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The Narrative Representation of Mental Health:

Iranian Women in Canada

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Abstract

The literature on mental health suffers from a lack of emphasis on the broader understanding of this topic, which is primarily framed as illness/depression. This lack has its roots in the Western dualistic epistemology that has forestalled alternative ways of being. I argue that mental health (inclusive of well-being) constitutes an integral part of life that is brought into sharper relief in the narrative accounts of disrupted lives. Illustrative examples are drawn from the settlement narratives of two Iranian women in Metropolis Vancouver. These narratives show how newcomers draw upon competing discourse and practices to reconfigure the meaning of their lives. The importance of the narrative genre is highlighted for a more nuanced understanding of the construction of lives subject to the impact of the dominant host culture.

Key Words: mental health, well-being, settlement narratives, Iranian women.

Introduction

Anyone doing research in the area of mental health in the West is confronted by a vast, complex and changing landscape. This situation is compounded by the fact that mental health does not lend itself to definition. It constitutes an integral part of our well-being. Subjecting this condition to measured criteria amounts to compartmentalization of lived reality. This observation is commonplace but in our new world order of medical technology and science,[1] a holistic understanding of mental health recedes into the background. Instead of looking at mental health as part of well-being, we have subjected it to a special domain of illness. What is the source of this deep-rooted dichotomy and what impact does it have on the way we conceptualize and research subjects deemed to be sick rather than well? How do mental health (illness) constructs impact on the lives of immigrant women (read "racialized women") who are constituted as a vulnerable population? (Agnew 1996; Bannerji 1995; Mohanty 1991). In this article, I explore these questions to further ground them into an epistemology of "what makes us human" - an age old project within the discipline of anthropology that has yet to be realized. [2]

My interest in this subject arises from two main concerns. First, illness, human suffering and health as these come to light through narratives and historical trajectories, as well as through institutional and social relationships, form part of the human condition across cultures. Second, in a world where asymmetrical relationships of power determine the availability of health resources, it is necessary to examine health and illness issues from the lived reality of racialized subjects.[3] The issue here is not merely that of "voice"

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[1] This term from Ginsburg & Rapp's work (1995) is used in a double sense. At one level it connotes the idea of control and distribution of knowledge within the biomedical system; at another level, it advances a cultural understanding of how a powerful system is understood and reworked. The latter leads towards the formation of an alternative world order.

[2] Moore (1988) frames this issue in relation to seeking out the similarities in human life through recognition of cultural uniqueness; over the last decade the discipline has struggled to recognize the coevalness of 'these others.'

[3] Ahmed (1993) identifies two approaches to the study of "race" and health in his work on black people in Britain. The first one is the "culturalist" approach where realities are constituted and explained in terms of "cultural differences" equated with deviance and pathology. Within this perspective racial inequalities

(Ahmed 1992; Becker 1997; Dyck 1995) but establishing a point of intervention whereby understanding and knowledge of health and medicine by disadvantaged subjects are validated.

In an attempt to engage with multiple issues — subjectivity, gender, dichotomization of health and illness, and the need to go beyond racialized constructs towards understanding humanlife conditions — I draw upon the genre of ethnographic narratives established as a valued tool "in the investigation of personal experience and its shaping within larger social and cultural frameworks" (Monks & Frankenberg 1995:107; also see Frank 1999, 1995). The narrative qualities of illness (and health) bring to light two salient themes. First, our understanding and knowledge of illness are derived from stories related by the sick, family members, doctors and healers.[4] The emergent phenomenology of reading illness/health stories may be comprehended within a broader context where what is experienced in discrete moments and from limited perspectives is reconfigured. The process at work within the narrative genre is that of revitalization of language and experience. Second, drawing upon the work of C. S. Lewis, Good (1994)[5] argues that there is a struggle between the series of events in a narrative and the themes represented in the series. The themes elude the stories and defy rational description. "It is for this reason that anthropologists often turn to stories of illness and suffering to be awakened to the ideas we sense are present in the lives of others, present but not readily described" (ibid:165). In this vein, Good has identified three analytical concepts to the

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in both health and access to health care are explained as resulting from cultural deficits. Integration on the part of the minority communities and cultural understanding and ethnic sensitivity on the part of the health professional then become the obvious solution. Personal and institutional racism and racial discrimination have no part in this equation. The second approach is of supposedly that of benign epidemiology premised on the notion of an unconcerned, value-free scientific observer making objective pronouncements on the basis of carefully collected evidence backed by rigorous scientific methodology. Race and class are then rendered irrelevant. Institutional and personal racism within and outside the health services have created "intellectual apartheid" of excluding black people from defining their own realities.

[4] I am indebted to Good (1994) for insights into this subject.

[5] Good (1994) lays emphasis on the synthetic process through which a reader engages imaginatively "into the world of the text shifting viewpoints to follow the perspectives presented by the narrative and the narrator... (ibid:144). I argue that moments at which such connections can occur cannot be taken as given; they need to be worked at and reconfigured with the possibility that they may remain disjointed.

narrative representations of illness (to which I add mental health), namely: the "emplotting" of illness, the "subjunctivizing" qualities of the stories, and the "positioning of suffering." Emplotment constitutes a means through which a story is elicited and authored. Subjunctivizing qualities refer to the process where the stories are read as texts open to multiple readings and potential outcomes, while the positioning stance provides a local context to the story (ibid:144). In this article, I focus on the concept of emplotment to understand the experiences of Iranian women during key moments of their lives in the process of "settlement" in Canada. As mental health is an integral part of this process, my analysis aims to unpack its meaning as it emerges from the narration of lived experiences.

Our research suggests that maintenance of mental health may be an active process of meaning-making and reconstruction of lives in a new country. The research therefore raises questions about conceptualization of mental health and its relationship to gender explicated in the literature along the lines of higher morbidity. While not underestimating the power of the socially constructed categories of difference: "gender," "age," and "race," I have steered clear from framing my research within this framework. The approach I have adopted is that of commenting on the cultivation of difference as it emerges from the narratives.[6]

In this article, I briefly review the Western discourse (the story of the relationship between anthropology and biomedicine) on mental health followed by narrative accounts of two women, highlighting their experiences of settlement in a new country. In charting this territory, I wish to identify the potential of narrative representation of mental health for racialized women. Rather than opting for the common strategy of internal dialogue within anthropology and between anthropology and other disciplines, I wish to establish narrative points of intervention of the subject population — alternative ways of looking at the world that are not wholly derived from the Western epistemology but are not confined within the unit of a discrete culture. Throughout my analysis, I expound on the narrators' representations of their stories and lived reality in relation to reader response theory to

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[6] Framing the anlaysis in this way suggests a more nuanced approach from that of the current focus.

elucidate the process of meaning-production as this is produced interactively between the reader and the text. Finally, I discuss the significance of the narratives for fostering dialogue at multiple levels. My goal is to bring into focus how knowledge is constituted: What is social knowledge for? What kind of knowledge is advanced and validated and what bearing does it have on the subject of health, illness and well-being?

