 years old.

One woman, Miriam, who had been living in Chile, recalled a situation in which she and a group of women were being prodded anally by electrical wires while soldiers swore and threatened to “screw” them. While some were physically assaulted, others were verbally harassed about the firmness and appearance of their “butts”.

Frequently, the women experienced the invasion of their homes by strangers who would interrogate them and disrupt their homes before leaving. This fear tactic was recognized as a form of torture as evident in this report by Raquel. She described an incident during which soldiers invaded her house, interrogated her about her husband, and ransacked her house with total disregard. After they left, she knew that, from that moment, their lives were in great danger and if they did not leave, her husband would probably disappear, be tortured and killed.

*Life Turned Upside Down.* In many instances, the wars were perceived to have begun very rapidly and the women found their lives had been completely turned around. Ariana from Bosnia recalled that one day she woke up in a war, where everybody was trapped in their houses and the entire town was surrounded. Mira, also from Bosnian, who refused to believe that war in Sarajevo was imminent, was forced to flee with her two children to Vienna to seek refugee status. Her husband stayed behind and fought on the Muslims’ side although he was not Muslim. Mira, did not hear from him for the next three years. After the war, her family managed to come to Canada where their lives were “turned upside down” once again, although now in a different way. The cool reception that they perceived from the host culture contributed to this feeling a

great deal.

*(Re)Thinking Normalcy.* As Julian (1997) astutely observed, for many people coming from authoritarian/military regimes, “a way of life that encompassed street fighting, disappearances and torture had been established as ‘normal’” (p. 203). Although most women in the study could recount a time in their lives before the war began, some women stated that war had become an everyday reality. Witnessing and experiencing violence was a phenomenon that became “normal”. It gradually became normal to engage in ordinary daily activities being followed by “authorities”, encountering armed soldiers and heavy war machinery in the streets. Fear and terror accompanied these women wherever they went.

Further, the black market flourished, inflation was rampant and long queues for water, milk, bread or meat, or buying basic food products such as flour, sugar, eggs, and beans at exorbitant prices became part of this “normality”. Perhaps the most disturbing aspect of this reality was that it increasingly came to represent the usual and expected state of affairs. One woman told of a time when she heard grenades going off one at a time and because this was so familiar to her, she knew they came in threes. After they went off, she would get out her broom and start to clean up the sidewalks, while soldiers screamed at her to take shelter that was provided.

*The Social Cost of Working for Social Change.* Before coming to Canada, many Latin American participants as well as their relatives and friends were trying to advocate for social change. Frequently, these efforts included such seemingly innocuous activities as participation in labor unions, literacy programs, health reforms, and so forth. However, in the social and

political context of their countries, such activities targeted them as subversives, or enemies of the system. Paula, a participant from El Salvador, recalled an incident experienced by her husband, a teacher. He had attended a teacher's union meeting to organize and plan activities for the school year when helicopters came and encircled the region. The army captured forty of the teachers, including Paula's husband, and took them to a clandestine jail where they were imprisoned and tortured for fifteen days. Later on, the army sacked their home destroying and burning most of their belongings. According to her, in addition to the repression experienced in the countryside, people in the city who were members of any human rights organization were forced underground. Their activities were perceived by the government as a threat. The outcome was typically persecution and/or death.

*Pain That Remains Unspoken and Unseen.* The women in this study frequently disclosed stories of physical, emotional, and spiritual changes that occurred because of war and the trauma that was inflicted on and around them. It was apparent that these women may not have always appeared outwardly distressed or injured but the internal damage was equally, if not more painful. One woman spoke of how her husband was tortured by whipping him using a belt that "would not leave visible marks, but it would cause severe damage inside of you. So you could not see the damage from outside, but people felt an awful pain and the tissue inside would be very damaged". This statement symbolizes how most of the women felt regarding their physical circumstances. They described how they were changed mentally and emotionally as a result of physical trauma, and noted that these changes in turn affected their physical health and well-being. One Bosnian woman sadly spoke about the consequences of living in war on her health:

losing her menstrual period due to shock, fear, and stress, and being unable to bear a child after the war. Excessive weight loss, malnutrition, and having hair and teeth fall out were also common effects.

During stressful times, the women learned new ways of survival. Their lives were deeply affected by the new conjunctures while their health and mental stability were seriously compromised:

All that time I was so desperate, like if I was not living. When we got finally together, we had very little resources. One day we got whole bread for four of us for three days. Then we started to save for bread and to bake it and sell it.

Deprived of electricity, water, and basic medication in the refugee and concentration camps, they developed a variety of infectious diseases caused by lice, diarrhea and disastrous living conditions that would require attention once resettled in Canada. Yet, these women were constantly grateful for being alive and for knowing, even if they were separated, that their families were alive too.

### *Facing a New Reality*

Regardless of how long the participants had been living amid war, or what countries they had come from, all described common feelings. The situations imposed upon them were too much to absorb at one time, and they frequently described feelings of numbness. One Bosnian woman stated, “I felt like I was not there. It was not real war, I thought, it was like a movie. I saw people dead, blood; parts of bodies.” This use of disassociation as a method of coping enabled the women to continue living despite the conditions and probably contributed to the occurrence of memory loss that many women reported during the interviews.

This new reality, where pregnant women and children were tortured and killed, instilled in the refugee women and their families a profound sense of disillusionment in life, including their spiritual beliefs. For some, fundamental beliefs in God were questioned. “So many kids were killed. This is why my husband says that there is no God because if there is one he couldn’t let those kids die.” From this woman’s perspective, the world no longer consisted of good and evil, but rather had been transformed into a place that was characterized by one horror after another.

That is the worst part of this war...they killed kids playing on the playground. There is no excuse for something like that. They knew that kids were playing and they would just shoot and kill kids. And you ask why.

