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“We Want to Talk, They Give Us Pills”

IDENTITY AND MENTAL HEALTH OF REFUGEE WOMEN FROM SUDAN

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Africa has been one of the two top sources of refugees to Canada since 1999. The number of refugees from Sudan has tripled from 1999 to 2004. Due to ongoing conflicts in Sudan, this trend is expected to continue, particularly with the tragedy of Darfur. However, studies on the issues faced by African women refugees are scarce (Cleaver and Wallace 1990).

Although refugee women are normal people who are forced to deal with abnormal and traumatic situations, they tend to be socially constructed as victims and needy. Refugee women experience many of the hardships of men, but they also experience gender-specific forms of presettlement violence such as sexual violence and intimidation (Cleaver and Wallace 1990; Cutrufelli 2004; Moghissi 1999; Rousseau et al. 1997). They face specific postsettlement challenges (e.g., changes in roles, isolation, cultural tensions, and barriers to accessing mental health services) that undermine the foundation of their identities and position them as vulnerable to mental health problems (Allodi et al. 1986; Blair 2001). Generally, when refugee women arrive in Canada, they experience a sense of relief as their physical safety and basic needs are met. The state of their mental health remains a hidden but serious issue. The stigma attached to mental illness and the fear of deportation may lead women to refrain from disclosing their problems (Chappel and Morrow 2000). However, refugee women have culturally specific ways of expressing their strengths and resolving their problems, which transform in the new context of their host country. The concepts of men-

tal health and healing are also culturally and socially constructed, and need to be conceptualized broadly.

This chapter presents research findings based on a participatory project conducted by a university-community interdisciplinary team which included researchers in the fields of Nursing, Medical Anthropology, Public Health, Women's Studies, and from the regional Settlement Services.¹ The team's objectives were to further understand factors that contribute to a refugee woman's well being, and how she copes with her past experiences and current situations as she reconstructs her identity. This chapter reflects upon the complex relationship between refugee women's identity transformation and mental well being as exemplified by a group of refugee women from Sudan. Authors also record how, because of their unsettling experience with mainstream organizations, refugee women from Sudan were led to construct a collective identity as a wall of protection from the outside mainstream world. The chapter title is in effect a metaphor for the various forms of silencing the refugee women encountered, particularly when they resettled in Canada, and the need and will for self expression they communicated in the course of the project.

The Need for Further Understanding

Research on the mental health of refugees is weighted toward studies that evaluate levels of psychopathology. The Harvard Trauma Scale is a standardized tool used to evaluate mental health that has been validated cross culturally (Silove et al. 2002; Sondergaard et al. 2001; Loughry, chapter 10). It has been used for comparative purposes among different refugee populations (Redwood-Campbell et al. 2003). However, this tool is based on the assessment of symptoms related to post-traumatic stress disorder and was particularly used among male Vietnam War veterans in North America. Its epistemological basis lies in Western psychiatric models of mental health, and thus has been called into question by medical anthropologists and cross cultural psychiatrists, who point out that there are deep cultural differences in the way that mental health issues are experienced and expressed. The meaning of symptoms is culturally shaped, and symptoms may have different metaphorical meanings cross culturally. As Helman states, "each culture has its own language of distress" (1990: 94). A Sudanese refugee woman experiencing mental distress may complain that her "head is not together," while one in Latin America might complain of "nervios," with entirely different sets of symptoms (Low 1985). To develop a gender-sensitive and culturally appropriate understanding of the mental health issues among refugee women requires an understanding of the perception of the women themselves about mental health (Guarnaccia and Rogler 1999).

Information about refugees' own definitions and perceptions of mental health services is limited in the literature on refugee mental health (Li 2000; Redwood-Campbell et al. 2003; Williams 2001). Canadian studies on mental health seldom use an interpretive approach with a focus on refugee personal experience; rather they focus on factors such as the process of integration examining services provided, and tend to target subpopulations by race rather than culture (i.e., Black or Native). Often Canadian research studies the integration experiences of immigrants and refugees, without distinguishing between the two. Gender-specific studies of refugees from Africa are rare (Cleaver and Wallace 1990). In order to implement effective and culturally sensitive mental health services, it is imperative to explore further how refugee women perceive mental health issues and how their culturally grounded healing practices contribute to positive mental health practices. A review of the literature suggests that fully understanding the unique cultural characteristics of refugee women is critical in treating mental health problems they may incur (Watters 2001). This can be achieved by examining help seeking behaviors (Foss 2002; Phan 2000; Weine et al. 2000) and culturally bound syndromes, while remaining focused on the perceptions and knowledge of the refugee women (Guarnaccia and Rogler 1999; Lock 1993). There also needs to be an understanding of the cultural variations in somatization (Foss 2002; Kirmayer and Young 1998; Li 2000), in the clinical presentations of depression and anxiety (Kirmayer 2001), and in cultural differences in the expression of emotional states (Foss 2002; Stevens 2001).

