Résumé

Analyse descriptive des expériences vécues par les réfugiées victimes de violence en temps de guerre

Helene Berman, Estella Rosa Irías Girón et Antonia Ponce Marroquín

Même si les femmes se retrouvent rarement sur la ligne de front en temps de guerre, elles en subissent néanmoins les conséquences de façon disproportionnée, comme c'est le cas dans plusieurs autres sphères de la vie contemporaine. Celles qui ont connu la guerre sont nombreuses à avoir subi la torture ou été témoins d'actes de torture ou de meurtre infligés à des proches et à des amis. Le recours au viol ainsi qu'à d'autres formes de torture sexuelle est un fait attesté par de nombreux témoignages. Les femmes forcées de fuir leur foyer et leur pays se voient souvent obligées de se séparer de leur conjoint, de leurs enfants et des autres membres de leur famille. Le nombre de réfugiés et de déplacés ne cesse de croître en raison de l'ampleur même des conflits dans le monde : on estime que les femmes en représentent plus de la moitié. La présente étude avait pour but de décrire l'expérience de réfugiées qui ont été victimes de violence dans le cadre d'une guerre. Huit thèmes se dégagent des données recueillies : la transformation d'une vie à jamais; de nouvelles conceptions de la normalité; un sentiment de peur permanent; la perte d'identité; l'impression de vivre à cheval entre les cultures; la place de la femme au Canada; le sentiment de porter un lourd fardeau — le rôle central des enfants; l'indifférence des intervenants de la santé. Les auteures examinent les implications de l'étude pour la recherche et la pratique, soulignant les limites des approches individualisées suivies en Occident.

Mots clés : réfugiées, femmes, guerre, violence, santé

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

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Although women are rarely on the frontlines of battle, as in many other realms of contemporary life they bear a disproportionate burden of the consequences of war. Many have experienced torture firsthand or been witnesses to the torture or killing of family, friends, and loved ones. The use of rape and other forms of sexual torture has been well documented. For those who are forced to flee their homes and countries, separation from spouses, children, and other family members is common. Because of the sheer magnitude of global conflict, the number of refugees and displaced persons throughout the world has risen exponentially. It has been estimated that women constitute more than half of the world's refugee population. The purpose of this narrative study was to examine the experiences of refugee women who experienced violence in the context of war. Data analysis revealed 8 themes: lives forever changed, new notions of normality, a pervasive sense of fear, selves obscured, living among and between cultures, a woman's place in Canada, bearing heavy burdens — the centrality of children, and an uncaring system of care. Implications for research and practice, including limitations associated with individualized Western approaches, are discussed.

Keywords: refugees, women, war, violence, trauma, narrative, health

Introduction

Although women are rarely on the frontlines of battle, as in many other realms of contemporary life they bear a disproportionate burden of the consequences of war. Many have experienced torture firsthand or been witnesses to the torture or killing of family, friends, and loved ones. The use of rape and other forms of sexual torture has been well documented (Bourke, 2006; Drumbl, 2000; Hynes, 2004; Liebling, 2003; Moussa, 1998; Nikolic-Ristanovic, 2000; Young, 1997). For those who are forced to flee their homes and countries, separation from spouses, children, and other family members is common. Because of the sheer magnitude of global conflict, the number of refugees and displaced persons throughout the world has risen exponentially. It has been estimated that women constitute more than half of the world's refugee population, a scenario that has led Apfelbaum (2000) to suggest that we live in an *era of uprooting*.

For refugee women, the usual responsibility to care for, protect, and nurture their families never stops. Despite the premigration atrocities they may have endured, they are still expected to carry out their "mothering." The disproportionate burden carried by refugee women, and the unique challenges they face, have received growing attention in recent years. However, theoretical understanding remains sparse and few programs have been developed that are responsive to the needs of these women. The purpose of this narrative study was to investigate the experiences of refugee women who have lived through violence in the context of war before migrating to Canada. Three research questions were addressed: *What experiences of premigration trauma have immigrant and refugee women had before arriving in Canada? How do premigration experiences influence current everyday life among refugee and immigrant women? What do refugee and immigrant women perceive as helpful or unhelpful in their interactions with health and social service providers?* It was expected that the knowledge gained from this study could be used to offer recommendations for the provision of nursing care to refugee women that takes into account the intersecting realities of their lives.

