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Economic Insecurity and Isolation: Post-Migration Traumas among Black African Refugee Women in the Greater Vancouver Area

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Economic Insecurity and Isolation: Post-Migration Traumas among Black African Refugee Women in the Greater Vancouver Area

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This research project was conducted as part of a larger study titled, "Raising New Policy Questions through Narratives of Trauma: Case Studies of Refugee and Family Sponsored Immigrants from War-Torn Countries" which is still ongoing and well into its second phase. I would like to thank my supervisor, Dr. Parin Dossa, for inviting me to participate in this project, and for extending me the opportunity to work largely independently and publish my portion of the research under single authorship. I am immensely grateful for her support and mentorship in this work and my doctoral studies in general, and lastly want to acknowledge her assistance in reviewing an earlier draft of this paper.

Abstract

This research project found that economic insecurity and isolation in Canada constitute the two largest forms of trauma for black African refugee women in the Greater Vancouver Area (GVA). Therefore, more than a function of historical events or memory, this research found that black African refugee women in the GVA experience trauma as a continuum of lived experience, which is characterized by power inequalities, and loss of security, control and social connection. Across the women's narratives, idioms of worry and the moral discourse of social justice also figure prominently. These research findings contest dominant Canadian medical and political discourses of trauma and resettlement which exclude domestic (as opposed to foreign) social and economic inequalities and insecurities as forms of trauma, and instead this paper presents qualitative evidence for how trauma is experienced in relation to present-day suffering in Canada. This paper includes a brief genealogy and critique of Post-Traumatic Stress Disorder (PTSD), and outlines a series of programmatic and policy recommendations at the end of the paper.

Introduction

This research project set out to explore the relationship between the lived experiences of trauma, migration and settlement among government-sponsored African refugee women from war-torn countries in the Greater Vancouver Area (GVA).[1] Methodologically, this project was designed with two primary objectives in mind: to open up narrative space for non-hegemonic discourses of trauma and settlement, and to facilitate the generation of programmatic and policy recommendations for African refugee women in the GVA. The former strategy is particularly significant given the predominance of medicalized discourses of trauma, such as post-traumatic stress disorder (PTSD), and the long-standing social and economic inequalities within Canadian citizenship for racialized minorities such as black African refugee women. The latter is significant given the simultaneous visibility and marginality of black Africans within the immigrant and refugee population in the GVA, the seemingly growing numbers of black African refugees in the GVA, a disproportionate number of whom are single mothers, and the internal and external exclusion of racialized women from decision making and policy-driven processes in Canada.

The research project found that economic insecurity and isolation in Canada constitute the two largest forms of trauma for black African refugee women in the GVA. Economic insecurity includes income insufficiency and lack of permanent full-time jobs. Isolation is an outcome of both social exclusion and social withdrawal, is manifest in the practice of staying 'at home,' and includes not feeling welcome, linguistic, economic and structural barriers to social and economic participation, and racism. Family separation from living family members, such as children, parents or siblings, who remain overseas in high conflict areas, also figured as a significant source of suffering and worry, and when combined with experiences of isolation became traumatizing as well. Refugee women in this study were also found to use the moral discourse of social justice as opposed to medical discourses of PTSD when experiencing, analyzing and narrating their trauma. In this way, this research found that trauma is more than a function of historical events or memory; rather, this research found that black African refugee women in the GVA experience trauma as a continuum of lived experience characterized by power inequalities, and loss of security, control and social connection. These research findings contest dominant Canadian medical and political discourses of trauma and resettlement which exclude domestic (as opposed to foreign) social and economic inequalities and insecurities as forms of trauma, and instead this paper presents qualitative evidence for how trauma is experienced in relation to present-day suffering in Canada.

[1] To clarify, the lived experience of settlement refers to the totality of settlement experiences, and includes experiences of settlement services but is not exclusive to such services.

Black African women refugees typically come to Canada having experienced tremendous political violence and suffering. All refugees interviewed for this research project literally ran to escape death, incurring temporary or permanent separation from some or all of their children and in almost all cases from their husbands, almost all described long-term periods of starvation, and over half were direct witnesses to children and adults being burned alive, or knifed or shot to death. All refugee women interviewed for this research project had been displaced from their country of origin for an average of five years, and a mean of 4.5 years before arriving in Canada; fewer than half had the benefit of irregular UN food assistance, and fewer still had lived in UN refugee camps.

Although it was not the intent of this study to focus on pre-migration trauma experiences, many of the refugee women narrated and dramatized pre-migration experiences of tremendous physical violence. Other interviews and fieldwork conducted for this study confirm the predominance of pre-migration physical and economic insecurity (i.e., threat to life and absolute poverty) for black African refugees in the GVA. Indeed, it is the profound nature of many African refugees' pre-migration suffering that foregrounds the moral arguments presented by many of the actors in this research project that proceed in this paper.