A Study of Sudanese Refugee Women

To address these gaps in our understanding, we conducted a study with Sudanese refugee women (Bhaloo et al. 2005). The objectives were: (1) to explore how mental health is understood, experienced, and constructed by refugee women from Sudan; (2) to describe their experiences with mainstream, community, and mental health services in Canada; (3) to explore culturally grounded healing practices that contribute to resilience and positive mental health; (4) to explore the process of identity transformation and the generation of informal support networks in the postmigration context.

A grounded theory approach was used for this research, which uses an inductive, from the ground up method to generate theoretical explanations when little is known about the topic (Glaser and Strauss 1967; Strauss and Corbin 1990). This is a fitting method for the exploration of the unique worldview, social context, social relations, social action experiences, and cultural constructs of refugee women's mental health, healing practices, and informal support system (Crooks 2001). A purposive sam-

ple of a diverse group of eleven refugee women from Sudan who have settled in Hamilton was recruited for this study. Two focus groups were conducted: one to collect the data and a second to validate the results. The initial focus group was followed by in-depth interviews with three participants from different regions and subcultures of Sudan. The transcriptions of narratives were analyzed collaboratively to develop consensual understanding. A constant comparative method of analysis, which looks for recurrent themes, was used to interpret the participants' responses to the questions (Glaser and Strauss 1967; Strauss and Corbin 1990). The eleven Sudanese refugee women participating in the study ranged from twenty-four to fifty years of age, and most have been in Canada less than seven years. They came from north and south Sudan, and belong to different cultures, religions (Christian and Muslim), and language groups. These women are survivors with strong voices and much to share that can be of benefit to their community, other refugee groups, and mental health professionals.

Identity Is Contextual and Relational

We have learned that a Sudanese woman's identity, self esteem, and mental well being is closely linked with her role in the community as a wife and mother, and the value placed on children and family in their close-knit communities. As one participant in the study said: "A woman has to know what is the meaning to be a 'woman,' and is prepared by her mother for the role of wife and mother." She further pointed out: "You are to be proud and concerned about your family. . . . You as a mother, as a woman, you are not like men. You are different and you have to understand that. . . . We have love and we have to take a big part of the responsibility" (Bhaloo et al. 2005: 24).²

Extended kin, elders, and the community provide support to women in this role. These women identified themselves as strong individuals who were prepared to make sacrifices for their families and be positive role models for their children: "I love my family and I can do what it takes to help them" (35). To be perceived as complete, a Sudanese woman has to get married and have children, for "[s]he feels if she has no man, she has no value"(29). As another participant stated: "Having children helps mental health—[you] needs to marry a man who will have kids with you otherwise no point" (30).

Family name is also a source of pride and respect in their community, for "in Africa it's very shameful to have a bad reputation in the family" (45). Family reputation is also associated with how well their children do in life, which reflects directly back on mothers. With such a high value placed on family and Sudanese women's role of wife and mother, it is not

surprising that, “[i]f they are happy in family, they feel everything is okay” (43). Family stability is the main contributor to a Sudanese woman’s emotional well being and positive mental health. The majority of these refugee women demonstrated great strength and resilience as they coped with very challenging circumstances that made them vulnerable and affected their mental well being.

Experiences Undermining the Identity of Refugee Women

Our findings indicate that four common experiences particularly undermined the identity and mental well being of refugee women: loss, life in limbo, economic hardship, and raising children in Canada.

The Impact of Loss

Perhaps the most profound experience affecting the women’s identity and mental well being has been the war-related forced displacement, and dismemberment of their families and support networks. Women who had never traveled outside of their village had to flee to new communities and had to mask their identity by adopting local customs in order to protect themselves from violent attacks. Sometimes, they had to undergo new scarifications—as local identifiers—on their face in order to blend with local ethnocultural groups. Many lost their fathers, husbands, children, and other relatives. Girls without a father to protect them socially became very vulnerable to rape and sexual exploitation: “They have no skills, no education and can’t get a job so [they] go to people who take them in. They do whatever to get money” (24). Often women’s husbands and young sons were forcibly taken away to fight in the war. Men who came back to their families alive often were traumatized, wounded, or disabled. Other men fled leaving their families behind. Some women had to leave their children behind and grieved their absence in Canada. Describing circumstances affecting their mental well being, the focus group participants told us that:

Women are affected more by kids taken to war and a lot of them became widows. Husbands disappeared sometimes. Husbands live far away for many years. Here in Canada, we face the problem of women coming alone, leaving kids back at home, and dreaming of getting kids together. This really makes a woman crazy (26).