The Policy Context for Refugee Women in Canada

In order to understand the sociopolitical status of refugee women in Canada, it is worth considering key documents that have informed policy and legislation over the past decade. Two papers, *Not Just Numbers* (1997) and *Building on a Strong Foundation for the Twenty-First Century: New Directions for Immigration and Refugee Policy and Legislation* (Citizenship and Immigration Canada, 1998), provided the framework for the passage of the *Immigration and Refugee Protection Act* (IRPA) (2001). With an emphasis on "human capital," the expectations and requirements for entry into Canada stipulated within these reports and by the IRPA are extremely restrictive. Entry would be granted only to those individuals who have high levels of formal education, are capable of supporting themselves or resettling in 12 months (in the case of refugees), speak at least one official language or have the ability to learn it quickly, are relatively young, are in excellent health, and exhibit the ability to adapt quickly and successfully to Canadian culture. Notably absent is attention to emotional trauma, imposed isolation, lack of a supportive social network, sexism, racism, and ethnocentrism. In a critique of *Not Just Numbers,* Arat-Koc (2000) observes that the paper is "a product of anti-immigrant, anti-refugee, and racist sentiments" (p. 18), especially with respect to newcomers from non-traditional source countries. Arat-Koc asserts that the report's recommendations overlook the most disadvantaged group of immigrants and refugees, namely poor women and women of colour, and, moreover, that 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" (p. 18).

Women and children are among those most adversely affected by these guidelines. Many refugee women have limited access to formal education, language courses, jobs that might provide them with needed skills, and financial resources. The fact that women are often victims of rape and other forms of intimate partner violence, while a large number of children suffer malnutrition and other health problems in the refugee camps, though well established, is essentially ignored in these documents. 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 to be an attempt to leave more space for a male-centred flow of human capital (Hyndman, 2000, p. 9). These facts make the report's stipulations not only controversial but unrealistic. Despite significant concerns with current policies, several positive initiatives have been undertaken in an effort to include women's needs and voices in the international agenda. For example, the Canadian Immigration and Refugee Board's decision to adopt the *Guidelines on Women Refugee Claimants Fearing Gender-Related Persecution* in 1993 represents an important effort to acknowledge the lived realities 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, we need more inclusive criteria 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, p. 22). In the absence of explicit recognition of the distinct forms of abuse experienced by women and children, the net effect is policy that privileges men over women and that relegates the needs and welfare of women and children to the fringes of immigration and citizenship legislation.

Literature Review

This literature review examines research that is relevant to an understanding of the experiences of refugee women. It includes studies related to premigration experiences, including rape and other forms of sexual torture carried out in the context of war, and postmigration experiences and resettlement. The review is a result of database searches in the fields of nursing, sociology, anthropology, and psychology. Because much of the current knowledge regarding the responses of refugee women to wartime

trauma is derived from research using the concept of posttraumatic stress disorder (PTSD), several critical issues are identified.

Premigration Experiences

Before coming to Canada, refugee women are typically exposed, directly or indirectly, to a range of premigration atrocities. During the war in Bosnia, many women knew that their husbands were being beaten and tortured while held in concentration camps; although they did not witness the beatings, they saw the aftermath — the physical and emotional scars — and were deeply traumatized, and forever changed, by the events (Weine et al., 2004; White-Earnshaw & Misgeld, 1996). Similar experiences have been described in research with women from Mozambique (Sideris, 2003), Iraq (Laban, Gernaat, Komproe, Van der Tweel, & De Jong, 2005), Ethiopia (Fenta, Hyman, & Noh, 2004), and El Salvador (Zentgraf, 2002).

Many refugee women spend months or even years in refugee camps in their own or neighbouring countries. Although women in these camps are safe from the bombing and gunfire, they often experience sexual or physical abuse, lack of food, inadequate health care, isolation, and severe emotional trauma (Cardozo, Talley, & Crawford, 2006). Commenting on refugee camps, Crisp (2001) notes the lack of funding from the United Nations High Commission for Refugees and the failure to promote sustainability and development in these communities, thus promoting a cycle of dependency for the aid recipients. Shanks and Schull (2000) write about the occurrence of gender-based violence in refugee camps, asserting that the perpetrators of violence are often the peacekeepers, who have coerced women to engage in sexual activity in return for food (Black, 1998; Hynes, 2004).