*Disappearance As a Form of Torture.* A common theme described by the women was the use of disappearance as an emotional and psychological form of torture. Armies would capture individuals and take them to unknown locations. Only a few would ever reappear. For these families, the grieving process could never be fully enacted as a result of the lack of closure that one normally experiences when a death has occurred. One woman remembered:

On December 29, we were looking for him everywhere: jails, all the detention centres, and then we started looking for him at those hospitals where they take all the expired. Finally my husband and all his brothers decided that they weren’t going to look for him anymore because of the situations, of the conditions of those of the hostess that they had seen at the amphitheatre. They were not humans. They were completely tortured. They didn’t look like human faces anymore. No arms, no fingers, nothing. No ears absolutely. So they decided that they would stop. They wanted to think about their younger brother as they had seen him the last time.

Despite the passage of time, many women continue to grieve the loss of the disappeared. In this sense, the “torture” persists to this very day. For others, the disappeared were eventually found deceased, thereby erasing all hopes of them ever returning alive.

*Witnessing Violence and Torture.* All participants suffered from vicarious trauma: the profound sense of helplessness of knowing or witnessing their loved ones were being tortured or were suffering in concentration camps or jail. They all expressed the profound impact witnessing torture and violence had, identifying it as equally devastating and debilitating as violence inflicted upon them. In one woman’s words:

I saw my cousin been shot at his face. His eyes were open. They shot him on his face!!! I had a disbelief and questioned why at his face? People that were killed were all neighbours and friends.

Another woman, along with revealing her husband’s torture and violence while imprisoned, also reported that once people were imprisoned they would take some prisoners outside and act out “mock executions” to instil fear in those left behind.

When remembering and recalling their stories, these women often had a difficult time, either laughing nervously or crying as they reflected on their past. The profound way in which war altered their lives was evident in the words of a woman who stated, “how war changed people, changed minds, changed everything!”

#### *The Impact of War on Everyday Life*

All of the refugee women in this research were asked how their pre-migration experiences influence everyday life in Canada. Many commonalities were noted in their responses. As a result of the circumstances leading to their arrival in Canada, refugee status was

reported to be a barrier to adjustment. For many of these women, the urgency to leave their homes and the “uprootedness” of their lives has had a tremendous impact on their adjustment.

*Living in Fear.* Despite the fact that the women are geographically far removed from the wars that so profoundly disrupted their lives, many still live in fear for their own safety and for that of loved ones who remain in their homelands. The fear was intensified by the social and political context. Once refugee claimant women arrive, they must face a board where they are asked for proof of their persecution which they don't always have due to the rapid timing of their escape. Thus, many of them live in fear of deportation. They also fear being unable to provide adequately for their children as they seldom have money, a job, or a social support network.

The participants repeatedly mentioned fears about being misunderstood due to the language barrier. One woman reported, “I am also afraid of talking or disclosing to medical doctors for fear of having a medical record that later could be used against me”. Many women reported a loss of trust associated with the experience of having had friends betray them in the context of war and subsequently have found it difficult to establish relationships with others. The inability to trust others contributed to a sense of isolation.

*Living in Denial.* Frequently, women reported a sense of loss of themselves, a loss of their identity. The pain they were suffering, combined with being in a different country with an unfamiliar language and culture, changed these women to the point where they did not recognize themselves.

The loss of their lives before coming to Canada had many different implications for the women. Sonia was a physician in Guatemala who was unable to practice medicine after arrival

in Canada, “It affects my life as I do not practice medicine, that for so many years I stayed home and I did not have a status in Canada, certainly all those losses especially the family and friends that I lost had an impact on my life and has an impact on my children as well.” Paula added that the loss of her previous life greatly affects her everyday life now. “I’ve spent a lot of time living in denial. I was here in Canada, but my mind was somewhere else, and I didn’t want to be here.”

*Avoiding the Pain.* There are many reasons why the women in this research have difficulty concentrating on everyday life. Every woman expressed these inner thoughts and desires in a different way. Raquel was preoccupied by questions regarding her decision to come to Canada, a country that from her perspective was not particularly welcoming. Paula found herself “constantly thinking about El Salvador, wanting to be there” and suffered cycles of depression for many years after arrival in Canada. Julia, a woman from El Salvador, explained that her husband became an alcoholic to lessen the pain and enable him to talk about events that had happened to him. Ironically, after he stopped drinking, he was no longer able to talk openly about his trauma. Their communication stopped entirely and they ultimately were divorced.

Having to relive the traumatic events and retell them in different languages appeared to precipitate a new sense of pain. Raquel stated that she dealt with a lot of pain when she was talking about the past in her native language, Spanish. When she retold her story in English, she felt that she was experiencing it all over again:

When I speak English that’s another person. Now, when I’m talking in English to you, I have to force myself. Because I think, in Spanish I have already tasted this...! haven’t done it in English. It is so still painful in either language.

*The Guilt of Survival.* Many participants spoke of a sense of guilt about surviving, about leaving loved ones behind, and about enjoying the peace and freedom they have in Canada. One woman expressed her admiration toward those who died as victims of a terrorist regime. She was overwhelmed by feelings of guilt:

The ones that died were the ones that were worth. We feel that the ones that were left behind are worth nothing. So we feel guilty of being alive. The violence was not only suffered there.

Leaving family and friends behind without knowing whether they were going to ever see them again tormented these women and prevented them from being able to take pleasure or joy in life. “I felt I should be with my people and whatever they went through I should go through,” one Bosnian woman said. Undeniably, it was difficult for these women to deal with the fact that so many innocent people were killed, that could very easily have had the same fate, yet they did not. This knowledge creates ongoing pain and guilt.

*Among and Between Cultures.* Adjustment was a difficult process for all women in the study. Coming from cultures different from the host culture, they had to transcend numerous barriers in order to adjust to the new society. Some felt that they would never fully identify with Canadian culture. Most women noted that their home represented the quintessence of their culture. Within that space, they preserved their customs, habits, values and traditional way of life “so we live in our own world in our house”.

Many women expressed their discontent with the roles that they had to accept during their first years of resettlement. Domesticity characterized their daily lives, a fact the women had not been happy with. As all of them had been employed in their countries of origin, the passivity they

were ‘condemned’ to due to the lack of language skills, lack of information and a support network, lack of legal residency status, to mention only a few. One Guatemalan woman, who had been a physician in her homeland, was isolated in the home for twelve years due to her husband’s uncertain legal status and her family responsibilities. Similarly, one Bosnian woman, who was a prominent fashion designer in her country, was dependent on social assistance despite her concerted efforts to find employment. Every woman had her own story of marginalization and seclusion, which deeply affected their lives. Although they were very dedicated to their families, the fact that their roles had been restricted to child rearing, motherhood and wifehood lowered their self-esteem and shattered their beliefs in a bright future. This alienation greatly contributed to the women’s refusal and inability to identify with Canadian society.