As a result of the forced displacement, their families were dispersed around the world and in refugee camps (i.e., in Yemen, Egypt, Kenya, or Uganda). Many were on the road for years: “I was born in a village. Village is not safe. I was in camps since 1984—since war started. The army

was always bombarding. We moved around until we found a camp” (25). As one woman explained, these losses have a lasting impact on their mental well being: “So we are getting well but not very well. . . . I lost my father and it was very hard, and my grandfather. . . . I lost everything because of the war” (26). War has widowed them, separated them from their husbands, or left them without news of their relatives and friends. The original identity markers have disappeared, official identity papers lost, markers carved on the flesh changed, and new markers are constantly being negotiated.

Living a Life in Limbo

When new environments are forced upon refugees whose identity derives from their belonging to a specific community, identity becomes intensely conflictual and stress-inducing. Moreover, this forced mobility has created insecurity, mistrust, fear of the future and of growing new roots, which makes refugees less likely to seek help and give priority to their own needs (Bowen 1999; Cole et al. 1992).

Time is experienced as fractured or “in limbo”; refugees are always waiting for someone or something, whether it is lost relatives or official papers. The Sudanese women felt that their life was spent in a waiting room. They had to wait for everything, and the uncertainty, temporariness, and precariousness of their refugee situation was taking a toll on them. Time was an issue when waiting to claim status, for family reunion, for their health card. The procedure for applying for refugee status was “a very long procedure . . . The time they call you to the hearing, you don’t know when. . . . Then when you go, you don’t receive the decision” (Bhaloo et al. 2005: 30). When one woman was asked how long she had to wait for her husband to join her, she said: “Nobody knows. Nobody knows anything, not even Immigration says anything” (30).

Economic Hardship

Most of these women experienced economic hardship—a circumstance that has affected their self esteem. Those trying to support their families found that the role of a Sudanese working woman had changed, both in Sudan and Canada. In Sudan, they found it increasingly difficult to survive with the restrictions imposed upon them by Islamic Law, which discouraged them from working outside the home. Suitable work was difficult to find, especially if a woman was not a “Muslim Sister” (active in Islamic movements). As one participant observed: “I think most of the Muslim Sisters now are not real Muslim Sisters, but for economic purpose, they act like that to get a job.” The situation was even worse for Christians to the extent that, “some change[d] religion to get a position”

(24). This undermined the reinforcement of their identity provided by a securely rooted religion.

Upon arrival in Canada, the skills, degrees, qualifications, and experiences of refugees are devalued and not recognized. A Canadian education is expensive, and as one participant said, "There is no guarantee if you go to school that you will find a job here" (29), due to a lack of Canadian experience and English language proficiency. A sense of loss of social status and having to beg for a job was felt as humiliating and stressful. Sudanese women experience difficult working conditions and occupational instability in Canada. Some women had no choice but to accept low paying jobs and resort to working at several small jobs, leaving little time to care for their families or themselves. Because occupational and financial stability is considered necessary for a marriage to take place, marriages were fewer and at a later age. Perceived as having an incomplete identity without a husband and children, Sudanese women confided that this stage was prolonged by their exilic circumstances, making them more vulnerable socially and affecting their mental health.

Raising Children in a New Environment

Sudanese women found "the Canadian system about the process of taking care of kids difficult" (30). Dealing with mainstream child-centered institutions such as the school system, the Children's Aid Society, and the police was very challenging, creating fear, anxiety, and anger in adults and children alike. For example, "[the children] are put in [a] class; they don't know how to read or how to learn. They are angry and stressed and that's why kids are getting in trouble now" (33). Many of the women did not understand the school system and were concerned that schools did not make the effort to get acquainted with newcomers' culture and history. Moreover, working conditions such as night shifts or juggling part time jobs, coupled with a lack of personal transportation, made it difficult for refugee women to attend meetings with teachers or pick up children on time. Educators who are unaware of these situations may label refugee women as "bad parents," and such misunderstandings are extremely stressful.