Anthropology and Biomedicine: The Story of a Relationship

A critical understanding of the relationship between anthropology and biomedicine requires laying some groundwork. Anthropology has acquired its historical legitimacy through the study of non-Western societies. While the Western world was engaged in colonizing large parts of the world, anthropology stepped in to provide "information" on colonized societies as well as a much-needed critique of Western society itself. This latter goal was achieved through implicit comparison that invariably led to an epistemological and social distancing between the West and the non-Western world. Furthermore, other societies were constructed within the framework of an orientalist discourse that granted the West the status of a Subject (Said 1978; Spivak 1988). These processes led to the generation of images whereby the West came to be constructed as a place of activity, an originating source for "scientific knowledge" and "biomedicine." By contrast, the non-Western world became perceived as stagnant (the ethnographic present) and inactive. This mode of thinking is embedded within conventional anthropology; its practitioners and ethnographers are the quintessence of mobility while subjects of research are incarcerated within the unit of a bounded culture (Appadurai 1992).

While medical anthropology has reflected the concerns of the parent discipline, it has also been engaged in chalking out a different terrain (Good et al. 1992; Gordon & Lock 1988; Hahn & Kleinman 1983; Kaufert & Lock 1998). To begin with, medical anthropology has the potential to address the issue of humanism at a broader and more profound level as health, illness, and healing are, through-and-through, human issues that do not lend themselves to compartmentalization. For example, certain orientations within

medical anthropology have leaned towards establishing linkages between human biology, the cultural construction of knowledge, and relations of power — domains that have remained separate within anthropological inquiry. Concern with human suffering and distress transcends established "dichotomies of theory and practice, thought and action, objectivity and subjectivity" (Lindenbaum & Lock 1993:x). Towards this end, medical anthropology has demystified and revealed the culturally constructed nature of biomedicine, which has presented itself as "natural." This venture, however, has been made possible through data drawn from non-Western societies. The latter have then served the function of holding a mirror through which Western systems can be refined, modified or revamped but more importantly this orientation has created a gap between Western and non-Western medical systems. Ironically, it is the "irrational" local systems of the non-Western world that provide the much-needed critique of the seemingly rational system of biomedicine. Medical anthropologists took it upon themselves to explain "irrationality" of other systems by demonstrating that they make sense in their cultures, thus reinforcing the parent discipline's orientation of Othering. As Good (1994:10) has observed "A central issue in the rationality debate has been the discussion of 'apparently irrational beliefs' . . . How do we make sense of cultural views of the world that are not in accord with contemporary natural sciences, it is often asked. Do we argue that members of traditional cultures live in wholly different worlds, and their statements are true in their worlds, not ours, or even that they cannot be translated intelligibly into our language?"

Like anthropology, the subdiscipline spoke for and represented the Other. It is only recently that critical/interpretive medical anthropology has turned its attention towards addressing humanistic issues that take into account the life worlds of the sufferers (Good et al. 1992; Kleinman 1998; Kleinman et al. 1997). The subdiscipline's ability to advance in this direction has only been materialized through adoption of innovative methods, salient among which is the narrative genre which has reached a high level of sophistication across disciplines (Frank 1999, Cruikshank 1998, Dossa in press b, d.)

Like biomedicine, medical anthropology has entered into specialized fields, such as mental health (understood along a continuum of depression and mental illness), AIDS, chronic illness, disability and others framed within the rubric of "illness." Entry into these domains makes it necessary to bridge the gap between theory and practice with a focus on a different set of issues. Does suffering lead to a more humane understanding of life or does it accentuate social markers of difference such as gender, age, "race," "disability"? If illness brings us closer to understanding the humanness of our condition, how do we identify the parameters that make us human — a situation complicated by the fact that the West has presented itself to be the repository of "humane" values. If we claim that there are different ways of being human, how do we communicate and understand our differences and at the same time find common ground of interactive encounters? Search for these answers involves a long journey where we can only take a few steps at a time. Here, I outline the contours of the first few steps through a brief excursion into "mental health."

The term "mental health" used interchangeably with depression/mental illness forms part of the common discourse in the West where is it presented as a universal condition present in human populations. Its origins have been traced to interacting biochemical and psychological processes (Kleinman & Good 1985; Krause 1989) and the suggested solution resides in administration of antidepressant medications and supportive therapy. Ethnographic documentation of cross-cultural variations have brought to light the cultural and, of late, sociopolitical dimensions of this condition, which continue to reveal the parochial and localized nature of Western psychiatry. Furthermore, ethnographic data have posed some conceptual problems. At what stage is depression considered as illness and at what stage is it a transitory mood or emotion experienced at various times by all individuals? If this condition, ranging from schizophrenia to milder anxiety disorders, becomes more severe and enduring is it attributed to a lack of supportive environment or is it genetic? Are there distinct boundaries between depressive mood and illness? In response to these complex issues, the American Psychiatric Association has produced a Diagnostic and Statistical Manual (DSM-III) which eschews cause altogether, treating psychiatric disorders as unitary diseases, precipitated by social

precursors and superimposed on enduring personality characteristics (Kelinman & Good 1985).

Medical anthropological interventions have added a new set of issues along the lines of different meanings and expressions attributed to depressive mood symptoms. A common example cited is that of the experience of "dysphoria" — sadness, hopelessness, lack of pleasure — which may serve as a marker of a journey into self. This observation should alert us to the fact that depression is culturally constructed and grounded in a Western intellectual and medical tradition (ibid: 1985).

For anthropologists engaged in the study of non-Western cultures, the issue addressed is that of the tension between the psychiatric community's universalistic stance and medical anthropology's grounding in relativism. It should be noted that it is the illness categories that inform the ongoing debate between these two modes of investigations. Informed by a critical stance within the discipline, medical anthropology has brought to light the cultural dimension of biomedicine to reveal its embeddedness in political economy. At the same time, this subdiscipline has begun to focus more intensely on the issue of voice together with the knowledge claims of local systems, which has formed the rationale for a body of work referred to as a critical interpretive approach (Good 1994; Kaufert & Lock 1998). In seeking to understand the native's point of view, critical interpretive anthropology has established diverse points of intervention with a focus on the social construction of illness. The challenge is to "pose the question of when illness representations are actually misrepresentations that serve the interests of those in power, be they colonial powers, elites within a society, dominant economic arrangements, the medical profession or empowered men" (Good 1994:52). Cumulatively then, medical anthropology seeks to make sense of claims of human biology and medicine while acknowledging the validity of local knowledge. Following this tradition, I want to suggest the genre of narrative as a point of entry into the complex terrain that includes life worlds in social and historical terms (Schutz 1975). I am especially interested in exploring how immigrant women (newcomers) engage in the narrativizing of experiences to reconstitute their life worlds. I argue that mental health is an integral part of this process of

reconstitution to be placed on the same level as the newcomers' search for meaning and material security.