Despite the cultural differences, many women recognized Canada as their home. They admitted that they “picked up many [Canadian] ways or attitudes” and spoke in laudatory terms about the value Canada places on people’s freedom and safety. Although they stressed that they would never consider themselves entirely Canadian and criticized the country’s failure to give the ethnic communities the recognition and respect they deserved, the women gradually came to view Canada as their home. However, coming to this position was always associated with a degree of tension and ambivalence.

#### *What Did and Did Not Facilitate the Transition?*

The women were asked to discuss what was and was not helpful to them after their arrival in Canada. Frequently, their responses to these questions overlapped. While discussing programs or services that they had received, and that were intended to be helpful, it was noted that most times

these services were delivered in such a way that they were perceived to be unhelpful. It was also evident that the type and extent of services available varied depending on their 'status' in the country. Those who were officially declared "government refugees" were entitled to more services than those who were not.

*Meeting Basic Needs.* Most of the women stated that they were provided with concrete assistance to help them meet their basic needs upon arrival in Canada. As by many of the women had to leave in a hurry, this type of assistance was perceived them as particularly useful. Dolores, whose husband was assassinated in Guatemala in the early 1980s, stated that because she had to leave in a hurry, she was allowed to bring only the most basic necessities. At the time of arrival, the government provided such things as furniture and a monthly income for food and clothing. Unlike Dolores, Sonia's difficulties in resettlement were compounded by the fact that she and her family were not classified as government refugees and were, thus, cut off from information and financial assistance. Although she believed that they met the criteria for political refugee status, they believed that her husband's family would send them money. As well, Sonia and her husband feared placing their families in Guatemala in further danger if they were to be labelled political refugees. An additional influencing factor pertains to the historical context. During the early 1980's, there were not many refugees from Latin America living in Canada and they believed that they were less likely to encounter discrimination if her husband were a student rather than a refugee.

Upon arrival in Canada, Ariana, her husband, and her grown son stayed at a receiving centre for government-sponsored refugees. They were very satisfied with the assistance they

received. In particular, her husband needed a hearing aid and a dentist, and they wanted to learn English. All of these needs were met without them having to pay for them personally. However, the reception they received and the housing conditions triggered mixed feelings among the refugee women. While some women were satisfied with the assistance provided at the receiving centre, others considered the conditions “disgusting”, “humiliating”, and “scary”.

*Establishing Connections.* Although she missed her family in Guatemala, Dolores considered herself “lucky” because she had two brothers-in-law already here with their families. From Sonia’s perspective, the most difficult aspect of resettlement, aside from deeply missing her family and culture, was the fact that she had no one to talk with about her experiences. Although she found a physician who was trustworthy, other people she talked to never asked her why she was in Canada. As many other women have stated, Paula deeply missed the warmth, culture, and community that she had with family and friends in El Salvador. These less tangible aspects of life seemed much more important to the women than the material comforts. In her words, “In spite of all the difficulties that they have in their homelands, people there are happier. They have less material things but, you know they have other things.”

*Learning the Language.* Learning to speak English was a high priority for all women, particularly since most spoke little or no English or French before arriving in Canada. There appeared to be a great deal of variation with respect to the quality of the language assistance received, as well as the consistency. Dolores noted that she was unable to begin English (ESL) classes until three months after arrival. During that period, she described feeling “imprisoned” in her apartment, reluctant to venture out without being able to communicate, all of which

deepened her depression. On a very practical level, Dolores, who could not find employment and had to live on social assistance for a while, would have liked to have access to more ESL classes. Concerns regarding the ESL program were also raised by Raquel who described an unpleasant exchange with her ESL teacher who questioned why she needed to know English:

Could you please teach English? I said, "I need to learn English" Because I mean, you wanted to survive, you have to know English. And then she said: "Yeah?! What do you need English for? When you're going to clean offices? You don't need to speak English". I said, "Yes, I do. Because when I sweep the floor I speak to the broom. And the brooms over here speak English".

Raquel's experience with her ESL teachers was not always an easy relationship. She spoke of a female teacher who advised her to find a job as a dancer in a nightclub because she was from Latin America. This remark profoundly affected Raquel who was a former teacher and a mother of three children. She noted that the ESL teachers should be more sensitive to the refugees' and immigrants' cultural background and avoid making discriminatory remarks about what their students should or should not do. This experience suggests a degree of ignorance and lack of sensitivity on the part of teachers and service providers towards the newcomers. It is important to note, however, that for many of these women, the experiences they describe took place 10-20 years ago, at a time when London had few newcomers.

*Value of Women in Canadian Society.* Several women spoke about the availability of services for women, in particular to assist women who are experiencing abuse. Julia came to Canada from El Salvador. When she was asked what was helpful to her, she spoke about the greater value placed on women here, as compared to Latin America. "Your life as a woman is worth. We do have support". While some women raised the issue of having a variety of services

directed toward the needs of refugee and immigrant women, other women had less knowledge of such services. Fatima, a Bosnian woman talked about the lack of violence-related services for women in Bosnia, and how this seemed natural to her people.

We don't have so many services [in Bosnia]...like a man could beat up his wife and kids and there is no place where they would be really protected, or if he got drunk or something.... Nobody would really bother to help out, only that embarrassment from some neighbours or workplace, but there were no services like this that you could call the police or if you feel threatened in every way. That is something that they [Canadians] have and we [Bosnians] didn't have.

Fatima observed that although women were more protected from domestic violence in this society, they were more likely to be under-represented in the labour market than were the women in Bosnia.

However, not all women were aware of the power of their voice and opinions, exhibiting low self-esteem and frustration about their financial dependence on their husbands.

Unfortunately, women's lack of confidence was reinforced by the discrimination and the low status that was rendered to them by Canadian society for being refugee women. Although they were aware that they possessed many skills, the fact that their skills were not recognized made them withdrawn, bitter and voiceless.