Sudanese women felt that their children's behavior was misunderstood and too often sanctioned. The women feared the police in Canada because they perceive that they treat teenagers like adults, and incarcerate them, whereas in Sudan the police treat teenagers like children. Thus, the women looked for help from their community, "trying not to talk to police because children become the victims" (32). Sudanese women expressed the fear that when they or their teenaged children did not comply with norms of the land, their children would be taken away from them. They also claimed that agencies that protect children did not understand certain occupation-related or family-related situations the women faced. After the

research project had ended, women felt freer to talk about the negative aspects of their experience with mainstream organizations, particularly with law enforcement. Criticism became sharper, and women spoke up, wondering why their adolescent sons were thrown in jail with hardened criminals for petty crimes that would have deserved only strong scolding and punishment by community elders. They felt that helping with education and employment would have been a more constructive approach.

All came to a tragic climax when one participant, who had spent her life in refugee camps, had her children removed—including her newborn who was “apprehended” right after delivery—by the local organization “for their protection.” There was a high level of cultural misunderstanding involved when the social worker had felt compelled to act, after identifying as “child abuse” what was perceived by the community as different rearing practices. Eventually, the court returned all children to the mother and father. This tragic case revealed the risk involved when one does not know the new language, the new laws and legal system, does not know the local communication style. The sense of alienation was again perceptible in court, where legal jargon entrenches power differences—“I don’t understand what they say, and it is my life and that of my children they are talking about”—the young mother lamented (51). Men and women from the community rallied around the distraught parents and attended court proceedings in a show of solidarity. As the mother later poignantly conveyed: “In our country, it is the army that kidnaps our children. We came here hoping to find safety for them, but here they are kidnapped by the organization that is supposed to protect them” (29). The mainstream organization had reenacted the family dismemberment experienced during the war, and unwittingly retraumatized the family and the community. A social gathering was organized by the community, at which time painful stories were shared, tears shed. Criticizing and mocking the institutions released the tension. Interviews or focus groups had a somewhat more inhibiting effect on women’s voicing than a spontaneous and congenial social gathering. It became clear why refugee women chose to stay clear of those organizations, and why they portrayed their community as ideal for problem solving.

Mental Health and Healing

Although their mental energies were weakened by their circumstances, Sudanese refugee women drew upon their strengths to assist them in coping with the resettlement process, and in reconstructing their identities in a new host country, as one of them emphasized, “I feel strong because I love my family” (36). To quote a participant: “For women, they can get humiliated but they are still going. They cannot give up easily” (29). A

belief in their own strength was a foundation to their mental health. These women had a built-in resilience and relied a lot on themselves, as one of them explained, “Nothing will keep me down” (29). They tried to work in order to keep their dignity, and they emphasized the importance of educating themselves and learning.

Study participants told us that there was no specific name for mental health in the Sudanese culture, explained then: “We don’t give name because name makes a person more sick so we don’t want to tell that person she is sick” (20). Sudanese women believed that to label a woman as mentally ill would “mark” her and as a result she would feel more isolated and upset. Rather, they had a culturally grounded functional definition and could easily identify members of their community who were in distress and needed their help. The Sudanese community watched for behavioral changes in their members, as did family members. For example, they observed: “She’s doing nothing for herself. She just stays like that. Some of them refuse to take a shower. . . . She just leaves all her duties. She looks as someone who is not aware” (23). Changes in explicit behavior such as self care, communication, household duties, and responsibilities were signs of something wrong in their friends’ life and alerted community members, giving them a pretext to contact women who appeared unwell to offer help.

Sudanese women said that they were not shy about going to doctors for physical ailments, but still preferred to follow their own way, looking for support from family, elders, and members of their community who could relate to their problems. The Canadian healthcare system posed major challenges for them, both in terms of securing healthcare coverage and receiving the care they needed in a timely fashion. Eligibility issues, the financial costs of healthcare, and difficulties accessing community-based psychiatric services represented major barriers for refugees. Professionals often did not have the time or the expertise to go beyond the physiological signs of mental health problems. Interpreters were too expensive for the service providers and often unavailable when needed. Mental health providers were too few and overworked with too many patients. The women described the system of referrals as frustrating, too long, and too bureaucratic. As one participant said, doctors “put you on waiting list to meet the specialist after 3 or 4 months. By that time, I have already become crazy or have become okay!” (35).

The women asserted that “Canadians [doctors] are really useless with us because they don’t know our thing” (35). They claimed that doctors only treated the symptoms with medication. As one participant explained, “the doctor will give you tablets and counsel you but this is not the solution” (35). In essence, their difficulties with the medical profession can be summed up in the phrase: “We want to talk, they give us pills.” For Sudanese women, the healthcare system in Canada does not take into account the

fact that changes, transitions, and healing are a gradual process, which integrates past experience and the knowledge of self in context. As a result, in keeping with the nature of their self-regulating and self-help community, they drew upon a number of culturally grounded coping strategies or healing practices, which included: reliance on family; reliance on elders and community mediation for family conflicts; reliance on close friends; strength in community participation; culturally grounded beliefs and practices (e.g., storytelling, rituals); mocking the system and collective laughter; reliance on self and self-help activities; and participation in community activism.