Background to the Study

Data for this study are drawn from ethnographic narratives collected in a Vancouver suburb that include: narrative interviews with Iranians (mostly women), and service providers, participant observations of the social and religious life of the Iranian community on Vancouver's North Shore and conversational engagement with individuals. Members of the research team (the principal investigator, one student and two indigenous research assistants) attended Iranian events and programs of social service organizations, such as ESL classes, celebration of Navroz (New Year), Quranic reading classes, mall-walking sessions and informal social events in Iranian homes. Interviews and conversations were tape recorded or written by hand and later transcribed; interviews in Farsi were first translated into English. The researcher met with and had regular discussions with the indigenous informants. Access to the Iranian community was facilitated by social service providers, research assistants and the author's own contacts with the community members. As with any piece of ethnographic research, building close and trusted relationships with the research community takes time. It was only after having been in the field for over six months that I felt at home with the members of the community, including social organizations. This process was facilitated by the fact that the author lives on the North Shore and is a Muslim. Prior to my entry into the field, I had worked with and established contacts with both the service organizations as well as members of the community. A field diary formed an integral part of data collection.

It quickly became apparent to me that an exclusive focus on elderly Iranians would lead to imposing artificial boundaries on a community that did not categorize the elderly as different. We thus made an attempt to include participants who had varied backgrounds in relation to occupation, educational level, length of time in Canada and marital status. Those who participated in the study had been in Canada for periods ranging from four to

fifteen years. All but one were Shi'a Muslims. The majority had university or college education and were employed professionally before migration to Canada.

The issue of positionality is important within critical medical anthropology poised to represent the "voices" of the subjects of research and beyond that to establish the subjects' interventions into the topic of health. There is a conflation between positionality and intersubjective encounters in the field. As ethnographers, we establish differential positions to engage with the research participants. My work with the Iranian community on the North Shore brought home to me the complexity of the research situation. The first narrative account revealed that I was engaged with disrupted lives: women and men who had lived through the revolution and an eight-year war (Iran–Iraq) and the aftermath that impacted the core of their lived reality: work, family life, community, and a way of life that cannot be easily described. As I began to listen to more accounts, it became apparent that mental health — the state of well-being together with built-in strategies to deal with affective disorder — forms part of the lived reality. Disruption of life compels individuals to draw upon elements of competing discourses and practices, a situation that can be captured in its nuanced form in life narratives. The dynamic at work is that of the individual being affected by the larger reality of life while shaping and reconfiguring this reality in local and in-between spaces that also includes mental health. In order to capture these nuances, I positioned myself to listen to narrative accounts, two of which I relate in this article. My purpose is to highlight one key dimension: the missing elements in the dominant culture with its dualistic epistemology where immigrants and citizens from non-Western countries are separated from those of European origins and where mental health is primarily understood as "illness/depression." As narrative accounts convey the lived experiences of people — remembered and retold in different contexts — they dilute and blur dualistic categories. The intensity through which the narratives were collected does not justify diluting them in retelling the lives. It is in this spirit that I convey the accounts

of two women among several others. The gendered aspect comes into play as primarily women came forward to share their life stories.[7]

Iranians continue to remain one of the least understood minority groups, despite the fact that there are approximately 50,000 Iranians living in urban centres in Canada. Although Iranians like other Muslim groups have been present in Canada since the 1950s, the majority arrived after the 1978-1979 Iranian revolution. About half of the post-revolutionary migrants came to Canada as refugees. The paucity of data on Iranians in Canada makes it difficult to draw any conclusions about the nature of this community. Some recent studies have indicated that, on the whole, Iranian migrants tend to be from a middle-class background with high educational and professional qualifications. One distinct feature of the community is its heterogeneous make-up comprising of Jews, Baha'is, Zoroastrians, Kurds, Assyrians, and Shi'a Muslims (Hoffman 1990). Faced with problems of lack of proficiency in the English language together with bleak prospects of employment in Canada, there is evidence that social and cultural cohesion among Iranians is growing — a process nurtured by the use of the Persian language.

The aim of my research was to explore the issue of mental health among the elderly population. The field situation proved to be different as I soon realized that the categories of "mental health" and "the elderly" as used in the service discourse did not capture the lived reality of individuals and families. My choice of the narrative genre was based on the need to uncover complex and layered meaning of mental health and aging. Thus, I did not exclusively focus on clinical mental health cases, but sought to understand the issue from an interactive point of view: the respondents' points of intervention into the socially constructed categories of "age," "immigrants" and "mental health."

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[7] The following general comments are meant to provide background information for the analysis of the narratives (Farr 1999; Hoffman 1990, 1989; Keddie 1981; Koser 1997; Lorenz and Wertime1980, Mirfakhraie 1999)

Narrativity, Mental Health and Lived Reality

For anyone doing research on ethno-cultural minorities, there are a number of issues that need careful reflection. The first one concerns the demarcation of the socio-cultural and ethnic boundary of the community in question. How do we research communities and talk to individual members who are connected with what Appadurai (1991) refers to as ethnoscapes — the shifting and ever-changing landscapes of people connected to multiple social and cultural traditions. A critical issue here is to acknowledge the fact that cultural and religious minorities engage with the larger society, a point that is overlooked in our concern to research demarcated and socially constructed communities. When it comes to research on mental health, we are compelled to deal with epistemological formulations that cannot be easily addressed. Here we are in the realm of the hegemony of biomedicine that has determined the parameters of sickness presented as universal and objective. Furthermore, as noted above, biomedicine with its tradition of reductionism (Lock 1993) does not address issues of well-being and health. In terms of my research, then, my task did not merely comprise clinical case studies on mental health, understood largely in the context of mental illness and depression. If I had followed this route, I would have not been able to capture the nuances and complexities of lived reality of immigrant women as they go about recapturing meaning and reconstructing lives in their new homeland. It is towards this end that I deploy the narrative genre, which in essence provides insights into how life worlds are reinterpreted and reconfigured in times of change and crisis (Becker 1997; Mattingly 1998, 1994). Unless, the narratives evoke a meaningful response and understanding in the reader, their significance is lost. Thus the position that I have adopted is that of a culturally hybrid ethnography that pursues many voiced narratives grounded in multiple situations. In the following section, I draw upon the analytical framework of emplotment.

A plot contains two structural elements: an underlying story and its "emplotment" towards reconfiguration of the story. Emplotment leans towards the imaginative dimension whereby people reconstruct the stories of their lives by bringing together elements that otherwise do not seem to have an obvious linkage. This reframing brings to

the fore the imagined end conceived in relation to the construction of several possible scenarios (Mattingly 1998).