### *Barriers, Obstacles, and Challenges*

A number of barriers interfered with the ability of the women to participate fully in Canadian society. From the perspective of the women, external resources that were intended to be helpful, including service providers, language trainers, health care professionals, government workers, and so forth, were often not as helpful as the women would have liked. Other factors that were intrinsic to the women and their families added to the hardships they faced. These included conjugal conflicts which sometimes led to separation, lack of financial resources,

physical and emotional health problems, and dental problems which made efforts to obtain employment more challenging, lack of a network of family and friends, and culture shock.

*An Uncaring System.* Most of the women described their encounters with various service providers. While a few women told of helpful and compassionate responses, many described attitudes that were condescending, patronizing, and demeaning. Interestingly, these concerns were raised by both the women from Latin American who arrived in the 1980's as well as by the Eastern European women that had migrated more recently. Several of the Latin Americans observed that in their view resettlement assistance has not significantly changed. From the women's comments, there was a general feeling that those working in this field lacked interest or understanding regarding the complex circumstances that forced them to leave their home countries. Furthermore, there seemed to be resentment, and many described racist or other hostile attitudes and behaviours.

Dolores elaborated on these ideas and recalled several unpleasant encounters with health care providers. One experience occurred when a doctor minimized her pain after falling on the ice. Dolores also recalled being told by social workers that she was "lazy", and pressured her to get a job. Speaking about the counselling services she received, Julia stated that she had minimum coverage which was insufficient to provide meaningful care. In addition, Ariana addressed the discriminatory attitudes she encountered. She stated her frustration that her educational credentials were not accepted, and was shocked that her experiences of trauma and torture were not acknowledged. Raquel and her husband were teachers in Guatemala before coming to Canada. They did not speak any English. When she was asked what was helpful

when she arrived in Canada, she spoke at great length about her attempts to get such services as housing, ESL training, and childcare. According to Raquel, the settlement worker that helped her husband and her find more permanent housing was condescending, showing her “filthy” apartments and disregarded their choices of where they wanted to live. As Raquel described her efforts to find a place to live, the issue of pride came up repeatedly. Although she did not suggest that her treatment was racist, she did very clearly believe that it was not respectful and condescending.

Particularly disturbing, two women told of sexual assaults inflicted by physicians during prenatal visits. Paula recalled an incident that took place a few years after arrival during which a physician at a walk-in clinic touched her inappropriately during her first prenatal visit. Too stunned and distressed to do anything at the moment, Paula later told her husband what had occurred and subsequently returned to the clinic to inform the chief medical officer. Paula to this day does not know if any action was taken against the doctor, but has continued to feel a profound sense of violation. Another participant in the study told of a similar experience inflicted by a gynaecologist. Although she called for her husband who had been forced to leave the room and was able to stop the abuse as it was occurring, no formal action was ever taken against the physician. In both cases, the women lacked the language skills to articulate fully what had occurred, as well as information regarding their legal rights; formal action was simply not an option. The women were left with feelings of profound shame and anger which remained with them until the present.

*Limited Services.* Ariana was a psychologist with a large company before she came to

Canada from Bosnia in 1993. Upon arrival in Canada, she had very few resources, financial or otherwise, no friends or family, and many fears. Ariana spoke candidly about the limited services available to her. In part, she attributed this to the fact that her husband was her sponsor: “The services were poor and there were no interpreters available. And when they got interpreters, they made some major mistakes”.

The need for counselling services was addressed by many women in the study as their inability to deal with the trauma they had endured which deeply affected the functioning of their families. One woman described her husband's inability to deal with his trauma and the lack of local counselling services for victims of torture. It is well documented that these difficulties often lead to marital separation or discord. In this particular situation, when the husband obtained treatment for his depression, his emotional problems continued.

Women also identified the need for more involvement from the settlement counsellors. They stressed that most refugees had no support network during the first months of arrival. Settlement workers were practically their only links to the new society. According to the women, settlement counsellors must be aware of the challenges that life in a new country presents

*Inadequate Health Care.* The lack of access to adequate health care was another problem cited by a few of the participants. Not only were there limited services, there was also a sense that they could not talk openly with their health care providers, that doctors did not understand their experiences, did not show an interest, and/or did not understand their unique health problems. Paula experienced a number of health problems, some of which continue today.

Ariana disclosed some of the physical and psychological problems her husband and she were coping with because of war:

I need dental work and it's too expensive and I cannot afford it. I fear talking because I feel that I won't be understood. Most men that came from Bosnia were tortured, beaten up, and even raped!!!! They had broken ribs. Many women were repeatedly raped. I am also afraid of talking or disclosing to medical doctors for fear of having a medical record that later could be used against me. Sometimes I have nightmares and flashbacks, memories of war come all of a sudden in my daily life. That is what is called Post-Traumatic Stress Disorder (PTSD). Sometimes I find myself sweating. I can tell you that my husband is a good actor. He doesn't complain.

*People Who Care.* While all of the women spoke about the importance of having support services in place, more important than the actual provision of services is the need for people who can provide them with an understanding of, and sensitivity to, the difficult circumstances that these women have faced. This idea came through time and again as the women recalled encounters with various individuals in the 'helping' professions, but who seemed uninterested in helping, resented the arrival of newcomers, lacked knowledge of the political and historical context that forced the women to flee for safety from their homes and countries, and/or were overtly hostile. Frequently, these attitudes came across through stereotyping on the part of social and health care workers.

Identifying what would have been helpful, Dolores noted that she would have liked social service workers to be more aware of the problems. As well, she would have liked adequate and sensitive guidance and counselling, including acknowledgment of the difficult circumstances of her life before coming to Canada. She emphatically stated that everyone coming to Canada should have counselling on a regular basis. According to Sonia, the importance to have a strong network of services and people who are aware of the issues faced by immigrants or refugees, are

empathetic and sensitive, and look at refugees as human beings. Sonia noted that all teachers, including ESL teachers, must be aware of these issues. From her perspective, “most of the time they are not”. Sonia added:

I would say that it will be helpful if in general Canadians could be more curious about immigrants and refugees. They need to be much more informed and aware of why the refugees are coming, about their issues, about their losses. It would be very helpful if Canadians would just perceive us as human beings as they are without putting stereotypes because I believe that there are always much more common things than differences.