Reliance on Family

The primary source of support for all Sudanese women was the family. As one participant said: "I feel comfortable when I am with my family. If there is a problem, family helps. Both sides of family help out when there is a problem" (37). Sudanese women also relied on elderly family members who acted as counsellors and mediated using stories and examples from their experiences to guide and advise.

Elder and Community Mediation

Elders were highly respected and provided mediation for family problems. People often called elders to ask them to help someone in the community, and to visit the person. When the elders went, they would "sit down and listen to the person who wants to complain . . . , so they can address the reasons [for the complaint]" (40). In the process, the elders' social usefulness, self esteem and identity were strengthened. As one elderly participant stated, she was "very happy because they accept me to be an elder. . . . All of them respect me" (40).

Mediation by community members (i.e., elders, family, friends, respected couples) to pacify, to scold, and to advise was highly valued in the local community. One participant gave an example of community mediation with a husband who drank to illustrate how the community dealt with this problem: "Back home they [women] cannot get very miserable because if [the] husband is a drunkard, people come [and] talk to him. . . . 'You have to change and leave the beer and have to start your life'" (40). A second participant expanded this illustration saying, "We will find old people to talk to him to, and even men. We try to find men who are close friend to him" (40).

Strength in Community Life

Many refugee women arrive in the new country without their husbands or extended family and have to readjust their lives accordingly (Cham-

passak 1995; Ellis 1994). A cohesive and welcoming Sudanese community often becomes a woman's primary source of support. Through their sense of community, the Sudanese refugee women followed each other's news and helped each other out. As a focus group participant said: "The community is so related to each other, so if you have any problem you speak openly." (38). The Sudanese community members enjoyed doing things together such as picnics, communal celebrations, giving presents, and cooking food for community members who were unwell. They even set up a small micro-credit system for families with special needs. The community essentially acted as observer, regulator, and helper to identify and resolve problems.

Later on, community tensions emerged that stemmed from the political situation in Sudan, and had been concealed by an idealized construct of an "imagined community." In reality, Northern Sudanese and Southern Sudanese were still suspicious of each other and not interacting much. Rivalries simmered, and some women were resentful of others who they thought received more help from local settlement organizations. However, they rallied together to organize a demonstration that called for public support for the Darfur refugees. It gradually became apparent why immigrant and refugee communities take pride in caring for their public image of unity and solidarity, which they construct for the consumption of the "outside world." They construct walls that protect them from mainstream institutions which they fear, and tend to keep their problems confined within those walls.

The Role of Friends

Women who had no family in Canada also tried to re-create an extended family with trustworthy friends, primarily women in the Sudanese community. They sought support and help from these friends saying: "To talk to our friend is easier than to talk to a counsellor" (39). They felt that other women understood their past and current situation. This was particularly true of teenage girls who faced specific issues and did not want to add to their parents' worries. As one of the participants said: "Girls share problems, support each other. Talk to solve problems. No need to go to parents for small problems" (41). But some women remained cautious and kept problems to themselves. Suspicion, but also human compassion, had been sharpened in refugee camps and during flights.

Special Beliefs and Practices

Certain cultural beliefs and practices facilitate adaptation, particularly the use of storytelling. Storytelling was often used by elders to mediate problems. By narrating successful examples, elders helped women who were

unwell feel better. For example, one elder told a person a happy ending story about someone back home and concluded that the person was “[n]ow fine” (41). Sometimes, constructive deceptions in the form of stories were necessary to make unwell women feel good: “I lied to encourage her. . . . In seven days she changed and she took a shower, fed her children, dressed well. So, I healed her” (41). Laughing about what was happening to them and poking fun at the mainstream organizations provided a temporary healthy release of tension. The practice of *zar* in certain groups was also mentioned:

In Sudan, some women solve their problems through Zar (Boddy 1989), a complex social ritual which seems to have a positive influence on mental health. During the Zar ceremony, female family and friends gather together to express and vent their feelings and problems. Through drumming, singing, and dancing, women enter a trance state in which they can speak the secrets in their hearts. This “letting go” of inhibitions has a healing effect on women who have repressed inner conflicts and tensions in order to focus on their family’s needs (39).