Much of the research related to the experiences of women exposed to war has focused on the incidence of PTSD. In their study of the patterns of psychological distress among Salvadoran women refugees, Bowen and colleagues (1992) found that more than 50% of the participants exhibited PTSD symptoms, including recurrent and intrusive recollections, dreams, flashbacks, and intense feelings associated with the event; 41% met the diagnostic criteria for PTSD. The authors conclude that "there may be a high incidence of PTSD among the general population in El Salvador, with particularly traumatic effects on women" (p. 271). Similarly, Eytan and colleagues (2004) report that, among a sample of Kosovar refugees, 23.5% suffered from PTSD, with higher rates among females.

With respect to women refugees in the host countries, PTSD may be exacerbated by "long-standing conditions of social illegitimacy, powerlessness and violence" (Farias, 1991, p. 179). When the stress of alienation is coupled with family disruption, unemployment, inability to speak

either official language of the host country, and lack of social support, women may experience "a sense of personal disarray" (p. 186). These findings are supported by those of Gafner and Benson (2001), who report that PTSD hampers the ability of Central American refugees to integrate into the host society.

Sexual torture, assault, and rape in warfare. Rape and other forms of sexual violence against women occur in times of war and peace. In warfare, however, the brutality and acceptability of rape are escalated by the fact that "in the eyes of the rapist, the woman is the enemy" (Nikolic-Ristanovic, 2000, p. 48). In a study conducted in Sierra Leone, women in 94% of the households surveyed had experienced wartime "rape, torture, and/or sexual slavery" (Hynes, 2004). The use of rape as a weapon of war has also been clearly documented in studies with refugees from the Balkans (Nikolic-Ristanovic, 2000) and Mozambique (Sideris, 2003).

The way in which women experience wartime rape is exacerbated by the patriarchal values ingrained in society and amplified by what Hynes (2004) calls the "culture of war." Sideris (2003) observes that gender discourses tend to lay the main responsibility for sexual integrity on women as the bearers of culture. For example, after the mass rape of women in Rwanda, the combined pressure of Roman Catholic values and social norms dictating that children of militiamen be rejected and considered "lixo" (rubbish) resulted in women giving birth in secret and abandoning their babies (Sideris, 2003).

According to Nikolic-Ristanovic (2000), during 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). Aron, Corne, Fursland, and Zelwer (1991) discuss the sociopolitical context of sexual abuse with respect to Guatemalan and Salvadoran refugee women. They delineate the differences between institutionalized (wartime) and non-institutionalized (peacetime) sexual assault. In state terrorism, sexual violence and rape are gender-specific and are seen as a means of annihilating the political opposition. Rape becomes a normal act, carried out to gain social control on behalf of the collectivity. The assailants are not punished because their acts are considered to be politically motivated. The authors note that, not surprisingly, refugee women often avoid speaking about sexual torture and rape for fear of losing whatever support they might have, not being believed, or, ironically, being blamed.

The shortcomings of the international human rights laws and their failure to adequately protect women's rights have been addressed by numerous human rights advocates (Copelon, 1999; Malone, 1996; Pratt & Fletcher, 1994; Walton-Roberts, 2004). In recent years, efforts have been made to have rape included 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 very broadly presented in the legislation, and the only article in the Statute that explicitly identifies rape as a crime is Crimes against Humanity, Article 5 (Copelon, 1999). While Canada has shown some leadership by recognizing gender-based persecution and using gender guidelines since 1993, the devastating physical and psychological consequences of rape need to be included in the legislation.

Postmigration Resettlement

Many researchers have described the multiple losses that 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, 2004; Jiwani, 2001; Momartin, Silove, Manicavasagar, & Steel, 2004; Warriner, 2004). Zabaleta (2003) writes of the suffering among refugee women who have lost their professional and personal identity, exacerbated by government policies that effectively restrict them to housekeeping and childrearing activities.

Resettlement is considered particularly stressful for women who have been separated from their families (Franz, 2003). Simich (2003) explores the supportive roles that the extended family can play in refugees' resettlement and notes that the ability to re-establish social networks and shared cultural experiences is critical. According to Beiser (1999), changing gender roles within the family heightens the sense of marginalization and depression among refugee women.