### *Pressures and Burdens Borne by the Children*

The women’s resilience was mostly reflected in their desire to see their children achieving the success and accomplishments they never did in the host country, so that their sacrifices would have a meaning, and they would have not suffered in vain. The children seemed to carry tremendous responsibilities. They had to meet their parent’s expectations while coping with hostility, racism and marginalization themselves. A Salvadoran woman spoke about the biased attitudes her children received at school from their classmates who called them “native Indians”. Mira’s children who had lived in three countries with three languages in a relatively short period of time were having a difficult time adjusting to the Canadian educational system. They were making enormous efforts to survive in school, efforts that often were not observed by parents.

When we came here, it was a new language, he [the son] didn’t know a word. But having experience from being a stranger in another country, he really gave his best to learn English. But, then, he lost his working habits here, moving to different schools. I think kids go through changes we are not aware of, not at all. I never ever thought about my son, how he is coping in his classroom before I went to Teachers College when I realized I am the only one among all these people who think I am stupid and ignorant because my

English was not as good as theirs.

### *Suggested Strategies and Approaches*

Most women in the study addressed the needs of refugees and immigrants. They highlighted the importance of having an inclusive agency that would foster their needs and provide counselling to those who suffered violence and trauma as well as to the children of the refugees who were perceived by the parents as being “lost between two cultures”. Julia offered the following when asked what would be most meaningful to her:

Something very important is that Canadians provide services to immigrants, specifically refugees to be understanding of the trauma that many of us carry. To be sensitive and patient. Their understanding. That’s what we need the most. They must be aware of that life circumstances in our countries are quite different.

According to Ariana, newcomers are not provided with adequate information needed for survival in a new country. Further, she asserts that there is little recognition of the emotional and psychological needs of this population.

Many refugees suffer from depression and this may be prevented if service providers knew better about the circumstances that these people had lived... I think that immigration did not hire people that will help us. I see that the government jobs are for Canadians, so I think a good way of helping refugees is to hire people who are aware about the issues of refugees and care about them...we need services that can provide good information and guidance to us, we need these services. We need *equal opportunities and access to services*.

When Raquel was asked what would be most helpful to newcomers, she suggested a “welcome office” but more important than any particular office or service, Raquel spoke of the need to *treat newcomers with respect*, where people speaking different languages would feel confident to speak regardless of their accents. In essence, Raquel believes that newcomers need

language services, to feel welcomed, and respected. As each of the women in this study has described, one of the biggest obstacles or challenges faced during resettlement was the perception of Canadians as “closed” and “distant”. The busy lifestyles of Canadians are not conducive to sitting down, taking the time to learn about people. Further, Mira suggested that Canadians “don’t want to know about problems in Bosnia”. As she stated, there is a need for an

Organization that cares about us. Who cares about us for any problems that we have. For my family. For my children. For my social problems. Sometimes people need just close talking about. Maybe they don’t expect some help, but just talking, I think to talk is good medicine.

An important aspect of any centre, from her perspective, is that it *serves people from all nationalities, cultures, and religions*; but a centre that “cares together, not separately”.

According to Ariana, the biggest barrier is the failure to acknowledge the education and training that newcomers bring to Canada. Almost all of these women held professional positions before coming here. One was a psychologist, one was a medical doctor, and several were teachers, but none were able to work in these fields until they became re-educated in Canada. As this was not feasible for all of them, many continue to work in positions where their skills and knowledge are not used, recognized, or valued.

The women’s general state of mind was not a positive one. They displayed feelings of disappointment, displacement, alienation, and disempowerment. Although they were making continuous efforts to adapt to the new environment, they felt rejected and undervalued by the dominant culture. The fact that their academic credentials and work experiences were not recognized, that they were discriminated against based on how they spoke or looked.

Some women felt that only half of their being belonged to Canada, while the other half

belonged to their native country. Other women felt that they would never become ‘real Canadians’ despite their citizenship status. This insight was underlined by a Guatemalan woman in this powerful statement:

We belong nowhere. We are not Canadians because there are some conditions or characteristics that people have set up for me to become Canadian. [...] I think I’m a tropical plant living in a cold environment. So something needs to be done to make sure this beautiful [plant] grows healthy.

### *Discussion*

The women’s journey between cultures was not without challenges. Many of them displayed resignation and were “just surviving”. Refugee women who arrived several decades ago and those with non-transferable occupational skills were more likely to be isolated in their homes, ‘stuck’ on social assistance, or relegated to unskilled jobs. Although these women came to Canada with valuable skills, because of the type of jobs they had to take in order to survive, they found themselves de-skilled and with few prospects. In a discussion between a Guatemalan woman who was a former teacher in her country and her ESL teacher, it was implied that the newcomers, refugees in particular, were expected to become manual labourers. It was for this reason the ESL teacher believed that the refugees did not need language competency. As the lack of language proficiency was identified as a major barrier to employment, the women realized that they had to make Herculean efforts to overcome the obstacles they encountered everyday. Other barriers identified by women were housing, health status (including mental health), lack of proper access to health care or counselling, isolation or rejection, culture shock, lack of empowerment, to mention only a few of them.

As forced migrants, the women refugees lost the “traditional support systems” (Martin,

2004:135), extensive family, neighbours and sense of community, and they all experienced trauma, directly (witnessed) or indirectly (heard). They were all overwhelmed by guilt for being the ones who survived or fled terror. At the same time, they felt uprooted, confused and disconnected. While a relatively small number of women seemed to be content with the quality of services they received upon arrival, most of the women participants in this research expressed dissatisfaction with the services provided to them. The general feeling was that instead of mutually agreeing upon a plan of action, the service providers assumed the role of “experts” and decided what was in the best interest of the women. The fact that the service providers were perceived as patronizing was disheartening to the women, and most addressed the need for more culturally sensitive settlement workers.