Plot is that which embodies the story within a larger framework. Among the Iranians in this study, the plot consists of the long period of modernization under the Shah's regime, the 1979 revolution, and the Iran–Iraq war (1980–1989) with its devastating consequences. These developments have led to forced migration of Iranians to the West. As people are compelled to leave owing to political instability, persecution, war and economic debacles, considerable losses are experienced. Immigrant experiences are often attended by a state of liminality — a space of in-between positions from an established past to an unpredictable future. Krulfeld and Camino (1994) note that immigrants (also refugees) are marginalized in their new societies as they experience a sense of alienation and a feeling of not being wanted owing to exclusion from domains of the larger society. "In such positions of liminality and marginality, all aspects of their lives are called into question, including ethnic and national identity, gender roles, social relationships, and socio-economic status. Such liminality does not, however, abruptly begin at the point in which refugees leave their homes, but is rather founded in the turmoil of their lives even before flight and resettlement, continuing during the search for asylum and relocation" (Krulfeld and Camino 1994). These losses are also expressed in relation to mental health. In the words of one narrator: "Mental health problems arise because of worries and insecurities of not knowing what life holds for us and our families." The process of reconstruction of lives necessitates tapping into new resources from within as well as outside cultural traditions. In some cases, adjustments may have to be made on a continual basis as people are often compelled to move in the face of numerous upheavals. Temporary sanctuaries and secondary resettlements seem to be a way of life for many immigrants and this was the case with the subject population that we studied.

The sense of dislocation expressed through the idiom of mental health has been noted in the literature. Social service organizations are cognizant of this issue and have begun to address this concern along the lines of vulnerability of the immigrant population, especially the elderly and women. However, there exists a wide gap between the social service discourse on mental health and the strategies deployed by populations to maintain

their well-being. By and large, service organizations utilize the medical model where mental health is understood in terms of illness symptoms and is addressed in relation to programs put into place with limited and fluctuating resources. The medical model has limited or no space to accommodate the viewpoints of "patients" nor is it geared towards establishing connections with the communities. In the process of adaptation, then, immigrants, while they report experiences of depression, and feeling down, nevertheless engage in creative endeavours to maintain a sense of well-being. The larger plot of migration and resettlement under conditions of marginality includes emplotment — narrative intervention of the subjects as explained above.

The narrative interviews and participant observation over the course of eight months were carried out by a research team comprising the author, one student and two indigenous researchers. Twenty six interviews (two to three for each participant) — forty-five minutes to one hour each — were taped in Farsi, translated and transcribed by the research assistants. The material presented in these narratives draws on women's articulation of their experiences of (re)settlement in Vancouver's North Shore suburbs and their explicit and implicit understanding of mental health, which emerged as centrally important in the context of their lives. Throughout the interviews, varied meanings were attributed to mental health. On the one hand, mental health was conceived by these women as a means to reconstruct lives in terms of a creative process. Also present, on the other hand, were images of unrealized goals and disappointments, also expressed in biomedical terminology. It is crucial to take note of the latter, as it shows active engagement of a marginalized population with the discourse of the larger society. Each narrative has unique features although it encapsulates the concerns of co-peers. This dynamic interplay points to the important role that women play in the (re)constitution of their lives and within broader communities of persons and institutions. "Writing the social" (Smith 1999), where the local is encompassed by and encompasses wider realms, constitutes part of human agency as the latter's engagement with the world is at multiple levels, as was the case with Iranian women.

The First Steps

Sultan came to Canada as a refugee in 1996. She speaks softly with a careful choice of words. She told her story with intense passion.

"The revolution (1979) put an end to my education. I had just finished my high school when the revolution started. All the universities were closed so I decided to work in the bank. I married when I was 26 years old and we went to Germany. My husband was an engineer. I lived there for 3 years and then I went back to Iran with my daughter as I was feeling lonely in Germany. I was happy in Iran, because I had a job and I was with my family and I don't have problems living there as I was used to that situation in Iran. Later on, I decided to come to Canada because of my daughter. It was very difficult for me when I came here, especially for the first year, as far as emotionally, language, and culture is concerned, and now life is much better for me as I know the English language, culture and community better."

Being unable to continue with her education after the revolution, Sultan resorted to the path open to women: work in a "respectable" gender ghetto of bank tellers and get married. Marriage brought in its wake another change. She went to Germany with her husband. While he could go abroad, this option was not available to Sultan as "it was not common for women to live in another place by themselves." She soon discovered that Germany was not the place for her: "My husband was an engineer and busy in his work and I was always lonely and my only hobby was TV and sometimes shopping. They ignore you when you go to stores or they turn their back on you when they see you and in their newspapers they write that foreigners have to leave the country."

This script resonates with the observations made on the reception of Muslims in present-day Europe and North America. Muslims are singled out as the Other and overtly racialized (Modood 1997). What is of interest in Sultan's narrative is that she takes one more step. She uses the word "you" to engage the reader and "they" to implicate the people (general mass) and the media. We are reminded of Bakhtin's observations that words are born in a dialogue and are oriented towards a "future answer-word: it provokes an answer, anticipates it and structures itself in the answer's direction" (1981:280). Part

of the answer's direction is mapped in Sultan's narrative as she explores other avenues, and part of it is embedded in the implicit understanding that eradication of racism and injustice is a collective effort. Finding the situation intolerable, Sultan went back to Iran after the birth of a baby girl and got a divorce. As her daughter started growing up, she realized that she could not continue living in Iran. She wanted her daughter to have a good education and "Iran was not the place where this would happen as the revolution had changed everything. The economy was getting worse and I knew that I had to leave the country." Sultan came to Canada as a visitor and filed an appeal for refugee status. "This was the only way. If I had applied from Iran, I would not have had a chance." The steps that Sultan took to secure a future for her daughter forms part of the larger script of post-revolution migration of Iranians. What is unusual is that Sultan is a woman and this compounded her struggles.

"I did not come to Canada with too many expectations," Sultan continued. "All that I want is a job and an education for my daughter." Sultan was soon to realize that the two goals were far apart. While her daughter was placed in a school within a short time, Sultan's own journey had just begun. She had taken the first step into a new world.

Razia first told her story in a shopping mall near a plant store. Pointing to one of the plants, she made the observation: "I have a plant like that one in my big house in Iran. I have left all my things in my house. When I came here, I was not sure whether I wanted to live here." These words set the tone for her story. The big house in Iran is the space pregnant with meaning as it here that Razia's memories of celebrations, daily activities and social relationships are inscribed. Razia recounted her busy life in relation to multiple tasks: teaching, running a house, bringing up children and maintaining kinship ties — all of which involve intricate undertakings. Razia related how she tried to balance her life so that she had time for everything. "When I first got married, I lived with my in-laws and I did not know how I would manage a household and work. But gradually, I learned how to manage. Women can do a lot more things than men and they manage well." Razia's profile is that of a resourceful person. Things changed for her, when she came to Canada seven years ago to visit her pregnant daughter. "My daughter was feeling very alone although my niece was living in Vancouver, but she still felt alone and she asked us to

come to Canada." After the birth of the baby, she returned to Iran and did not want to come again but her younger daughter refused to leave Iran, unless Razia accompanied her to Canada. Razia decided to migrate for her fifteen-year-old daughter. Like Sultan, Razia's trajectory of migration was determined by her children. Soon after she realized that she would have to adjust to a different life; "both my daughters keep very busy and if we don't spend time with each other, the family can't remain close." Razia attributes the "change" within her family to the larger social order that "makes people work very hard. I cannot blame them because they are pressurized by the society." Razia's own state of loneliness brings back memories:

"I was a teacher in Iran and taught for twenty-seven years. Twenty-seven years is a long time. My career became finished when I came here. I would have liked to work here. But I cannot speak English. Even if I did speak the language, I am not sure whether I would get a job here."