Seu (2003) conceptualizes the barriers to successful adjustment as either societal or individual. The societal barriers include racial, sexual, and cultural discrimination. Seu observes that xenophobia, cynicism, and the stereotyping of refugees are often internalized among citizens of host countries. From Seu's perspective, derogatory labelling and treatment of refugees is a defensive mechanism by which citizens avoid social responsibility for human rights abuses and express feelings of righteous indignation.

Culture shock and the relegation to minority-group status contribute to women's isolation and sense of displacement. The language barrier constitutes another significant impediment for refugee women and is one of the main obstacles to finding employment (Warriner, 2004). Language programs for newcomers in Canada are largely underfunded, and where courses are available refugee women who have suffered trauma may experience memory and concentration problems, making the task of learning a new language exceedingly difficult (Warriner, 2004).

Underemployment is another significant stressor in the lives of refugee women (Beiser, 1999). In her research with Bosnian refugee

women, Franz (2003) found that many accepted low-paying, low-skill jobs so as not to "upstage" their husbands; in this way, traditional gender roles were reinforced and sustained. In research with women from El Salvador, Zentgraf (2002) observed that work outside the home is not new to many refugee women and often gives them confidence and a sense of autonomy.

In sum, refugee women who have experienced violence in the context of war face a multitude of premigration and postmigration challenges. While much of the research related to this population has focused on the incidence of PTSD, several researchers have questioned the validity and relevance of the PTSD construct with respect to refugees from non-Western countries (Bracken, 1998; Friedman & Jaranson, 1994; Muecke, 1992). According to these researchers, PTSD is a diagnostic label established among individuals from Western societies who had experienced trauma and subsequently applied to refugees from non-Western countries. While they admit that all individuals display some similar symptoms, Friedman and Jaranson (1994) point out that "ethno cultural differences in the expression of traumatic stress may not conform to the diagnostic criteria for PTSD" (p. 215). Thus, the ethnocentricity and narrowness inherent in the PTSD model might affect our ability to fully comprehend the meaning of trauma in the lives of refugee women. Further, Salis Gross (2004) argues that the concept of trauma is often threatening to refugees, as the acceptance of the trauma discourse may undermine their experiences as victims of human rights violations, forcing them to accept a label in order to achieve legal status in the host country.

Research Methods

A narrative research design was used to address the research questions. Although narrative research embraces many theoretical approaches, several assumptions are shared. One of these is consensus on the pervasive nature of stories and storytelling. Under this assumption, human beings are storytelling organisms who, individually and socially, lead storied lives. Although storytelling has historically been accorded a marginal position in research, it has emerged as an approach with considerable potential (Berman, 2000; Dossa, 2004).

All of the women took part in an individual interview, conducted in an informal manner that encouraged dialogue and reflection. Thus, the semi-structured interview guide developed for this research was used flexibly and consisted of open-ended questions on aspects of the women's lives before, during, and after migration to Canada. The interviews were conducted by two of the authors in either English or

Spanish. The Spanish interviews were translated using the "back translation" method. All interviews were audiotaped and transcribed verbatim. The interviews lasted approximately 2 hours and were conducted at a location chosen by the participants, usually in a quiet room in their place of residence. Ethics approval was obtained from the Health Sciences Human Subjects Review Board of the University of Western Ontario prior to data collection.

Data were analyzed using methods suggested by Mishler (1986) and Riessman (1993). These entailed re-transcribing sections of text that appeared to take a narrative form, thus establishing the boundaries of the narratives; reduction to the core narrative; and analysis of the core narrative. A qualitative computer program was used in the coding and sorting of data. By attending to the context and content of the narratives, we attempted to create a "conversational space" through reflexive listening and reading. Our challenge was to listen to the voices of the women in ways that allowed us to capture their "lived realities" while simultaneously understanding how these realities are shaped by dominant social and political systems.

Upon completion of the interviews, all participants were invited to attend a focus group during which emerging themes were shared, discussed, and revised. Six of the women took part in this process. In addition, an invitational community forum was held with health and social service providers, community stakeholders, policy-makers, and most of the study participants.