When researchers probed them further on that question, Sudanese refugee women in our project did not give much importance to the practice of *zar*, claiming that “mostly uneducated rural women do it” (41). Retrospectively, one could ask: were the academic researchers more attracted to the creation of “an exotic other”? Or were the refugee women themselves dismissing the practice of *zar* in order to deflect potential “othering” and criticism? The answer here is less important than the question.

Reliance on Self

Using leisure and pleasurable activities such as singing, taking a walk, and even eating helped refugee women cope. Muslim Sudanese women also turned to their holy book, the Qur’an, for help. Some said that: “This kind of problem is for myself. If nobody consoles me I just go and pray. This is a kind of solution” (37). Sudanese women also tried to avoid thinking about their problems, reduced their expectations, or gave up. Avoidance may have led to withdrawal, isolation, and silence, but it was considered the best solution in certain contexts. For example, women feared that open discussions of family problems in the broader community would have attracted unwarranted attention from mainstream organizations such as agencies for child protection.

Activism

Sudanese women who had taken on leadership roles in their community had come to recognize the importance of citizenship and responsibility;

they had become vocal and organizing. As one participant declared: “We have to participate at all levels, take the decision itself, not just obey and listen. . . . I participate in . . . election campaigns. . . . I am not keeping silent” (43). Seeing a positive effect through political activism helped Sudanese women deal with their own issues, and built confidence and self esteem. For example, one participant said: “I help newcomers. I know things now and I can help them to use facilities here” (40). Activism increased sharply after the “crisis” with the child protection agency; the experience empowered women and fostered leadership in several.

Hope and Optimism

As also found in other studies (i.e., McSpadden and Moussa 1993: 221), refugee women emphasized the energizing effect hope and optimism had on their mental health. They cultivated hope and optimism between themselves: in their terms, being “positive and hopeful,” or “seeing the glass half full.” They used various strategies to help each other, and to help their husbands and their children to overcome moments of discouragement and pessimism. They offered positive “examples to learn by,” emphasized the importance of “giving a chance,” encouraged “patience for gradual changes” (Bhaloo et al. 2005).

Tensions in Identity Reconstruction

For this group of Sudanese women, mental well being was closely linked with identity perception and transformation in the new host society. As new experiences were reshaping their identity, they met with a number of challenges both within their own community and within the Canadian mainstream society—linguistic, cultural, generational, and gender-based.

Learning Yet Another Language

Language is a major barrier that many refugee women have to deal with in their new host country (Ellis 1994)—a barrier in finding employment, locating a school for children, doing day-to-day activities, accessing health-care, or describing health symptoms. It can be a great source of frustration and tension for newly arrived refugees. As one participant said: “I have to study the language first, because language is the first barrier. To find a job is not difficult, but language is the problem” (Bhaloo et al. 2005: 43). Language is one of the most serious difficulties refugee women encounter when interacting with mainstream healthcare services (Li 2000). The most recently arrived participant confided that, “[c]ommunication is number

one, especially for women. I was advised to go to school and learn the language and about the Canadian system a lot so I can know the good and bad sides of it" (42). She firmly believed that learning the language will make the transition less confusing and scary.

Cultural and Intergenerational Tensions

Due to the weakening of family support, refugee women face numerous cultural and intergenerational tensions in Canada. Those who arrive alone as single mothers or widows find it more difficult to be accepted by the Sudanese community. In our study, Sudanese women who were single or did not fit the cultural "norms" claimed that members of the community observed their behaviors more carefully and were more prompt to judge them. One focus group participant lamented:

I am married to a foreigner and in the Sudanese community this is not acceptable. So, when I introduced myself to the Hamilton community, I had a lot of questions asked about me. You want to be active, join the community but they feel there is something behind this story. Imagine how this affects you. You are already alone. You miss the family because in my town everybody knows who I am (45).

This lack of acceptance frustrated women who had adjusted to a different lifestyle—be it by marrying a foreigner, refusing to wear a *hijab*, or drinking and smoking. As a participant told us: "The most difficult pain I get in Canada is from my own people. . . . The same traditional beliefs follow me here. We have to mend that" (46).

Associated with cultural transformations, Sudanese women also noted that they experienced generational challenges in Canada. An example would be when the elderly "want to give advice to young women and some of them ignore them and they don't want to listen. . . . They lose respect" (46). A major cause of this challenge is the framing of what is reality in Canada. Television creates illusions and expectations in the minds of younger Sudanese, who think that what happens on television is real and the norm. This results in problems and misunderstandings. For example, the public expression of affection is different in Sudan; it is particularly discreet between men and women. In addition, young Sudanese women feel pressure to rely more on their physical appearance, on brand name clothing or make-up, in order to increase their chances of finding a job, a husband, or just to feel part of the new society. This can result in a lack of communication between mothers and young girls who are reframing their culture, as a mother complained: "They want to copy what they see on TV . . . this may confuse elder people; . . . girls are now doing things in secret" (46).