A close reading of this account reveals the presence of two scripts. The first one is that of a woman who has been a teacher for twenty seven years — a long span of life that is likely to be filled with invaluable experiences, especially when it comes to a service sector such as that of teaching. (Razia explained: "teaching is highly valued in Iran and anyone who is a teacher receives great respect.") The second script is drawn from the dominant discourse: "I cannot speak English," and therefore this lack disqualifies her from work. Razia is cognizant of the fact that even if she did have the language skills she is not sure whether she would get a job. Migration for Razia has led to erasure of social and professional life as she had known it "back at home."

Realizing that she had to make her own way, Razia decided to take the first step towards establishing contacts. Her first "natural" choice was her neighbour. Interestingly, Razia approached her because she thought that she could help her: "I usually don't go to visit our neighbour unless I feel someone likes me to go to their homes. For example, I have a neighbour who is a senior, and when I moved to this apartment I visited her regularly and then I thought that she might not like me to visit her and so I stopped phoning her for a few days and she never called me back. So then I stopped visiting her."

While future decades may chronicle the unusual absence of generic communities and networks in our society, for Razia, this was a telling experience. She realized that she would have to look beyond her neighbourhood to ensure that she did not have "too many moments of loneliness. Anyone who is lonely for long is bound to become depressed."

In recounting their initial experiences, Sultan and Razia focus on circumstances of their migration. Both women migrated for their daughters with the expectation that they would have a better future in Canada. According to the women, mental health is part of this process of settling down. Razia put it this way: "Like everyone else, we want to be occupied, have a sense of security and a support system. This is my understanding of mental health."

Sultan's priority is to find work. She is more hopeful as she is younger and she thinks that some opportunities will arise. Razia, on the other hand, has accepted the fact that she will never be able to find work. Both women realize that they will have to chart their own territories to bring meaning to their lives: "All that I want is a job and an education for my daughter." "I keep on thinking about my house in Iran; I want a house in Canada too." These two statements from Sultan and Razia respectively encapsulate their struggles arising from the larger plot of uprooting and resettlement in a new country. Emplotment — reconstitution of life — is an involved process where the issue of mental health is simultaneously reworked.

"All that I want is a job and an education for my daughter"

Soon after coming to Canada, Sultan was able to place her daughter into school "without many difficulties." This last phrase is used in comparison with her own aspirations. At the time of the interview, Sultan was still looking for a job. This scenario may be explained in relation to the primacy of the market-economy model advanced in the work of Eisdorfer (1983). This author states that the market-economy model is structured hierarchically with the youth at the top and "dependant" others at the bottom. Society invests resources in the youth, the first group, in the hope of productivity in the years to come. The second group of adults are individuals engaged in generating goods and services for the broader

population. Society lends assistance to this group at critical junctures, for example, unemployment compensation and health benefits. The third group is composed of the "nonproductive" segment of society: "older adults," stay-at-home mothers, "unassimilable" immigrants and the disabled. This group is at the mercy of the welfare system that essentially determines its quality of life and the state of its health. As a non-English speaking woman from a Muslim country ("unassimilable" individual) Sultan falls into the lower rungs of the hierarchy. She explained:

"I did not want to stay home. I wanted to work. I went to Manpower and they told me that I had to have experience. Someone suggested that I should do some volunteer work. I was given some addresses and so I went to some of these places and they did not allow me to do work of any kind. They told me that I have to have a proper status."

Obtaining the proper status was not easy as the whole process took over a year: "I went through worries for a year as this is the time it took the court to grant me landed immigrant status. This was the most difficult period of my life. I feel much better emotionally as my refugee status is approved. Not only did I worry, but these worries were prolonged as I had to prepare four times for my hearing. Every time I prepared myself for the questions for the court, it was canceled due to absence of the judge or not having the empty room, and then I had to go back after two months. You can imagine how my mind was filled with worries until the next court hearing. In my court, they questioned me for eight hours and because still they were not satisfied and my situation was not clear for them, then they kept it on hold. They were curious to know about my personal life, but anyway it was solved and I was accepted as a refugee here."

This was Sultan's prolonged exposure to the system. Her shaping of the narrative, however, evokes the reader's response through a temporal structure. "I went through worries for a year . . . not only did I worry but the worries were prolonged." First there was the issue of fixing a court date, which in itself took one year; then there were four cancellations. When she finally went for the hearing after a two-month waiting period, she was questioned for eight hours. The year, the months and the hours constitute a frame

that a listener can relate to as our sense of time and its experience constitutes a common ground of communication. The process of temporal distancing of the Other (Fabian 1983), however, has forestalled a situation where we can reach out and experience the world of others which is fundamentally a human world. Narratives provide a space where this human enterprise can be accomplished. The narrators/subjects reconstitute their own stories "in a manner congruent with current understandings; the present is explained with reference to a reconstituted past, and both are used to generate expectations about the future" (Garro 1992:100).

While drawing the reader into her world, Sultan also brings to light the parameters of the larger script of the Canadian immigration system. The latter is evoked in the narrative through the images of the judge, the court room, the long hours of questioning and the probing of her personal life, all of which takes us into the heart of the current debates on immigrants and multiculturalism in Canada. As Foster (1998) has shown, the key issue concerns conflict and contradiction between the social order and social justice. According to Foster, maintenance of social order requires existence of fluent social relationships with relative lack of conflict while social justice calls for "egalitarian relationships, guided by the values of liberty, equality and the rule of law," (ibid:20).

Sultan's arrival in Canada in the late nineties coincides with the government's recognition of Iranians as a legitimate refugee population; this acknowledgment has only recently began to consider the appeals of female Iranians (Mirfakhraie 1999). Nevertheless, the conflict between social order and social justice looms large and impacts on immigrant women. There are greater resources for a person who fits into the immigration system's norm of "assimilable" category — a male middle-class English-speaking individual. Non-English-speaking female newcomers do not fare well in Canada, a fact that has been well documented (Agnew 1996). Sultan's case is no exception, except that her story contains other dimensions. While she talks about her struggles, she simultaneously foregrounds alternative ways of being that bring to light fresh/forgotten insights on the issue of mental health. What Sultan has to say through reconstitution of her narrative may appear to be commonplace — looking for work and the search for

meaning are basic concerns of humankind that need to be highlighted in bold colours, especially for those who are marginalized.