Sample

Sample size was determined according to the criterion of saturation, meaning that that sampling was discontinued when no new themes emerged from the interviews. The final sample consisted of nine women: three from Bosnia, three from Guatemala, two from El Salvador, and one from Chile. The women from Central and South America had arrived in Canada during the 1980s, those from Bosnia in the 1990s. One participant had not completed high school, six had undergraduate degrees, and one had postgraduate university education. All of the women had respected professions before arriving in Canada. Included were two teachers, one doctor, one psychologist, one clerk, one nurse, and one artist. None of the women were able to practise their profession in Canada as their academic credentials and professional experiences were not recognized or validated. Four women returned to school and earned new degrees. The others, after years of being underemployed and holding low-paying jobs, managed to achieve what they considered a respectable lifestyle. Some were still trying to gain social acceptance and a sense of belonging within Canadian society.

Findings

The women described traumatic experiences that included both direct and indirect exposure to violence. It was evident that their 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 the findings, all names are pseudonyms.

Violence of War in the Lives of Women

Before coming to Canada, all of the Central and South American participants had been involved in various forms of social action. Their efforts included the seemingly innocuous activity of participating in labour unions, literacy programs, teachers' associations, and health reforms. However, in the social and political context of their countries, such activities targeted them as subversives. Paula, a participant from El Salvador, recalled an incident involving her husband, a teacher. He had attended a teachers' union meeting to plan activities for the school year when helicopters began to encircle the region. The army captured 40 teachers, including Paula's husband, and took them to a clandestine jail where they were imprisoned and tortured for 15 days. Later, the army destroyed their home and burned most of their belongings. According to Paula, people in the city who were in any way associated with human rights organizations were viewed as a threat and forced underground. The outcome of being found was typically persecution and/or death.

Virtually all of the women acknowledged that, in addition to the violence of war per se, other forms of violence — physical, sexual, and/or emotional — became an integral part of their lives. Many stated that they knew women who had been raped or that they had been sexually abused themselves. Although the incidents occurred long before, in some cases as much as 20 years, their accounts were clear and detailed. One woman described an incident in Guatemala when she was 15 years old:

> *[The soldiers] 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… 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.*

Miriam recalled an incident in Chile when soldiers prodded her and a group of women anally using electrical wires while swearing and threatening to "screw" them. Some of the women were physically assaulted and others verbally harassed about the "firmness and appearance" of their "butts."

Frequently, the women's homes were invaded by strangers who would interrogate them and raid their homes before leaving. Raquel recognized this tactic as a form of torture. She described an incident during which soldiers invaded and ransacked her house while interrogating her about her husband. After they left, Raquel began to comprehend the enormity of the danger she and her husband were in, firmly believing that they would face torture, and possibly death, if they did not escape.

Lives forever changed. In many instances the wars were perceived to have begun very rapidly and the women's lives were changed suddenly and dramatically. Ariana, from Bosnia, recalled that, without apparent warning, she "woke up in a war, where everybody was trapped in their houses and the entire town was surrounded." Mira, also from Bosnia, had not believed that war in Sarajevo was imminent when she was forced to flee with her two children to Vienna, where they sought refugee status. Her husband stayed behind and fought with the Muslims, although he was not Muslim. Mira did not hear from him for three years. After the war, her family managed to come to Canada, where their lives were once again "turned upside down."

The women described how they were changed emotionally as a result of physical trauma, and noted that these changes, in turn, affected their physical health and well-being. One of the Bosnian women said that her menstrual periods stopped, which she attributed to shock, fear, and stress. After the war, she was unable to conceive a child. Excessive weight loss, malnutrition, and loss of hair and teeth were also described by the women.

All participants shared a deep sense of helplessness knowing that their loved ones were being tortured or were suffering in concentration camps or jail. They described the profound impact that this had on them, stating that witnessing violence was as devastating as having violence inflicted upon themselves:

> *I saw my cousin be 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.*

A woman who had described her husband's experience of torture and violence while in prison explained that soldiers would take some prisoners outside and stage "mock executions" to instil fear among the others.

The women often had difficulty, not surprisingly, remembering and recounting their stories, either laughing nervously or crying as they reflected on their past. The profound way in which war had altered their lives was particularly evident in the words of one woman: "War changed people, changed minds, changed everything."

New notions of normality. Although most of the women were able to recall life in "better times," they stated that once war began it became a defining feature of everyday life. Witnessing and experiencing violence became commonplace and "normal." It became routine to be followed by the "authorities," to encounter armed soldiers and war machinery in the streets, and to hear the sound of gunfire sporadically both near and distant. The black market flourished, inflation was rampant, and long queues for water, milk, bread, or meat became the norm. According to the participants, the most disturbing aspect of this situation, and a somewhat eerie one, was that it came to represent the usual state of affairs. One woman told of a time when she would hear grenades going off, one at a time, and because the sound was so familiar to her, she knew they came in threes. After the three grenades went off, she would get out her broom and sweep the sidewalk — just as one might clean up any other debris from the streets.