Unlike other large Canadian cities, such as Toronto and Montreal, black Africans make up only 3% of the immigrant and refugee population in the GVA, and make up less than 1% of the GVA population as a whole, according to the 2001 Census (Crease 2005). Anecdotally, there is a sense among service providers working with newcomers that more black Africans are immigrating or being resettled to the GVA, but that trend has yet to be confirmed with the results of the 2006 Census still forthcoming. That said, black Africans remain marginal in terms of crude demographics, and political and commercial resources in the GVA. Black Africans in the GVA also face heightened racialized visibility in relation to the overwhelming majority of European and Asian settlers in the region, the continued salience of racial marking among European, Asian and Indian settlers, and the racialization of African-Americans in the U.S. (ibid).

As might be expected for a community with a relatively recent settlement history, this research found that language, cultural expectations and limited professional representation all present basic challenges for community organizations providing care and services to black Africans in the GVA. In the past few years, immigration and settlement services in the region have responded by hiring more bilingual workers of African decent, and health services have worked to find more translators. Black African immigrants and refugees have compensated for potentially undesirable or inadequate public services through participation in ethnic networks, religious membership, and more recently, by establishing parallel services through community-based initiatives. Apart from language

and cultural expectations, service providers in this study also identified the following three problems specific to service delivery: staff is overworked, therapeutic trauma models are too narrow and largely inappropriate to the needs of their African refugee clients, and front line workers have limited mental health training.

Recent counselling psychology literature reveals a growing professional crisis regarding the adequacy of cultural training for mental health workers, and questions how well equipped they are to address the trauma needs of refugees. Central debates include how best to reconceptualize trauma and the therapeutic relationship given western psychiatry's obscurification of the root causes of trauma and its complicity in dominant cultural racist practices, arguing that western therapeutic models may in fact cause additional harm to clients, especially those who have experienced more chronic forms of trauma (Sanchez-Hucles and Jones 2005; Gozdziak 2004; JoMoore 2000). Many mental health professionals have responded to these concerns by expanding the definition of trauma, and exploring the therapeutic value of more generative and community-based counselling (van der Kolk et al. 2005).

In order to contextualize the differing meanings and trajectories of trauma for black African refugee women in the GVA, I present an overview and critique of the literature on PTSD. I have also chosen to provide detailed descriptions of my research methods in order to enhance the accessibility of this paper to a wider audience less familiar with qualitative methodologies, and to facilitate transparent assessment of this study's reliability and generalizability. My discussion of research findings traces the social origins of new traumas for black African refugee women in the GVA, and explores how worry, social justice and home spaces figure into black African refugee women's narratives and experiences of trauma. Programmatic and policy recommendations are outlined at the end of this paper.

A Genealogy and Critique of Post-Traumatic Stress Disorder (PTSD)

PTSD was first included as an official diagnosis in 1980 by the American Psychiatry Association's 3rd Edition Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Referent to the combat experiences of American soldiers in the Vietnam War, DSM-III defined trauma as an external stressor in the form of a discrete event which fell "outside the range of usual human experience" (McNally 2004: 2). The original definition proved problematic because it was unclear what constituted 'usual' in a global perspective, and similarly clinicians were finding that many events which seemed to trigger PTSD, such as car accidents or assaults, were far from uncommon (ibid: 3).

DSM-IV (1994) officiated two significant changes to the diagnosis of PTSD. The new manual preserves the original emphasis on event-based trauma, but introduces subjective perception and experience to the diagnostic criteria, in addition to expanding the range of trauma to include both threat or violence to self or others. This new criteria is included in Part A of the six-part PTSD DSM-IV clinical diagnostic criteria. Part A states that a "person has been exposed to a traumatic event [so long as] the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, [and] the person's response involved intense fear, helplessness, or horror" (APA 2004).

Part B requires that the traumatic event is persistently re-experienced often through recurrent and intrusive recollections, recurrent distressing dreams or waking flashbacks. Part C requires at least two types of "persistent avoidance of the stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma)," often including the avoidance of particular activities, people or sounds and emotional detachment. Part D requires at least three forms of "persistent symptoms of increased arousal (not present before the trauma)," and often includes insomnia, hypervigilance, difficulty concentrating, irritability or outbursts of anger, and exaggerated startle response." Part E requires that symptomatic disturbances last for more than one month, and Part F assesses the severity of the psychological impairment and distress according to length of symptoms: less than three months is characterized as acute; over three months is defined as chronic, and; delayed onset occurs in cases where symptomatic onset is delayed by at least 6 months following the traumatic incident (APA 2004), although this last symptomatic category is increasingly unpopular among clinicians (McNally 2004).