Similar sentiments were expressed by women when talking about their experiences with health care professionals, dentists, and counsellors. Many women addressed the importance of having more local counselling, therapy and interpretation services available, which, according to them, were crucial in the case of people who suffered trauma directly or indirectly. Many women recalled how lost they felt when they arrived in Canada and their view that the settlement workers did not understand their language or their culture.

### *Programs for Refugee Women*

Undoubtedly, pre-migration and post-migration experiences deeply affect the women refugees’ mental health and can have serious effects upon the resettlement process. Many challenges in developing programs that assist refugee women have been identified. Much of the literature on existing programs is based on United States programs with an emphasis on health

and well-being from a biomedical perspective. Many of these programs lack a holistic thrust and instead focus on the physical health of refugees, prioritizing vaccinations and parasite screening (Ford 1995; Kennedy et al. 1999). In Fowler (1998), mental and emotional health problems are prioritized. Particularly, Fowler (1998) recognizes that “mental and emotional health problems are the major burden of illness for refugees in North America” (p.389) and women are more likely to develop these problems than men. Fowler contends that depending on the host community’s hospitality and understanding, the refugees can adapt more or less quickly. For this reason, she believes that coupling primary health care with language and resettlement services is very beneficial for the newcomers - immigrants or refugees.

One challenge addressed by both Goodburn (1994) and DeSantis (1997) is that refugees feel frightened and mistrustful as they have undergone the stress of persecution with an emphasis on mistrusting individuals in official positions. Thus, health officials who rely on a foundation of trust in the relationship face challenges in establishing programs for this group. Most notably, the refugees may be reluctant to approach the health care worker with their specific needs. According to DeSantis (1997), creating healthy immigrant and refugee communities requires that they be empowered to facilitate agency and solidarity. Therefore, developing trust must be a priority in caring for refugees when working with individuals and communities.

According to numerous researchers, it may be difficult to elicit a detailed account from refugee women, as the telling may potentially stimulate emotional distress (Herbst, 1992). At the same time, many investigators have suggested the opposite. The telling of their stories has been recognized to have therapeutic and healing effects (Aron, 1992). Aron (1992) provides an

insightful account of the beneficial effects of *testimonio* when dealing with people who suffered psychological trauma under state-sponsored terrorism. Developed as a psychotherapeutic tool by two reputed Chilean psychologists, Lira and Weinstein, who published their theory under pseudonyms Cienfuegos and Monelli, *testimonio* is a “verbal journey” (p.174) that takes place outside the clinical context. It targets mostly women and children who strive to reconstruct their identities by appealing to their “pre-trauma experience to find a reference point for normality and to establish a standard for judging the perversions of the existing order” (p.176). Aron posits that *testimonio* proved a very effective tool for women because “it validates personal experience as a basis for truth and knowledge, and personal morality as a standard for public virtue” (p.176). Furthermore, women use *testimonio* as a modality of denouncing the sexual violence perpetrated against them during the war and as a way of urging the community to punish the perpetrators. As a result, “the community is liberated from an ideologized reality that has become internalized” and stops “believing that victims of sexual assault are to blame for the crimes committed against them” (p.178).

The main principles that underlie the *testimonio* are “the right to free expression”, “a belief in the human capacity to vanquish, through solidarity, the negative human capacity to destroy life; and a belief in one’s own value as a human being and a member of a community” (Aron, 1992:178). Utilizing various forms of self-expression, the *testimonio* is used both in the countries where the acts of violence occurred and in the countries that host refugees who experienced sexual abuse and state-sponsored terrorism. However, telling their stories in foreign countries can be problematic for the refugee women because they “cannot benefit from the

liberating interactive process, which is possible only within the community” (p.180). It is therefore essential that the testimonio occurs within “a community of victims in diaspora”, so that “the individual’s cultural identity receives validation, as does his or her personal story” (p.187). Although Aron admits that the testimonio is “far from a final solution to the psychological damage wrought by political repression” (p.186), she also emphasizes its incontestable positive effects on both the people and the community.

Young (1998) also recommends testimonio as an efficient long-term therapeutic technique in order “to help survivors reframe their experiences” (p.404). According to her, this can be achieved “by *normalizing* and *validating* (author italics) the patient’s reactions and experiences” (ibid.), which will help them to understand the after-effects of their traumatizing experiences. In addition, Young emphasizes that the survivors need help to ‘purge’ themselves of the burden of guilt and blame for being alive and “reattribute the responsibility for what happened to their torturers and to the repressive and violent tactics of the regime’ (p.405). Finally, Young stresses the healing effects of testimonio in the case of the women who lost their husbands and sons and felt burdened with guilt and “extreme powerlessness and helplessness” in protecting themselves and their families (p.406). By recounting the traumatic experiences and “connecting her feelings with the torture”, Young asserts that women are able to “grieve and mourn in a healthy fashion” over the losses in their families.

In her work, *The Blue Room*, Agger (1994) also writes about the healing effects of the testimony, a trans-cultural therapeutic tool (p.9) that serves as a principal research method to explore the shattered lives of a group of Middle-Eastern and Latin American refugee women.

The author sets the therapy setting in the Blue Room - which is the first room of the women's journeys - where together with her subjects they will develop the blue room culture, a culture of the women who suffered political persecution, rape, incest, loss of the loved ones, and domestic violence. Her main goal consisted of relieving the women of their psycho-emotional burdens by demonstrating that "the private shame can be transformed to political dignity and by providing "a source of new knowledge about the methods of the dictatorship, and at the same time heal the wounds inflicted through these methods" (p.10).

Eastmond (2000) approaches the refugees' "narratives of suffering" (Eastmond, 2000, p.76) from a critical medical anthropological perspective scrutinizing "the wider social and economic forces that structure or rupture social relationships, shape collective experience, and make certain groups particularly vulnerable" (p. 76). Eastmond insists that often the refugees' traumatic experiences are "easily medicalized or misdiagnosed by the institutions of the host society, and refugees responses are best analyzed in their own terms and interpretation situated in the local cultural context of their experience" (p.76). Similar to Herbst (1992) and Aron (1992), Eastmond believes that refugees need to go through the cathartic process of telling their stories (*testimonio*) as they " form part of the meaning-making process, structuring personal meaning out of events and processes, constituted in the telling, and thus mediating between personal experience and cultural explanations" (p. 76). Focusing on the concept of "suffering", Eastmond underlines that suffering does not refer only to the medical aspects of a refugee's well-being, but also to "the existential and moral dimensions that accompany reactions to loss and bereavement, connecting the individual, [...], to a wider socio-cultural context" (p. 76-7).