Over time, the toll on the women's health and well-being became evident. Deprived of electricity, water, and basic medication in the refugee and concentration camps, they developed a variety of infectious diseases. Despite the hardships, the women expressed gratitude that they and their families were alive, even if separated.

Arrival in a New Country: The Influence of War on Everyday Life

The women were asked how their premigration experiences influenced their everyday lives in Canada, upon their arrival and at present. Although they came from different countries, and in different decades, their stories contained many similarities. For all, the sudden nature of their flight and their uprooting and displacement, both geographically and emotionally, were central to the shaping of their lives.

Pervasive sense of fear. Despite the fact that they were now geographically far removed from war, many of the women continued to fear for their own safety and that of their loved ones, some of whom remained in their homelands. The fear was intensified by the Canadian social and political landscape. As refugees, all of the women were required to provide proof of persecution, something that was not always possible. Thus, many lived for years in fear of deportation. As well, they feared being unable to provide for their children, as they seldom had money, jobs, or support networks.

The women expressed fear of being misunderstood, combined with a distrust of people: "I am afraid of talking or disclosing to medical doctors for fear of having a medical record that later could be used against me." The women from Bosnia spoke of being betrayed by friends and neighbours during the war, explaining that they now found it

difficult to establish trusting relationships, which contributed to their marked sense of isolation.

Selves obscured. Frequently the women reported a loss of the sense of self and identity. The physical and emotional pain they had endured, combined with being in a new country with an unfamiliar language and culture, changed these women. In some cases, they commented that they no longer recognized themselves.

The loss of the lives they had known before coming to Canada had different meanings for the women. Sonia had been a physician in Guatemala but was unable to practise medicine in Canada:

> *It affects my life, as I do not practise 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 former life greatly affected her everyday life:

> *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.*

Raquel continued to question 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 stated that she has suffered from depression in recent years. Julia came from El Salvador. She explained that her husband became an alcoholic to "lessen the pain and enable him to talk about everything that happened." After he stopped drinking he was no longer able to talk openly about his trauma and, after several years in Canada, they divorced.

Among and between cultures. Relocation was a difficult process for all the women. After arriving in Canada they encountered numerous barriers. Some commented that they would never fully identify with Canadian life. Most said that their home represented the quintessence of their culture. It was there that they preserved their customs, habits, values, and traditional way of life. As Paula said, "We live in our own world in our house."

Many women expressed discontent with the roles they had to accept, especially during their first years of resettlement. Domesticity characterized their daily lives, a stark contrast to the professional lives they had had in their countries of origin. Paula recalled being isolated in the home for 12 years due to family responsibilities and her husband's uncertain legal status. Similarly, one of the Bosnian women, who had been a prominent fashion designer in her country, was dependent on social assistance despite her concerted efforts to find employment. Every woman told a

story of marginalization and seclusion, which deeply affected their lives. Although they were dedicated to their families, the fact that their roles had been restricted to those of mother and wife left them discouraged, pessimistic, and in some cases depressed.

At the time of the interviews, some of the women had been in Canada for almost 20 years. While they recognized Canada as their home, this reality was always associated with a degree of tension and ambivalence. They praised what they viewed as a Canadian valuing of freedom and security but stressed that they would never consider themselves entirely Canadian. Moreover, they criticized what they viewed as racist and xenophobic attitudes and Canada's failure to give racialized communities the recognition and respect they deserve.

New Roots and Old Connections: Facilitating the Transition to Life in a New Country

The women were asked to discuss what had and had not been helpful to them after their arrival in Canada. In their responses, the positive and negative frequently overlapped. The women reported that programs or services that were intended to be helpful were often delivered in such a way that they were in fact unhelpful. All of the women spoke about the importance of having their basic needs met and reconnecting with family members who had arrived before them. Dolores considered herself fortunate because she had relatives already here. Sonia noted that the most difficult aspect of resettlement was having no one with whom to talk about her experiences. Although she found a physician whom she viewed as trustworthy, she was never asked by him, or anyone else, why she was in Canada. These intangible aspects of life seemed to be much more important to the women than material comforts.