Some clinical trauma counsellors are currently lobbying the APA to include Complex PTSD as a new trauma-related psychiatric disorder (see Bryant-Davis 2005, and van der Kolk et al. 2005; Sanchez-Hucles 1998). PTSD has been highly contested among clinical trauma counsellors working with highly racialized and/or immigrant and refugee populations precisely because PTSD in the DSM-IV (Classical PTSD) only recognizes short-lived event-based traumas, and fails to capture prolonged and repeated interpersonal, political and generational traumas. Indeed, clinical trauma counsellors interviewed for this project for the most part diagnose and treat their refugee clients on the basis of Complex PTSD, even though Complex PTSD has yet to be officially recognized either by the American Psychiatric Association (APA) or Canadian Psychiatric Association (CPA).[2]

[2] The Canadian Mental Health Association does not even include a description of or proposal for Complex PTSD on their website. The U.S. and Canadian Departments of Veterans Affairs, however, both provide information on Complex PTSD on their respective websites. Both the APA and CPA provide access to various proposals on Complex PTSD on their websites.

Complex PTSD builds on the symptomology of Classical PTSD, and includes higher problem incidences with emotional and impulse regulation, memory and attention, self-perception, interpersonal relation, somatization, and systems of meaning or faith; Complex PTSD is generally thought to be harder to treat. Clinicians also suggest that individuals with Complex PTSD also experience a higher comorbidity of PTSD and other Axis I and II disorders, which include depression and anxiety, and personality disorders (Kilpatrick 2005; van der Kolk et al. 2005). Relatedly, some clinicians are also proposing racism and racist incidents as another form of chronic trauma (see Bryant-Davis and Ocamp 2005, Bryant-Davis 2005, Sanchez-Hucles and Jones 2005, and Sanchez-Hucles 1998). They argue that the cumulative impact of chronic microaggressions, in the form of institutionalized racism or more overt racist abuse, can result in traumatic stress symptoms, although the literature is not clear if these clinical advocates are looking for recognition of racist traumas under Classical or Complex PTSD.

Attempts to generate sufficiently inclusive and flexible diagnostic criteria for PTSD have been complicated by the fact that medicalized discourses of trauma are largely discordant with other cultural idioms of distress and trauma. The problem goes far beyond developing cross-culturally valid diagnostic questionnaires; it is really about the cross-cultural validity of trauma as a psycho-pathological condition. The question is, if a person interprets an experience as traumatic, is it necessarily pathological? Or perhaps more to the point, if a person interprets an experience as traumatic, will they necessarily interpret their emotional responses through a medicalized lens of individualized illness and expert treatment?

Critics of PTSD argue that many societies without western medical and psychiatric traditions do not in fact presume psycho-pathology as a result of a traumatic experience. Rather, trauma is far more likely to be interpreted within a socio-political framework; that is, trauma takes on meaning in reference to its social origins and political context (Breslau 2004; Dossa 2004; Gozdziak 2004; Summerfield 2004; Pederson 2002; Das and Kleinman 2001; Zarowsky 2000 and 2004; Antze and Lambek 1996). Within this framework traumatic responses are, if not normalized, then at least politicized within a moral, not medical, worldview.[3] This difference in origins and meaning has significant repercussions for how the resolution of trauma is staged and practiced. A medicalized framework prioritizes internal factors, such as subjective perception and mental culpability, whereas a socio-political framework prioritizes external factors, such as social justice, collective survival,

[3] The critical literature on PTSD typically dichotomizes pathological and normative cognitive responses to trauma. Their point is that traumatic responses, rather than being an indicator of abnormal cognitive functioning, in fact represent healthy cognitive functioning in the face of trauma. This rhetorical strategy is

sustained livelihoods, and morality. When the social, economic and political roots of trauma are kept in clear view, physical and emotional traumatic responses have the potential to be experienced and expressed as moral and political critique, rather than as individual maladaptive behaviour (e.g., Dossa 2004; Zarowsky 2000 and 2004). Resolution in this case may include intrapsychic strategies, but it ruptures the west's predilection for the individualization of suffering and posits healing through a social lens of social and economic equality, human relationships, and moral decency.

Oddly enough, humanitarian organizations are chiefly responsible for the increasing global reach of PTSD; PTSD treatment has now become almost a taken-for-granted dimension of humanitarian assistance (Breslau 2004). Institutionally, PTSD "provides for expression of psychological suffering in terms that are consistent with the chartering motivation of much work in international health: direct response to the impact of particular events, be they natural disasters, wars, or other humanitarian crises" (ibid: 116). Politically, PTSD is appealing to humanitarian organizations primarily because of the way in which "PTSD offers scientific credibility to claims of victimization" (ibid: 120).