"I keep on thinking about my house in Iran; I want a house in Canada, too"

"I have relatives here but our relationship is not as close as it used to be in Iran. I have some family here but we just go to their home on special occasions like when there is a visitor from Iran and we also go to visit for our New Year. Also, I am not close to my children because they don't understand me. There are some issues that are important to me, but they think they are not important so that is why I try not to talk about these to my daughters. They are busy and they don't have time. My daughters are always tired, one of them works full time and she has children and the other one is a student. They are always busy and tired and we never have time to get together."

Razia paints a picture of feeling cut off from the world. She stated that family is very important in her culture and the experience of familial distance touched her very deeply. More importantly, her situation is not peculiar. It encapsulates the concerns of other Iranians. The message conveyed was explained by one female narrator: "We come here for our children but there is a heavy price as the children get virtually no exposure to our cultural traditions. This creates a distance between them and us." Rupture of intergenerational relationship is identified as a potential source of depression — a point that was emphasized by a majority of the respondents and is reiterated in the literature. Narrative data include other dimensions that are not captured in conventional quantitative approaches. Razia and her cohort are engaged in creating social spaces that have the makings of an imagined community — a term that I use to explain multiple connections. Realizing that Razia's familial and social space is relatively confined, the house in Iran is a source of comfort and solace — a symbol of a transmigrant determined to establish new spaces of interactions. Razia talked about her travels prior to her migration: "I have visited Austria, Sweden and that I liked very much . . . I have seen Spain, that was nice too. I have seen India and I went there to visit my daughter. And before I came to Canada, I went to USA." Presently, Razia's extended family — her siblings — live in

different parts of the world including the countries that she visited. Through her contact with these relatives by means of telephone, letters and exchange of videotapes, Razia forms part of an increasingly transnational Iranian community. Contrary to the popular discourse of divided loyalties, the house in Iran serves as a territorial anchorage for (re)imagining other worlds — emplotting imagined life worlds.

Sultan's search for a job and Razia's endeavour to create social relationships converge into the larger issue of creating meaning in their new environment. I discuss the intricate process of meaning-making — an issue with close connections to mental health — through two narrative moments. I find this theoretical construct to be of value as it shows how subjectivity is constituted both through discourse (Dossa, in press, b) as well as through embodied practice.

Moment One: Remembering Sultan's Encounters

In November 1998, Sultan entered the offices of a female service provider. "I went to the Manpower and told them that I wanted to join an English program. The person there told me, there is a long waiting list. Then I told him that I wanted to do some courses in bookkeeping or computers so that I can prepare myself for a job. I said: 'For me with a child, I want to be active. I don't want to stay at home and the government pay me for years. This does not give me satisfaction. I like to be active and do something for the community. I started to work when I was young and I want to be active all my life.' The officer in charge said: 'There is nothing I can do. I have put your name in the waiting list and we'll call you when there is an opening.'"

The moment captured in Sultan's narration has a context: that of a speaker telling her story to the listeners. By virtue of the fact that stories are grounded in a particular time and place, they are invariably dialogical. The first part of the dialogue refers to the centrifugal dimension (Bakhtin 1981) where Sultan notes that her goal of getting work-related training has been relegated to the margins (long waiting list). She then redirects the conversation to a domain condensed with meaning — essentially a semantic and condensed network . She is a mother who wants to remain active. Apart from moving

away from being a recipient of the welfare system she wants to be a contributing member of society. Once again she evokes a temporal framework but this time her efforts are directed towards rejuvenating the past — "I started work when I was young" — to reinscribe it in the present with the goal to remain "active all my life." Work and leading a meaningful life form the mainstay of mental health.

Sultan's experience with the system leads her in the direction of having to start from scratch. "As it is, it is difficult for anyone to begin a new life in a different place. But when you learn that they do not recognize you and that your past experiences do not mean anything, it is difficult, very difficult." Having realized that she is on her own, she explores in-between spaces to engage and/or circumvent the system. The process of reconstitution is also observable in the way in which she narrates her story. Her switch from the "person" when she is exploring a couple of options (bookkeeping, computers) to the "officer" (who brings a sense of closure) is telling. A story is told to the former; from the latter one knows where one stands in relation to the system. Having learned that there was no place for her within the system, Sultan joined a church group that she was introduced to by the mother of her daughter's friend. "At first I felt very uncomfortable joining a church group but I was feeling lonely. I had to come out. This is also the place where I can practice my English."

Sultan's boundary crossing to use the "Christian" space appears to have occurred from her recognition to maintain a sense of well-being: "If I stayed home and did not go out, I am bound to feel sad." Her pragmatic response arose from the fact that other places were "closed" to her. In her search for new resources, she enters into unusual spaces that she had not dreamed of. Sultan states that she has a mission. "In the church group we talk and I tell them about Iranian culture. This way they have a different picture than what they get from the newspapers." This comment resonates with the observation made by a service provider: "It is though human (cross-cultural) interactions that you can help reduce prejudice." Ironically, Sultan's usage of the Church space is in response to, in her words: "there are not many other communities here. In Iran you do not look for a community. It is there for you."

While in one situation, she accesses the distant space of the church, in another one, she draws resources from within her own (close by) cultural space. "Once I did not have the Care Card and my daughter fell sick and had fever. I phoned my worker and she told me to take her to a hospital downtown. It was raining and I could not take the bus and the journey was long. I went to the North Shore Health and they did not agree to see my daughter without the card. Eventually I took her to an Iranian doctor on the North Shore."

In response to my question as to whether she can count upon other Iranians for support, Sultan explained: "Just because a person is Iranian, that does not mean that you can count on her. A friend of mine who does not speak any English had an appointment with an English doctor. Her daughter who was to meet her could not make it. My friend went to a nearby Iranian shop and asked the store owner to accompany her. The woman told her that she could not help her as it was not possible for her to close the store. Then she phoned an Iranian doctor and asked her if she could do the translation over the phone. The doctor told her that she does not provide this kind of service."

In a second interview, Sultan observed: "Whatever system we have, it will only work if people are responsive. " That systems should be established for the people rather than people having to fit into the system is a moot point. In Canada, the social security system has a profound impact on people's lives as it determines the resources available to its citizens. Assumptions and images on socially created categories, such as immigrants, are elaborated through a set of policies, administrative procedures and a host of service organizations. Who gets what kinds of services is determined by political decisions on the distribution of scarce resources. While working her way through the system and outside it, Sultan spells out what her needs are:

"I would like to be active in my life and have a job. I do not like to stay home and wait until I receive the cheque from welfare every month. I don't like to be useless. This is a perfect place for me to live, if only I could find a job in my profession. It is not just the money. You have to enjoy and get satisfaction. I hope that my child and I could be a

useful person for the community. I think if some one is not useful, then it is not good for oneself mentally."