Further, she stresses that the clinician's tendency to label refugees/victims of war as 'traumatized', and, thus, to stigmatize them, diverts their attention from the "more multifaceted definitions of their problems" (p.81), and, ultimately, interferes with the process of healing. The author concludes by addressing the need that clinicians approach human suffering from both clinical and anthropological perspectives in order to broaden their understanding of the refugees' experiences instead of being entrenched in universal/Western-based scientific models that may fail to respond to their needs appropriately.

In research conducted by Kennedy et. al (1999), it was observed that "Western allopathic concepts" (p.475), very traditional and basic mental status exams as well as "lack of cultural knowledge and competence" (p.471) were present in the health and mental health screening of the refugees. In order to change the status quo, several goals needed to be achieved:

- establishment of a multi-disciplinary team effective in providing health screening for refugees;
- implementation of a comprehensive system for refugee health screening;
- provision of full health assessments for all refugees with special focus on their mental health;
- enhancement of the cultural competency of health, mental health and resettlement services providers;
- implementation of a comprehensive and effective system of referral and follow-up for refugees;

- selection of culturally competent and experienced interpreters with “training in interpreting of psychologically sensitive material” (p.476).

The researchers recommended that training with providing, tracking and assessing follow-up care were vital in a program designed to meet the needs of refugee populations. In Fowler’s (1998) research, two health concerns that are common amongst refugees, namely mental health and reproductive health, are profoundly affected by culture. Thus, culturally sensitive health care is needed when working with refugees. Peer counselling involving other immigrant women trained for counselling and supports have been successful in helping overcome language and cultural barriers, while simultaneously promoting social networks (Fowler, 1998).

Levy (1999) places special emphasis on the therapy of refugees and she proposes a bi-dimensional healing approach. Specifically, she believes that therapy resides in *containment* and *validation*. Containment represents “the therapist’s attempt to manage the survivor’s internal, feeling states of mind” (p.239), while validation “refers to the therapist’s acknowledgement of the client’s actual experience and not simply the feeling state of the client” (ibid.). Handling and comprehending the refugee’s testimony and, then, validating it represents a strenuous process that can reveal “profound personality breakdown” (p.242), or, on the contrary, can lead to “interpersonal breakdown” (246). The author indicates that cultural differences (especially where political or religious issues are involved) can seriously affect the therapist-client rapport. Describing the obstacles she had to overcome as a Jewish therapist counselling a Muslim political refugee woman with strong anti-Semitic feelings, Levy managed to find new strengths

and innovative professional approaches to successfully contain and validate both the woman's dramatic experiences and her anti-Semitic sentiments. She specifies that constructive and empathetic communication can reduce the danger of misinterpretation and facilitate the process of validation.

Ekblad et al. (1998) warn about the misinterpretations that might occur from the relationship between a non-native speaker and the therapist. The clinicians stress that the therapist "should be careful of interpreting disturbances in speech or thought process" when the evaluation takes place in English. When the clinician has little knowledge of the refugee's culture, "a reliance on history may be more useful than focusing on the patient's dress and mannerisms" (p.56). The therapist might speak the client's native language differently which would elicit the client's distrust and unwillingness to speak. The use of an interpreter can also be problematic as s/he might not feel comfortable translating some of the refugee's traumatizing narratives or might paraphrase what the client says, preventing thus the therapist "from accurately assessing the emotional content and affect" (p.57). In addition, the use of an interpreter "alters the traditional patient-clinician relationship to include a third party". Therefore, the interpreter should receive specific instructions from the therapist on how to conduct the translation process and create a pleasant environment to the client (ibid.). Finally, the clinicians treating refugees might have to modify their usual diagnostic assumptions and treatment approaches, and should make efforts to empathize with the client's needs and cultural values. As Ekblad et al. conclude, the therapist's main role is to "treat the individual, not his or her culture or immigrant status" (p.63).

Brody (1994) recommends that refugees be approached from three perspectives: the individual perspective, the community perspective, and the political or human rights perspective. The individual perspective implies that the clinician identify “indications of depression, anxiety, or other features that do not necessarily constitute illness” (Brody, 1994:61), and monitor the refugee’s capacity to adapt to the host culture. The community perspective takes into consideration a number of indices such as (un)employment, education, family functioning, attachment to community agencies and organizations, criminal activity, if any, and mental disorders. Unfortunately, Brody notes, refugees are often diagnosed “on the basis of an ethnocentric view of health that prescribes how refugees should express their distress, how their disorders should be classified, and how the distress should be ameliorated” (p.63). Culturally sensitive clinicians are vital in order to help the refugees (re)integrate into the community. The human rights perspective presents as imperative the implementation of less authoritarian assistance programs for refugees in the countries of asylum in order to alleviate the effects of the trauma experienced in the home countries as well as the provision of “assistance in the achievement of autonomy and self-determination” (p.63).

Jablensky et al. (1994) suggest four approaches to enhance refugees’ living conditions and reduce the level of stress and violence in refugee camps. Although these strategies were described with respect to interventions in refugee camps, they are also relevant to services for refugees in community settings. The first approach refers to designing and implementing services and clinical practices that reflect a “concern for mental health within the context of total health” (ibid., p.336). This implies that the therapist and/or the human rights worker look not

only at the stressors but they also review their own mode of approaching the refugees (personality, communication skills, “human warmth”) in order to provide them with the help they need. The second approach requires a “systematic monitoring of refugee plights, health problems, and coping methods” (p.336). The third approach recommends the use of traditional healers as a complementary form of mental health assistance, which would provide refugees “with a greater sense of cultural continuity and identity amidst the uncertainties of transition” (p.337). Finally, the fourth approach resides in adopting multidimensional health policies and action programs that would actively facilitate both the medical practitioners understanding of the refugees’ mental health problems and the refugee’s recovery from the traumas experienced in the past.