Further analysis of the political economy of PTSD suggests, however, that we ought to be cautious about the legitimization of suffering through medicine. In the context of humanitarian assistance, PTSD has become a type of political currency; that is, PTSD confers moral status to the exclusion other forms of trauma and suffering (Breslau 2004; Gozdziak 2004; Pedersen 2002). In fact, in Switzerland, refugee status is contingent on PTSD diagnosis (Breslau 2004: 112). We also need to question whose interests are served when the social, economic, political and historical roots of trauma are occluded, and non-medicalized healing practices are marginalized. Despite attempts to make PTSD diagnoses more accessible to those suffering from more chronic traumas through the incremental universalization of PTSD diagnostic criteria, PTSD does not lend to structural solutions; suffering is legitimated and treated at the individual level (e.g. Sanchez-Hucles 1998), and trauma risks being depoliticized and decontextualized.

While PTSD is in part predicated on the existence of social, political or historical suffering, that context can be easily eclipsed by medicalized explanations and solutions. Introspective talk may be appropriate in various cross-cultural contexts, but an exclusive focus on expert-driven talk therapy hardly resonates with the social, collective and moral resolutions of a socio-political framework (Breslau 2004; Summerfield 2004; Zarowsky 2004). In a sense, these depoliticized and decontextualized outcomes are hardly surprising given the construction of PTSD itself. The focus of

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unhelpful if the truly disordered phenomenology of trauma becomes eclipsed in the process of normalizing traumatic responses.

PTSD is on past events or threats, as opposed to present or future ones (Breslau 2004; McNally 2004). With trauma fixed in the past, moral and political critique is circumscribed.

It is important to note, however, that the application of PTSD in clinical practice is variable. While the majority of service providers interviewed for this project chose to talk about trauma and suffering, as opposed to PTSD, a few clinical counsellors saw PTSD as a way to recognize the social origins of trauma and preserve an element of context within a medicalized setting. In fact, these counsellors were frustrated that psychiatrists predominately referred clients, who they felt were obviously traumatized, with diagnoses of depression, panic attacks or anxiety, and rarely made referrals to them on the basis of PTSD diagnosis. They want to see PTSD treated as a valid clinical diagnosis.

Other service providers resisted the discourse of PTSD altogether, and worked to maintain their inexpertise and prioritize their clients experiences in their practice. As one service provider said, "We don't see trauma as a disorder. We see it as a coping mechanism. We work with survivors, we don't work with victims. So our approach would be more that these are normal reactions… We try to maintain our inexpertise. The person is the expert" (Int. 10). Another service provider avoided defining trauma clinically because she felt it risked reifying trauma: "I feel that in a lot of the stuff that I do it's giving voice, or creating a space where people can just talk about their experiences, and not being clinical about the experience, and not trying to sum it up… Trauma is such a heavy-laden word that I don't think it gives a voice to how people try to sum it up themselves… We don't want to take away from their own experience" (Int. 4).

The point here is that trauma is a flexible social construct, and even among service providers it is widely contested. While some service providers spoke about trauma as linear and event-based, many more viewed trauma as cumulative, and for racialized refugees, their professional experience led them to conclude that trauma is a continuous process. All the service providers interviewed for this research project rejected the Canadian myth that resettlement to Canada saves refugees from further trauma. Instead, with the exception of a few clinical counsellors (three of the eighteen service providers), each service provider defined a category of 'new traumas' which was predominately related to poverty, social exclusion and isolation, and family separation in Canada. These service providers overwhelmingly defined old and new traumas in terms of loss of security, loss of sense of control, loss of social connections, and power inequalities. One service provider spoke of trauma in spiritual terms as "soul-killing," emphasizing how trauma cuts to the core of what it is to be human. Instead of defining experiences such as poverty or isolation in Canada as new traumas, the

aforementioned clinical counsellors understood such experiences as factors which exacerbated trauma, and constituted barriers to treatment.

With respect to trauma as a subjective experience, my interviews with service providers suggest that a relative view of trauma is justified so long as it is context-specific. Many could not explain why some people have their functioning impaired more than others who have experienced similar traumatic circumstances. Service providers who had been African immigrants themselves suggested that part of the answer may lie in the extent to which the benevolent image of Canada is played up internationally, and the disjuncture between expectations and reality that ensues. They said that Canada's reputation for human rights and the portrayals of the west in the movies sets refugees up for inflated expectations: women are not given an accurate description of what life will be like in Canada. They argued that African refugees do not understand the extent to which Canada is a classed-society, and the daily struggles the working poor and unemployed suffer here. This point was so eloquently expressed by several service providers that I have chosen to provide two excerpts:

> In coming to this country, they think they're coming to a place where there's no suffering… They thought they were coming to paradise but all of a sudden they realize you are home bound, you have no job, your husband has no job… You see, they know they are in a refugee camp, they know they are in a civil war, they know they are in a hostile environment, but when they come here, they thought they were in a friendly environment. It takes them by surprise… It's like, you're looking at something pretty and beautiful, and yet, when you reach for it, it's not there. You know, that does something to your psyche. (Int. 1)