At a fundamental level, Sultan's needs are no different from those of other citizens. She aspires to live a life that brings her joy and satisfaction. She wants to be a contributing member of the society. This is how she defines the issue of mental health. She is also aware that there are situations "when people feel down and unhappy. If this happens to me I take a bus and just ride until my transfer expires. I watch the people and scenery. I walk around Lonsdale and sometimes I meet someone that I can talk to. I try and keep myself busy." As much as Sultan is engaged in making space through her own initiatives and resourcefulness, she is also utilizing the in-between spaces that exist in the community in which she resides while being acutely aware of paradoxes and dilemmas. She knows that she will not be able find a full-time and secure job for herself. At the time of the interview, the very act of looking for one and exploring different avenues had in itself become a "career" as it occupied her fully. Sultan remains hopeful that she will be able to find something one day. "If I give up hope, it would be difficult for me to keep on going," she explained, her last words during the third interview.

Moment Two: Making Space within an ESL Class

In November 1998, eight adult students have gathered at a community centre for English language training. Canada's demographic reality of being a multicultural society is reflected within the space of a small class: five adults are Iranians (four females, including Razia, and one male), two are Chinese (one male and one female) and one is a male Vietnamese — all members of visible minorities. Their female teacher is white — a retired volunteer. As the majority are Iranians, an Iranian translator/volunteer has been recruited. The spatial framing of the class evokes a narrative text that has been articulated in terms of the hegemony of Western education. My notes as well as those of the research assistants indicate that the content is drawn from two sources: local newspapers and the teacher's own understanding of "functional" knowledge of English. Local newspaper articles include topics considered to be "newsworthy," such as garbage collection and

"discussion" of interesting places in Vancouver, and instrumental concerns that the teacher thought would be of interest to the students: how to apply for a job, how to rent an apartment, what kinds of social services are available in Canada. This exclusively Canadian content acted as a deterrent towards using alternative pedagogy. At one point the teacher asked: "Is there anything else you want me to teach you? I do not always want to bring the topics up myself. I also want you to tell me what interests you." There was silence. Razia related:

"No one said anything because we are still learning about Canada. The teacher was frustrated because we all spoke different languages in class and the teacher could not understand the conversation. She kept on saying that we must all speak English. She even asked us if we spoke English at home. Most of us said we did not. She said: 'If you have come here to learn then you must speak English at home.'"

This scenario provides some insights on the paradoxical nature of multiculturalism, namely that cultural and/or linguistic differences can only be recognized within the distinct and bounded space of one's culture. Outside this sphere, it does not have much meaning. Interestingly, the teacher could only relate to a "multicultural" group through dominant pedagogy and content. Although there were three different groups (Iranians, Chinese and Korean) in the classroom, whatever was said about other countries or cultural traditions was in comparison with the Canadian topics. Other cultural traditions were discussed in so far as they are "safe" and "soft" topics, for example food and festivals. There was no discussion on issues of racism or fundamental problems highlighted in the two narratives: work, meaningful engagement with the world and social interactions. However, it must be stated that the Canadian content was appreciated by the students as were the teacher's efforts to teach them on a voluntary basis.

In response to the question posed by the teacher — "Do you have rules for your children as to when they should speak English?" one Iranian woman said that her children prefer to speak English as opposed to Farsi while the other woman mentioned that her children do not speak English at all. The two languages of English and Farsi are positioned to be not only distant but also engaged in competition. This situation is not

presented to critique the teacher's good intentions of making students learn. The point that needs emphasis is that ESL classes are a reflection of the education system in Canada that has not vigorously explored the issue of multicultural education. More importantly, the competition between languages, cultures, and ways of life has a bearing on mental health. In Razia's words, "when you always have to choose between what is Iranian and what is Canadian, you start separating your time and this affects interactions between people and also between parents and children." It is not surprising that the participants attended ESL class for social reasons as much as to learn the language. This point was brought home to me by an example provided by an Iranian service provider:

"There was one woman who attended ESL class for a couple of years. The teachers thought that she had reached an advanced level and that she should move to another group. I noticed that she was very unhappy and she stopped attending the class. I phoned her and promised to put her back in her original group. You see, finding a group and socializing is very important for people. You can say that ESL class addresses mental health of people. Maintaining mental health is to get the opportunity to socialize with people."

This example shows that contrary to the main thrust of research to identify "cultural" understanding within distinct groups such as the Iranians, Chinese, and South Asians, mental health covers larger issues of life common to humanity. Social interactions and the need to establish social arenas where one's life experiences are recognized and validated are primary areas also recognized by teachers. One example among many others from the ESL class serves to illustrate this point. One day, the classroom was filled with a burning smell. The teacher turned to the Iranian man and said: "You are an engineer, where do you think the smell is coming from?" The man was pleased to be identified as an "engineer." "I am not a smell engineer, he replied jokingly" (field notes [RA] November 1998). This example illustrates some of the social encounters that take place in daily interactions. It is also important to note that all encounters are not positive as racism and prejudice forestall potential interactions among people with different historical, social and cultural experiences.

Being A Postcolonial Migrant

"I have traveled a lot in Iran and I have seen many cities in North, West, East and Centre of Iran. Also before the revolution, I had visited Europe. I visited Austria, Sweden that I liked very much . . . I have seen Spain, that was nice too. I have seen India and I went to visit my daughter. And before I came to Canada, I went to USA."

Razia's travels, as those of many postcolonial migrants, destabilize conventional anthropological notions of nativeness and native places as bounded and reified. Her Iranian identity is not that of a Persian tied to a particular territory. Before her migration, she had been a mobile person. Such a situation gives rise to "inventing homes and homelands in the absence of territorial, national bases — not *in situ* but through memories of and claims on places that they can or will no longer corporeally inhabit" (Malkki 1997:52). The fact that Razia has not permanently moved to Canada — "I have still kept my house in Iran and I often think of the plant in the living room. I hope it is growing" — does not necessarily have to do with two loyalties as the official version would have it, but can be attributed to her attempt to remain a transnational person. Her imaginary world constituted through her family does not have reified boundaries: "I have a brother in California, my sister is in France and my husband's brother is in Germany." The uppermost question in her mind is expressed through an intensely felt tension that exists at the core of the migrant's experience: "How do we participate in the life of the host society and maintain what we value in our culture?" Taken on a level playing field of intercultural dialogue, the tension can be addressed. However, the fact of the matter is that there exists an asymmetrical relationship between the two domains. The culture of the host (Western society) is assumed to have a superior status vis-à-vis the cultures of the non-Western world. Other than its extensive documentation in the literature, its translation into an everyday life situation is revealing. Razia related how a social service worker arranged a couple of classes for "Cooking Persian Dishes." After some time, the supervisor told her: "This is good for entertainment. We cannot offer this program on a regular basis."