A woman's place in Canada. Several women spoke about the availability of services for women, particularly for women who are experiencing abuse. When asked what was helpful to her, Julia spoke about the greater value placed on women here, as compared to Latin America. "Your life as a woman has worth. We do have support." While some women spoke about services for refugee and immigrant women, others had little knowledge of such services. Fatima, a Bosnian woman, spoke about the lack of violence-related services for women in Bosnia:

> *We don't have so many services [in Bosnia]…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.*

Several women expressed frustration with their financial dependence on their husbands. Their lack of confidence was reinforced by the discrimination they endured and the low status accorded to them as 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.

Bearing heavy burdens: The centrality of the children. The participants viewed the academic success of their children as validation for their sacrifices, making them feel that they had not suffered in vain. Although the children did not participate in the study, it appeared that their mothers' expectations of them imposed tremendous responsibility on them. As well, several participants shared their concerns about their children not being accepted socially. One woman from El Salvador spoke about the prejudice her children faced at school, with classmates calling them "Native Indians." Mira had lived with her children in three countries over a relatively short period. She said her children were having a difficult time adjusting to the Canadian education system:

> *When we came here, it was a new language. He [her 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.*

An uncaring system of "care." Encounters with health-care providers were varied. While a few women told of helpful and compassionate responses, many described attitudes they perceived as condescending, patronizing, and demeaning. These concerns were raised by the women from Central America who arrived in the 1980s as well as by the Eastern European women who had migrated more recently. Several of the Central American women commented that, in their view, resettlement assistance has not changed significantly over the years and health and social service professionals continue to lack understanding of the complex circumstances of refugee women. Some described explicit instances of hostility, racism, or other forms of violence. All indicated that, generally, health professionals showed little interest in learning about what had happened to them, and two participants noted that, in response to their efforts to speak openly with their physicians, they were given antidepressant medication.

Two women told of sexual assaults by physicians during prenatal visits. Paula recounted an incident several years after her arrival. A

physician at a walk-in clinic touched her inappropriately during her first prenatal visit. Too stunned and distressed to do anything at the time, Paula later told her husband what had occurred and subsequently returned to the clinic to inform the chief medical officer. Paula did not know if any action was ever taken against the doctor, but continued to feel a profound sense of violation. Another participant told of a similar experience with a gynecologist. Although she called for her husband, who had been forced to leave the room but 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 necessary to articulate 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 that remained with them.

Discussion

The women who participated in this research thoughtfully and sensitively shared stories about their lives, how they were shaped by violence in the context of war, and about their efforts to establish themselves and their families in a new and unfamiliar country. Although the interviews often evoked deeply painful memories, the women repeatedly commented that they welcomed the opportunity to talk. Their need to tell, to bear witness to the horrors of war, is not surprising. Aron (1992) discusses the beneficial effects of *testimonio* for people who have suffered trauma under state-sponsored terrorism. According to Aron, testimonio "validates personal experience as a basis for truth and knowledge, and personal morality as a standard for public virtue" (p. 176).

In this study, the narrative interviews provided a vehicle for denouncing the sexual violence perpetrated against the women. Upon completion of the study, a follow-up invitational forum was held. It was attended by most of the women who participated in the research as well as community leaders, public health nurses, social service providers, and policy-makers. The forum served as a "safe space" for the women. They made a public plea for punishment of the perpetrators and called for the establishment of sustainable programs that are responsive to their distinct needs. In *The Blue Room*, Agger (1994) writes about the healing effects of testimony: "private shame can be transformed to political dignity, providing a source of knowledge about the methods of the dictatorship, while healing the wounds inflicted through these methods" (p. 10).

Several of the women in this study spoke about depression. The tendency to medicalize and individualize the "narratives of suffering" is discussed from a critical medical anthropological perspective by Eastmond (2000). According to Eastmond, refugees' responses are best

analyzed in their own terms and interpretation, situated in the local cultural context of their experience. Like Aron (1992), Eastmond believes that refugee women need to go through the cathartic experience of telling their stories (testimonio) as part of the "meaning-making" process. Further, she asserts that the tendency to label refugee women as "traumatized," and thus to stigmatize them, diverts their attention from the "more multifaceted definitions of their problems" (p. 81), ultimately hindering the process of healing. She implores health providers to approach human suffering from both clinical and anthropological perspectives in order to broaden their understanding of the refugees' experiences. This approach contrasts with deeply entrenched Western-based scientific models, which often are unable to yield comprehensive understanding of the needs and concerns of refugee women.