> I think that one of the biggest traumas is for women who leave their country with a different vision of the new country they are going to. Because mostly, when we hear about the west, when we hear about Canada, we think of happiness, we think peace, we think love, we think unity. So when you are in Africa, you want to come to this place, you want to come and experience this difference, this new life… And then we come here, we realize that no, there's no Garden of Eden. It's only there for some people, not everyone… So you come here and you hope you are going to enjoy the goodness, but you realize there is no goodness, that it's a struggle. And life becomes a struggle that is forever a struggle. (Int. 20)

These service providers, and many others, felt that the new traumas of African refugees have to be understood in the context of their previous suffering, and their expectations for a better life upon resettlement.

The concept of "social suffering" has gained tremendous popularity among medical anthropologists as a way to capture the multiplicity of everyday violence and suffering which social orders bring to bear on people (Das and Kleinman 2001). The term immediately contextualizes and

politicizes trauma, and opens up trauma to multiple interpretations and intervening strategies. In many ways the concept of 'social suffering' circumvents much of the preceding debate because it does not attempt to distinguish between suffering and trauma; rather the concept of social suffering was developed in response to empirical evidence in which the boundaries of memory, everyday life, public discourse, state practices, and social and political violence were blurred. This research is embedded within the tradition of researchers studying social suffering, as reflected in the project's exploratory interest in the possibility of non-hegemonic discourses of trauma and settlement, and its refusal to delimit or define trauma. The term 'trauma' has been preserved in this project in consideration of policy relevance and contributing to the critical discourse on trauma.

Methodology

Beginning December 2005, this research project spanned six months of data generation, finishing June 2006. Twelve semi-structured interviews were conducted with service providers working with black African refugee women. Eight longer semi- to unstructured interviews were conducted with black African refugee women.[4] Three additional participant observation sessions, including one focus group, were also conducted at one community centre with strong African immigrant and refugee women participation. In total, this project's sample included eighteen service providers and eight African refugee women whom I call the 'women participants.'[5] Interviews between the two sample groups were staggered, with women participant interviews beginning approximately half-way through the service provider interviews. I conducted two women participant interviews primarily in French, and another two were conducted in Arabic with peer-translation. All interviews were audio recorded and transcribed, with the exception of one woman participant interview.

Service providers were initially contacted from a generated list of immigrant services in the GVA and later from colleague referral, and were selected primarily on the basis of their work with African refugee women from war-torn countries, and secondly on the basis of occupational diversity. The best effort was made to secure a regionally diverse sample, however the sample of service providers reflects the distribution of immigrant and refugee social and medical services in the GVA; that is, the majority of the service provider sample was located in Vancouver City, this despite the fact that the majority of new African refugees (and immigrants) reside in the suburban cities of

[4] In one case, one woman and her children were sponsored by her husband who had arrived in Canada three years prior as a refugee. She was included in the sample of refugee women.

[5] Among the service providers, some interviews were conducted in groups of two or three co-workers. Several interviewees in the service providers sample were African refugee women themselves. These interviewees were not included in the group of 'women participants' because they were primarily speaking to their professional experience of working with African women refugees from war-torn countries.

Burnaby and Surrey. The sample of women participants was generated through service provider and peer referrals. Women participants were only contacted after the women had granted permission for the release of their name and phone number. Women participants were paid a $20 honorarium for sharing their story in an interview; focus group participants were not provided an honorarium. All women participants resided in Burnaby and Surrey at the time of the study. With the exception of one case in each sample group, service provider interviews were conducted at their worksite, and women participant interviews were conducted at their home.[6]

Interviews with service providers focused on how they understood and addressed trauma in their community practice, and were approximately 1 to 1-½ hours in length. Service provider interviewees were also asked to speak about the settlement process for black African refugee women in general, the gaps and barriers in mental heath and settlement services for this population, and the impact of traumatic responses on the settlement process. Where possible, service providers were asked to provide case study examples. Interviews with women participants were approximately two hours in length, and were referred to as 'sharing your story' by the women participants and the researcher. Participants were asked to relate their overseas' experiences to the degree they felt comfortable. However, this research was primarily interested in their experiences upon migration and during the settlement process. In relating their post-migration story, women participants were prompted by six possible broad narrative streams including what everyday day life is like in Canada, what makes them happy and sad, what would make their life better, what they like about life in Canada, their use of services, their health, and future aspirations. Autobiographical storytelling is a particularly effective methodology when working with marginalized populations. As Smith and Watson argue:

> For the marginalized woman, autobiographical language may serve as a coinage that purchases entry into the social and discursive economy. To enter into language is to press back against total inscription [by the] dominating structures… Deploying autobiographical practices that go against the grain, she may constitute an 'I' that becomes a place of creative and, by implication, political intervention. (1992: xix)