Many respondents in this study expressed concern that living in the West can be a lonely existence where the onus is on the individual to find her way around and get settled. For the maintenance of a healthy emotional state, there was agreement that it is necessary to develop non-familial spaces of interactions. Many of these spaces are found in the social service sector where the Iranians constitute the largest minority group. While they are perceived as recipients of the services, this is not always the case. A nuanced reading of the data reveals that the Iranians occupy in-between spaces within which the hegemonic understanding of social services is reworked, as illustrated in the case of an ESL learning program. The importance of these spaces is not recognized and hence symptoms of depression are readily classified as medical and addressed primarily at the symptomatic level largely through medication.

Conclusion

What then may we learn from our (re)reading of the narratives on "mental health"? Does the narrative genre bring us any closer towards formulating an epistemology of "what makes us human?" These two questions have informed this research leading to the following observations.

I began this article with questions on the biomedical definition of mental health grounded in the Western tradition of reductionism. A cursory glance at the narrative data reveals that mental health encompasses a broader domain that includes strategies of well-being as well as the life worlds of people. The subjugation of this commonplace understanding has given rise to the critical/interpretive approach in medical anthropology. While this framework foregrounds the voice of the subjects, it is at the same time cognizant of the impact of the larger forces conceptualized as the political economy. Medical anthropology, however, has not been able to push the frontiers of biomedicine in the direction of embracing issues of well-being. Its engagement with the larger anthropological project of giving voice to the subjects ("patients") continues to remain problematic in the light of the unresolved dilemmas surrounding the "crisis of representation." Medical anthropology has also been slow in conceptually engaging with

the lives of marginalized non-Western newcomers. Knauft's (1996) observations on multiculturalism are valid. This author argues that while at one level, multiculturalism comprises the existence of multiple ethnic and cultural groups within a society, at a more profound level the issue is whether differences are valorized (ibid:250). Anthropology's entry into this field would be valuable as this discipline has long been engaged on the topic of cultural diversity abroad. Its failure to gain a viable entry point at home (that is, within Western societies) is partially due to the fact that anthropology's conventional study of cultures has been based on the assumptions that they are self-contained and bounded units. Of late, critical anthropology has brought to the fore the notion that cultures are in fact sites of contestation and resistance, deeply entrenched in fields of power and representation. It is within this framework that questions on the how, what and why of knowledge production have been brought into focus.

The issue of knowledge production provides several entry points for the study of mental health. First and foremost is Foucault's (1965) premise that the whole subject of mental health, perceived exclusively as illness/"madness" during the time of the European Enlightenment, is nothing more than "a vast silencing exercise in which various authorities have employed rational knowledge to repress the 'unreason' of the mind" (Turner 1995:56). This line of reasoning has given rise to the social and cultural constructionist approach which, by and large, has remained textual and divorced from practice. Second, ground-level service providers and medical professionals are interested in eliciting "cultural" beliefs of multicultural minorities. The tension between the two lines of inquiry has been articulated within medical anthropology. The leap from the ethnographic ventures towards theory is not easily accomplished. Anthropologists are well aware of the tension between well-grounded ethnography and fresh theoretical orientations arising from the fact that the former can remain anchored in the ground while the latter can become divorced from lived reality of people, the *sine qua non* of the discipline. A more challenging task is to engage the discipline with the worlds of people from diverse cultural and ethnic backgrounds to which the issue of gender brings another complex dimension. Not only is gender constructed differently across cultures, but it has also become an integral part of the global circuits of migration and resettlement of women and men.

As noted above, theoretical and ethnographic horizons of anthropology have not been brought to bear on the subject of mental health, primarily defined within Western dualistic epistemology. Here, mental health leans heavily on illness, depression, and schizophrenia rather than well-being. It is important to note that this approach has not made inroads towards addressing the concerns of people labeled as "mentally ill" or "depressed." The medical geographer Hester Parr (1997) has shown that despite the community integration of persons labeled as "mentally ill," there is no marked improvement in their lives. Although these individuals occupy public spaces, they are subject to stigma and the labeling process of Othering — attributes that also existed within more institutionalized settings. They assert their identity and sense of self in places that are not subject to the public gaze (parks, side streets and out-of-the-way spaces).

In the case of multicultural minorities, the contours of the dominant script on mental health take a specific form: (a) the effect of displacement is disabling with the result that it precludes acculturation into the host society; (b) psychiatric evaluation and treatment is difficult owing to the existence of cultural barriers. These points were brought to my attention by service providers at the higher echelons of the organization. My first interview with one service provider was telling:

"These [the Iranian women] people when they come here they don't want to do things differently. They have had a hard time. Revolution, war and separation from family is not easy. But they have to learn to socialize through "Canadian" ways. They should know that going out for coffee with friends is done here all the time; participation in programs is necessary. If they stay home, they will feel depressed."

Service providers entrenched into institutional settings speak the institutional discourse where there is little room for the lived reality of people. Institutional discourse as Foster (1998) and others have argued has a set agenda that in the case of newcomers includes the overarching theme of integration. While this may be a desirable goal, at stake is the issue of how multicultural minorities may also reconstitute cherished values and practices. There are different ways of being human and in this article I have tried to show how this humanness across diversity is linked with mental health. This leads me towards

some final observations on the narrative genre as both a method and an epistemological intervention into the current orientations within medical anthropology.

There exists a large body of literature that has foreground the narrative genre as being central to capturing the voices of the sick and the disabled. Unlike other methods that have their origins in positivist approaches, this genre emerges from the grass-roots level. As Good (1994) has observed: "Much of what we know about illness we know through stories — stories told by the sick about their experiences . . . " (ibid:164). The value of the genre lies in the breadth of contextualization (across different domains) and in its encapsulation of societal and cultural concerns (Monks and Frankenberg 1995). As individuals relate their stories, they shape the cultural milieu of which they are a part. Their impact is felt both in terms of the telling of the story and its reconfiguration — emplotment — and at the level of embodied practice. Both these dimensions are found in Sultan's and Razia's narratives. In (re)telling their experiences of settlement defined broadly in terms of the past ("what it was like before"), the present (disrupted now) and the future (imagined possibilities), both the women reveal reconstitution of life within in-between spaces which potentially point to communities of identity that are "increasingly constructed, imagined, and remembered across disparate spaces and times" (Knauft: 1996:254). Mental health, then, squarely belongs to this arena — an arena where our common humanity may be expressed in terms of distinctiveness of other ways of being. This study brings to the fore two points. First, it is futile to search for and identify distinctly Iranian ideas on mental health. Mental health (inclusive of well-being) is closely linked to the life issues of work, social relationships and meaning-centered activities. Second, the importance of "making spaces" and in-between strategies to circumvent dichotomized categories embedded in Western epistemology seems to be an appropriate avenue for therapeutic intervention.

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