Many of the participants in the study displayed a sense of resignation, saying that they were "just surviving." The 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 the women had come to Canada with valuable skills, their credentials were not recognized and they found themselves de-skilled and with few prospects. A Guatemalan woman who had been a teacher in her home country reported that, in a private conversation, her ESL teacher had implied that newcomers — refugees in particular — were expected to become manual labourers. As 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 every day. Other barriers identified by the women were poor housing, poor health status, lack of proper access to health care and counselling, isolation, rejection, racism and other forms of violence, culture shock, and powerlessness.

The women in the study were cut off from their traditional support systems, from family, friends, and a sense of community, and they had all experienced trauma, directly or indirectly. They felt uprooted, confused, and disconnected. While a few of the women seemed satisfied with the quality of services they received upon arriving, most expressed dissatisfaction with the services provided to them. The general feeling was that, instead of mutually agreeing upon a plan of action, health and service providers assumed the role of "expert" and decided what was in the best interests of the women. The women were disheartened by what they perceived as the patronizing attitudes of service providers, and most expressed the need for greater understanding.

The findings from this research have implications for all health providers. Undoubtedly, the premigration and postmigration experiences of women refugees deeply affect their physical and emotional health and

can have a significant impact on the resettlement process. Many challenges in developing programs for refugee women have been identified. Much of the literature on existing programs is based on American programs that place the 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, Seymour, & Hummel, 1999).

One challenge addressed by both Goodburn (1994) and DeSantis (1997) is the fear and mistrust of refugees who have experienced persecution at the hands of untrustworthy officials. Health providers who rely on a foundation of trust in the relationship face challenges in establishing programs for this group. Most notably, refugees may be reluctant to approach the health-care worker with their specific needs. Therefore, developing trust must be a priority in caring for refugees, whether at the individual or the community level.

We need comprehensive approaches that include examination of societal, institutional, and individual factors that impact on health. The trauma of migration, racism, marginalization, and exclusion, and the dynamics of violence should be considered in tandem with assessment of the health needs of refugee women. Efforts to reduce the women's sense of isolation should be promoted through active outreach strategies and the deployment of public health or community nurses. Fluency in the person's language is a necessity, as is knowledge about the community's social and historical experiences. The unique and very challenging circumstances of refugee women have prompted a movement towards contextualized care. Such care takes into account the intersectionalities of oppression and includes a comprehensive analysis of gender, class, culture, and the political environment (Adams & Assefi, 2002; Atlani & Rousseau, 2000; Gasser, Dresden, Keeny, & Warren, 2000; Guruge & Khanlou, 2004; Jiwani, 2001; Sidieris, 2003; Whittaker, Hardy, Lewis, & Buchan, 2005).

One limitation of this research concerns the nature of the sample. As a group of well-educated women, the participants possessed resources and opportunities that would not be shared by refugee women with less education. Thus, research with refugee women from more varied socioeconomic backgrounds would yield more comprehensive understandings. Another limitation is the inclusion of women who had arrived in Canada during two distinct periods. Finally, it might be argued that the inclusion of women from different ethnocultural backgrounds was a limitation. However, we are reluctant to advocate ethnospecific research because of the tendencies in both scholarly and popular media to reinforce unwarranted stereotypes (Dossa, 2004; Jiwani, 2001).

The stories told by the women who participated in this research are just a beginning. From their position in the margins of society, these courageous women do not need nurses or other health professionals to tell them how they should live, or to individualize their problems and deflect attention from the larger social, cultural, and structural barriers they face. Nor do they need medication to lessen the pain. Rather, they need social spaces and networks that can sustain the element of struggle and a belief in the possibilities for change; they need jobs and people to whom they can talk openly and honestly, without fear of retribution or judgement.

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2009 update: *Helene Berman's positions are unchanged. Estella Rosa Irías Girón is Volunteer and Crisis Line Coordinator, Sexual Assault Centre London. Antonia Ponce Marroquín is a Counsellor at Women's Community House, a shelter for women who have left abusive relationships.*