Autobiographical storytelling has the potential to contest dominant representations, resist the process of individual negation which results in the ideological construction of a generalized other, and politicize individual or otherwise private experiences. Autobiographical stories also have the potential to become collective stories. This is especially the case when women's autobiographical aim is to politicize their personal experiences, or in my case as an anthropologist, when I analyze narrative data

[6] All onsite service provider interviews were conducted with the permission of their employer or supervisor, and women participants were offered the chance to share their story in a neutral location, such as a community centre.

for social patterns. Speaking to the shared nature of storytelling and social suffering, one woman participant spontaneously closed her narrative by saying, “But I talk for all of us, not just for myself” (Int. 13).

Due to the staggered data generation between the two sample groups, I was able to generate an anonymous and safe dialogue between and amongst service providers and women participants. This allowed me to assess the validity of preliminary research findings and analysis, in addition to strengthening my understanding of emergent themes through explicitly comparative discussion. Further opportunities for dialogue between service providers, women participants and policy makers will be made possible through a series of upcoming workshops in fall, 2006.

Profile

The sample of service providers was predominately female (83%) and chosen from a range of professions and community organizations including employment counsellors, settlement counsellors, social workers, clinical counsellors, trauma counsellors, multicultural workers, community outreach workers, and public health nurses. The service providers ranged in age from late twenties to late fifties, with a median and mean age of 42. Nearly all the service providers had an undergraduate degree or higher. As a whole, interviewees outside of medical services (nurses and clinical counsellors) were admittedly over-qualified for their position. Eight of the service providers interviewed were black African and had come to Canada as immigrants or refugees.

The women participants’ countries of origin included Sierra Leone, Liberia, Congo and Sudan. As a group, they had sought refuge in Congo, South Africa, Egypt, Ghana, Guinea, Zambia, Rwanda, Kenya and Sierra Leone. In many cases, women running from political violence arrived in other countries which soon broke into political violence, and were forced to run for refuge again. Women participants ranged in age from 35 to 52, with a mean and median age close to 43 years. On arrival, two were moderately fluent in British English, and another two participants spoke what they called Broken English. At the time of their storytelling, two women participants were fully literate in English, with an additional three fully literate in their first language.

As a group, the women participants arrived with a total of 30 children; all of the women in this study are mothers. Three of the women participants had left behind 2 children each overseas; two of these mothers had lost their children in Sudan and had never heard from them or their extended family since they ran from the country. Only one woman participant had become pregnant and given birth since settling in Canada; another woman was expecting her second child in three months. Four of the women participants lived with their husbands, and another woman had been separated from her

husband; he was still alive in Sierra Leone. Three of the women participants were widowed overseas due to political violence. Four participants had been in Canada between 3-9 months, another two had been in Canada for 2 and 4 years, with the remaining two in Canada for just over 5 years each. One participant had been a government employee in her country of origin, and another two had received college education in nursing and commercial banking, respectively.

Five of the women participants described being troubled by physical and emotional reactions to trauma which were similar to some of the symptoms of PTSD. These women experienced insomnia, flashbacks, panic attacks, inexplicable body pains and headaches, avoided loud noises, and could not watch much TV, especially violent films or news. A few of the women were also hyperviligent at night, and some suffered from periods of emotional detachment and loss of function (2-5 days in length) in which their capacity to parent was moderately to severely compromised. On the whole, the most incapacitating symptoms lessened over time or with medication, although most of the women still practiced several forms of avoidance as a means to suppress intrusive thoughts and memories from their past, and many still experienced somatic illness or ghost pains. Three women participants did not relate any classical traumatic symptoms when we discussed their health, and instead complained of mild depression and somatic illness, which became disabling if they happened to “talk too much” about their life overseas, or “think too much” about their suffering here in Canada or the suffering of their family members still overseas. For all eight women participants, worry figured as one of two predominant idioms of trauma; that is worry was both the trigger and the medium through which trauma was experienced and expressed. The other idiom of trauma was the moral discourse of social justice, or what could be termed socio-political critique.

Research Findings

This study found that economic insecurity and isolation in Canada constitute the two most significant traumas for black African women refugees in the GVA. When combined with experiences of isolation, family separation can become another trauma, although this was not as consistent a finding as economic insecurity and isolation. While economic insecurity is by far the most immediate trauma black African refugees face in the GVA, by all accounts, isolation makes the experience of financial and familial traumas all the more intense; to sit alone at home is to worry. The fact that the home is the primary site where new traumas in Canada are emotionally and physically experienced reinforces the need for social inclusion and social connection among and for black African refugee women in the GVA.