New Gender Roles

Generational and cultural challenges arise in part due to the new gender roles all generations of Sudanese women experience in Canada. The reversal of traditional gender and generational roles constitutes a major component of their identity transformation. In the study, some Sudanese women had to provide for themselves and their children because they came alone or had male family members who were unemployed or disabled by the war. They had more responsibilities inside and outside of the home than in Sudan, and their tasks were more fragmented. In addition to playing the role of wife and mother, women strove to continue their education. One participant noted that: "They started to go to different places to develop themselves. They are changing" (47).

The Sudanese women demonstrated considerable ability to take on multiple roles and be self-reliant in Canada. As one participant said: "I go for shopping, drive kids to school, go to emergency, and do everything here by myself" (47). Most were grateful to have more autonomy, but also felt tired by the workload and responsibilities they had in Canada: "Since I have been here in Canada, I'm not tired, I'm exhausted!" Without the family support system they had in Sudan, they found their roles to be overwhelming at times. They claimed they did not have time for themselves like they did in Sudan. As one participant exclaimed: "The only messy thing here is me!" (47). Yet the women equated Canada with education and freedom. When asked what has changed for young Sudanese women in Canada, one participant responded: "Education . . . We are allowed to go to school. We can go shopping alone, do things freely, even when we are married" (47).

The focus group participants were more aware of their rights as women. As one participant told us: "Husbands think women are changed" (47). As a result, Sudanese men felt more vulnerable as they had lost their traditional control and their role as main wage earners, and felt threatened by the fact that women enjoyed more freedom, financial independence, and rights. Participants recommended that all newcomers learn the laws that protect women in Canada, and their rights and duties.

Role adjustments in the new country differed for each woman based on her socioeconomic status back home. The higher their status in Sudan, the more difficult the change and risk to their self-esteem and mental well-being. For example, one participant, who had practiced medicine and had domestic help in Sudan, was jobless and found it challenging to take on the responsibilities of the house by herself. Women from lower socioeconomic backgrounds remarked that they benefited from learning about the Canadian system and enjoyed their independence in Canada: "I've been here one year in Canada, a single mom and do all things alone. I can do bills, go to bank and sit in a group to discuss my problems and I like that.

I learned from friends. I'm more independent and even if my husband comes later, I'll depend on myself more" (49).

Throughout this process of identity transformation, they continued to view themselves as important positive role models within their families and community. As a focus group participant said: "We came to Canada as a second home. It's an independent world where you need to be strong . . . I develop my skills and although I find it more difficult I like it" (49).

Identity Transformations: Questions Arising

Refugee women come with a past that continuously threads its way into their present, permeates it, and affects it. Their mental well being is intimately connected with gendered identity, and both are influenced by their historical context, their culture, and their human environment. It is particularly the case for Sudanese women, who do not experience their identity as autonomous, rather as dependent on family and community. To be recognized, respected, and have self respect at every stage of their life is important for women in the Sudanese community. The experience of displacement and relocation creates ruptures in the continuity of identity formation and mental well being, which affects their identity reconstruction in Canada. The prefix "dis" precedes every facet of their experience: *dis*-placement, *dis*-memberment, *dis*-location, *dis*-connection, and *dis*-ruption. It is what rips them away from their body, their self, their family, their community, their country, the continuity of cultural values held dear from one generation to the other—what for them used to be and should be safe spaces. Sudanese women, like other women in the world, were constructed to nurture and protect those spaces and feel safe in them.

In transforming their identity, the issues associated with their mental well being are complex, interrelated, and permeate all aspects of their lives. The process of identity transformation not only follows the temporal course of their life, it is deeply affected by the changing locations and the new contexts. It is affected by the nature, extent, and impact of their trauma, the level of resilience and family/community support, by the different social environments in which they are sent to live, by the memory of their past, the circumstances of their present, and their hopes for the future. A caring ethnocultural community has both a protective function and a regulatory function. It can build self esteem and mental health but also harm them, particularly when these women are perceived as "changing too fast," or not abiding by cultural norms.