### *Recommendations*

A number of recommendations must be highlighted in order to increase awareness and develop supportive and culturally appropriate programs, services, and policies to refugee women whose lives have been shaped by the atrocities of war.

- More local health and mental health services that provide comprehensive assessments, prevention and intervention programs. Researchers believe that mental health services should be part of the general health services, avoiding thus the stigma associated with mental health problems (Kaplan & Webster, 2003). Also, the refugee women should receive comprehensive screening upon their arrival. Fowler (1998) indicates that “new and non-English-speaking immigrants are less likely to receive screening for cervical and breast cancer than other Canadian women” (p. 389).

- Clinicians should employ “a holistic approach to assessment” and take into consideration all causes that might have contributed to women’s difficulties (psychosocial, biological, socio-economic, etc) (Kaplan & Webster, 2003). The more perspectives (medical anthropology, ethno psychiatry, multi-dimensional therapy, etc.) are explored, the higher the chances for a healthy and faster healing.
- Researchers and clinicians should channel their efforts to construct a more comprehensive model of traumatic stress. The current research shows that the Post-Traumatic Stress Disorder model fails to present all aspects of the refugee women’s traumatic experiences and “it must be broadened to incorporate ethno cultural differences in the expression of traumatic stress” (Friedman and Jaranson, 1994:216).
- Higher receptivity, responsiveness and cultural sensitivity from the settlement workers, ESL teachers, health and mental health professionals are imperative in facilitating the refugee women’s transition from a life in disarray to one where interactions are characterized by order and predictability. Refugees are not to be assessed based on origins, beliefs, religion, or the way they speak, look or dress themselves. Social service providers, teachers, and health care professionals need to approach the refugees from a non-biased and non-judgmental perspective and always keep in mind that their mission is to serve and treat individuals, not ethnicities. Anti-racist strategies need to be an integral component of all programs designed to serve this population.
- The interpreters used by settlement agencies, clinics, hospitals, and so forth need to be well trained in order to provide translation in a professional and ethical fashion. They

need to be aware that accurate, thorough and objective interpreting is essential for both service providers and refugees in order to establish a relationship based on trust and understanding.

- The various programs offered to refugee women such as therapy, support and discussion groups need to broaden their spectrum of objectives by placing particular focus on empowering women by encouraging them to voice their problems and by teaching them how to combat the colonialist attitudes displayed by the dominant culture, attitudes that contribute significantly to widening the gap between the ethnic groups and dominant culture.
- Although children were not the focus of the current research, it is difficult to discuss the challenges faced by refugee women without addressing the needs of their children. These children of refugee women represent an extremely vulnerable segment of population. Service providers and educators need to develop and implement programs that raise awareness about the children's trauma and difficulties they cope with when entering a new culture. Health service providers need to have a greater awareness of diverse cultural approaches to child rearing. At the same time, families need to be informed regarding the legal responsibilities under Canadian law.
- While these children have many strengths and much resilience, it should not be assumed that they have the resources to heal on their own. In fact, the children's needs should be constantly addressed by social service providers, health care professionals, educators, and spiritual leaders. Further research with this group is needed to fully understand the

unique challenges they face. Researchers recommend that parenting programs be provided to the refugee women in order to help them deal with their children's suffering and their own trauma (Kaplan & Webster, 2003).

- Governments must allocate adequate funding; this is crucial in providing the necessary services and programs to these women and their children. Continuous research that includes community and academic partnerships, and realistic needs assessments are vital in obtaining and maintaining these funds.
- Individual, couple, and group counselling must be available to women refugees as they are very likely to experience family disruption, intimate partner violence, and dramatic changes in their gender roles. As women might feel uncomfortable using this type of service, the agency workers should inform women about the alternatives they have in moments of crisis, and encourage them to seek professional advice. The common practice of simply providing lists of shelters and emergency numbers is an inadequate response.
- A wide range of therapy methods should be employed when dealing with refugee women's war traumas such as group psychotherapy, family therapy, supportive psychotherapy, reality therapy, art therapy, "natural therapies", "traditional healing", "intensive practical support such as accompanying clients to appointments" (Kaplan and Webster, 2003:118), to mention just a few. Prompt and comprehensive psychosocial support and treatment should be available to these women and their families in each Canadian Reception Centre. Long waiting lists for assessments and treatments are

extremely detrimental to them as their lives are kept on hold and contribute to their isolation and alienation in the new society. In addition, the therapy groups and programs must be designed to serve a large number of clients.

- That a serious attempt be made to reflect a more representative portrayal of immigrant and refugee women in the Canadian mass media. There is a tendency of focusing on the trauma experienced by the refugee women (rape, violence, political, social and economic oppression, etc.) ignoring the knowledge, the skills and the cultural richness these women bring with them. At the same time, the refugee women also need to be made aware of the Canadian diversity, its social, religious, political and economic issues in order to facilitate their adjustment to the new society. As some refugees may come to Canada with their own biases against certain cultures due to the political/religious conflicts in their homelands, they also need to learn to accept and understand these cultures and live together harmoniously.
- That educational, consciousness-raising manuals, videos, CD-ROMs, and other forms of programming and educational material be developed; that these be accessible to teachers, employers, and those who are interacting with refugee women and their families.
- That women and their families be involved in the production and dissemination of their own forms of media, and that the relevant agencies be encouraged to distribute work that reflects their concerns and realities.
- Adequate and sustained funds to train refugee women so they may run support groups.

- That governments create mechanisms to enable refugee women to use the knowledge, skills, credentials, and experience they already possess in the service of their community.
- That mental health services incorporate a recognition that war-related trauma occurs in a broad socio-political-economic context. Therefore, the traditional approaches that emphasize “individual pathology” are insufficient and inadequate responses. Instead, we recommend creative approaches that afford women the opportunity to collectivize their stories, their pain, their courage, and their hope in a productive manner.
- That governments recognize that, although women show resilience and courage, and have the capacity to cope with trauma, the effects are long lasting and profound. Therefore, sustainable programs are needed that provide services beyond the immediate aftermath of arrival in a new country.
- That a centre be established to provide research, education and services to this population in a comprehensive, integrated, and humanitarian manner.

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