What is remarkable is how clearly the women participants' narratives dispute the dominant medical and political discourses of trauma in Canada which temporally and geographically delimit trauma to previous political violence from 'back home.' Although many of the women currently or previously experienced emotional or bodily symptoms related to their pre-migration and migration traumas, traumatic memory constitutes a secondary form of trauma here in Canada. It is not that the women are uninterested in minimizing the impact of their traumatic memories, which they do in fact find disturbing and at times debilitating; it is more that their experiences of traumatic distress are primarily in relation to present-day experiences of social and economic inequality and insecurity as opposed to social and economic inequalities and insecurities of the past. These women are not living in the past as a PTSD perspective would suggest, rather they experience new traumas as they attempt to make a future.[7]

The women participants also use the moral discourse of social justice to inform their experience of trauma, to express, analyze and critique the social origins of their trauma, and to implicate the Canadian State in their suffering. In this way, social justice functions as a broad alternative discourse to psycho-pathological discourses of trauma. In particular, the women question why the government of Canada would bring them here only to fail to offer them adequate assistance, and have them suffer again.

Government Abandonment and Economic Insufficiency

Government-sponsored refugees in the GVA are all received by Welcome House, a temporary boarding and orientation facility run by Immigrant Services Society of BC. During their two-week orientation, refugees receive free accommodation and are provided a settlement counsellor. Within those two weeks, refugees are assisted in opening a bank account and applying for social insurance and health care, and begin receiving their Federal Refugee Allowance. During their two-

[7] In fact, despite my best efforts to identify ways in which pre-migration and migration trauma, as opposed to post-migration traumas, are likely to impact on the settlement process, I was only able to identify two: social withdrawal and poor language acquisition. While most of the women were unhappy to be spending so much time at home because of how lonely it made them feel, and how being at home offered few distractions from thinking about their past and present suffering, staying at home did offer some women a sense of physical safety and rest when they were most overcome with traumatic memories. This outcome was identified across both sample groups. Almost all the service providers identified poor language acquisition as another impact of trauma on the settlement process. Service providers said that trauma resulted in an inability to concentrate which made it more difficult for these refugee women to study English. The women participants in part contested this interpretation. Several did not dispute that they find it hard to concentrate or that they make slow progress in learning how to speak, read and write in English, and some said trauma made them think more slowly, but most were more likely to blame old age, the distractions of present-day struggles, and disruptions of caregiving responsibilities. Others yet had been able to learn how to speak English in a relatively short amount of time, a few without any formal ESL schooling. None of the women saw their pre-migration or migration traumas as a barrier to employment.

week orientation, refugees must also find housing for their family, but this search is conducted on their own, without assistance from their settlement counsellor. In some cases, leaders within their ethnic or linguistic group drop into Welcome House and provide some suggestions on where to begin looking for housing, and may assist with transportation needs. The failure of the government to assist refugees in finding housing is a turning point in women's participant's narratives. Desperate to feel welcome at a time when the strangeness of their resettlement is all pervasive, the women experience a sense of abandonment and fear that perhaps they are not in fact welcome:

> They picked me up from the airport and took me to Welcome House, it was an Indian girl, but if I see her now, I don't even know her, just drop me there, and I don't see her again until orientation finished. Then show me about me cards, show me how to use bank card… How can you live here by yourself, find house for yourself? I can't even imagine. On my own? We don't expect that. The UN said, when you come, you get a group, they will take over, they help you for get house for you, and try for help you for one or two years, and show you how this country works, how to use the economy, or how things look like to this country. But we don't have no help. After the account, they leave you. They say, 'You need to find a house.' How can I find house? Nobody supports me. I come to this country, how they meet me like this? Nobody support me. Who is the person who is supposed for help me for some other things? (Int. 13)

> We went to Welcome House—Welcome House sent us to a hotel because it was full. So went to a hotel. What I did not like is we are new. Here, we don't know anything. What I don't like about Welcome House is we are new. We don't know where we are, and we don't know where we are going. So, they will just give you money. And they will just say, 'Oh you are here for two weeks. You have to find your own place.' How can I find place? They won't help you to find place. They will say, 'Oh, you take the bus schedule.' Even they won't show you how to take—they will say you have to find place. So we have to find—so we had to ask is there any Sierra Leoneans here. And they said yes. So we have to call—they gave us their number—we call them. So the Sierra Leoneans that we met here, they came to Welcome, and take us around, drive us around, show us different places, help us find house. So that's how we started. But it's like, we wanted to go back. This is the first time we feeling homesick… Like, the way we getting reception was not good. (Int. 17)

Refugees in Canada receive the refugee allowance for a full year, as opposed to provincial welfare payments, and are provided with 6-9 months of free ESL schooling and have the opportunity to take a free home-support course. Refugees must also begin repaying the full amount of their air transportation costs to Canada after six months in Canada. Considering that the average size of African refugee families in the GVA is 4 children, that means families must typically repay air transportation costs for 5-6 persons. Refugees must save a portion of their refugee allowance, income assistance or employment earnings, and make monthly repayments. For example, one woman participant was asked to begin repaying $100 a month while receiving her refugee allowance, but after completing a budget with her settlement counsellor which still did not take into account

transportation costs, she only had $5 remaining each month. In the end Canadian Immigration lowered the monthly minimum payment to $20. The fact that refugees arrive in Canada in debt in the upwards of $8,000 seriously contributes to their experience of economic insecurity, and also seriously deters refugee adults from taking out student loans for college training or upgrading until they have paid back their initial debt to the Government of Canada.