Over the duration of the project, researchers realized that Sudanese women felt the need to protect the good reputation of their community—out of pride, out of fear of mainstream institutions, fear of losing their refugee status, and to ensure positive attention and good services. The

women also communicated the need to continue transforming tensions and rivalries into celebrations of strengths and respect for differences. One cannot stress enough the importance of time and trust when developing dialogue in research. Dialogue helped to nuance narratives, because narratives can be constructed by participants who may have their own agenda. It uncovered factors such as racism, which had not been discussed with researchers at first. What was true, constructed, or concealed in their narratives? When meaningful information was obtained outside of the research process, such as during a social gathering or during a car ride offered to the participants, researchers also faced an ethical dilemma on whether that information could be included in the findings. Finally, given the relatively small sample size, one cannot affirm that the findings presented are representative of the mental health situation of refugee women from Sudan in general. As a result of the researchers' dialogue on research methods, a Participatory Action Research (PAR) process well suited to future research with refugee women was initiated. The researchers also had to rethink their concept of mental health and coping strategies, reflect on the continuous presence of the women's past, and on the inclusion of cultural representations and practices. Frequently, refugee women and their community tend to idealize a home and a life to which they cannot return, and in which they had a specific role. A gender-based tension exists between this idealization and their new life with its new challenges and freedoms. Questions arise that reveal the complexity of what could be construed as mental health: is retreating into this idealized life a healing coping strategy, a survival instinct, a necessary transition, or a harmful regression? What is a measure of mental healing—the subject's "feel good" declaration, or the therapist's pronouncement, which is also imbued with her own cultural representations? Who defines norms of mental wellness and decides when it is attained? In Western therapies there is a danger in "premature unification" (Hermans and Hermans-Jansen 1995: 143). Still indebted to a Cartesian frame of thought, they separate the real, the dreams, and the imaginary, whereas these are all part of the same living experience in many cultures, including in the Sudanese culture. A Cartesian approach also tends to individualize and isolate experience, while individuals and factors are interconnected. Rather than seeking to label them under known diagnoses, mental health specialists should investigate the self of refugee women (and men) as complex, layered, and transcultural. This leads to a "depathologization" of the self, which not only enriches our understanding of mental health, but respects the identity and the agency of women, and, in and of itself, has a positive effect on mental health.

Participatory therapy, which is based on the same principles as Participatory Action Research, offers an approach that is conducive to the enhancement of mental health. An interdisciplinary practice, it promotes a holistic understanding and is suspicious of categories and assumptions.

In the process, it looks at the root causes of mental health issues, removing responsibility and guilt from the individual. Colearning, the validation of identity, agency, knowledge, culture, and context, the inclusion of all forms of communication, contribute to rebuild identities that integrate and make sense of past and present experience (Hermans and Hermans-Jansen 1995). Rather than rely on pills, participatory therapy relies on dialogue and connectivity, and strengthens the sense of self of refugee women.

Each stage in the lives of refugee women from Sudan represents at once both challenges and opportunities. Sudanese women expressed the need to find solutions to their challenges, but also to help mainstream organizations and society at large communicate appropriately with culturally diverse individuals and communities. They had a strong interest in reaching out to various mainstream organizations to educate them and befriend them, such as the Children's Aid Society, the police force, schools, churches, healthcare providers, and so on. Sharing their experience and suggestions with the researchers and the community at large enhanced the awareness of, and respect for, the Sudanese culture and women among non-Sudanese, which in turn enhanced the women's sense of self and self esteem. They felt useful to their community, and were eager to see concrete results. The Sudanese women strongly advocated the use of community mental health workers who would be familiar with the cultural context, language, and specific mental health issues faced by refugees from their country.

For the members of the research team, the research process proved to be both enriching and unsettling. Researchers held a variety of roles related to refugee women—a community board member, a program director for a settlement service, a physician, a public health nurse. As we began to engage with the Sudanese women, hearing their stories, we began to reflect on our professional roles with refugee women. The women had been silenced or had constructed narratives because of a lack of interest and ethnocultural sensitivity in mainstream organizations, because of a lack of time, because they were racialized, mostly poor, and women. We learned to listen and to appreciate the importance of time and bonding, in the common pursuit of knowledge. Pills are just a camouflage for what we do not find the time to hear, or do not want to know. It was humbling to see ourselves and the Canadian institutions for which we work reflected through their eyes. Their challenge to each of us is to strive to make the services available for refugees more relevant, accessible, and culturally appropriate.

Notes

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2. Quotations from the participants originate from the report *Refugee Women from Sudan and Their Mental Health*, by S. Bhaloo, A. Carias, M. Hadjukowski-Ahmed, L. Hayward, J. Ploeg, and K.Trollope-Kumar. 2005. Hamilton, Ontario, Community Care Research Center, McMaster University.