After one year, refugees must begin looking for work. If refugees are unable to find work, BC income assistance legislation still requires all claimants without dependants under 3 year's of age actively look for work. Income assistance claimants are eligible to receive financial benefits for up to a maximum of two years at a time, and to a maximum of 5 years over their lifetime. All the women participants made it clear that they came to Canada expecting to work: in their interviews with UNHRC officials, prospective refugees are told that they can only come to Canada if they are willing to work. Many of the women were also quick to point out that they liked to keep busy, and emphasized their capacity to work either by relating professional work experience or training, or how they made 'small monies' in the markets before and after they had fled their country. For instance this Liberian woman said:

> African women don't like to sit at home for nothing. We are used to work. We go to farms, we make our farms, we trade, we go in the markets, and then, those who are educated they go to work in the offices, teaching, all those things. But if come here, you don't go out to trade again. There are no jobs here, and if you sit at home, you'll be traumatized. (Int. 12)

The problem is that black African refugee women find themselves poorly qualified for jobs here in Canada and largely unemployable. All the women participants, in fact, were frank about their limited job prospects: "Where are you going to get a job when you don't even know the language?" (Int. 19), and "You cannot get a job around here. Even if they offer you casual work, you take it because you know you get no choice. You need money. It's very hard for African women getting jobs around Vancouver" (Int. 13). Six of the eight women participants planned to seek, were seeking or were currently working jobs as cleaners, either in hotels or office buildings. These cleaner jobs were almost always casual and part-time, although they kept holding out hope they would find a full-time cleaner position. The seventh woman was fully literate in English upon arrival and was seeking work as a caregiver for seniors or children. Only one of the women participants was working full-time. She was also fully literate in English upon arrival and was one of the two women who had received college education. She worked alone, outdoors at a variety of worksites as a security guard, where she experienced ongoing workplace safety issues. This participant had completed the home-support

course, but was unable to find work as an a nurse's aid or senior's attendant because, as it turned out, nursing homes only hired students from accredited colleges.

Women with preschool aged children found it particularly difficult to find work. These women could not afford the cost of childcare:

> You have to work, but you can't find work because you have a small child. Where I suppose to leave her? How am I supposed to find work? If my husband works, just by himself, the money isn't enough. And I want to put money away for my daughter's education, for when she grows up. So, I also have to work. But where can I leave her? The daycares are too expensive: eight hundred dollars. Yeah, eight hundred dollars, each month, at the daycare. And so if you are earning eight dollars an hour, and the daycare is eight hundred—then you have your rent. So, if you pay for daycare, you wouldn't have money for rent… But I need to work. If I don't work, I won't survive here. And if I don't work, I'm always stuck at home, and I won't have any money, and I won't have money for daycare, to even have the money to work. (Int. 16)

> Because Africans, even if you one goes to work, the other one stay with kids, for free, for nothing. You know? But here, you know, if you have kids like four years, three years, two years, it's very difficult to stand up to go to work. Here in Canada, if you don't have money, you can't find somebody to stay for your kids. It's not easy. Like me today and tomorrow, I found a job. I know that job is paid very nice [$10 per hour]. But I have to pay somebody to baby-sit. Eight dollars an hour. Yeah. It's difficult... In my country, it is free. You go somewhere, you leave your daughter somewhere, some neighbour. You come back, you find her there. (Int. 14)

In fact women participants and service providers both told me stories about women who had had their children permanently removed by Child Protection because they had to go to work and could not afford to pay for childcare. These women explained that in Africa, it is much easier to go out to work: there is always someone around you can leave your children with, and children can be left at home alone, unsupervised, at a much earlier age.

The women's narratives also problematized the notion that paid employment is always preferable to government assistance. In my sample of women participants, four were receiving federal refugee allowances. None were receiving provincial income assistance, although two had previously received income assistance before the two-year time limit was introduced in the province. So of the other four women participants who were not receiving refugee allowance or income assistance, their monthly family income was generated through a combination of employment earnings and child benefit payments. What is important to note is that only one of these four women had been able to fractionally exceed the sum of her refugee allowance, and none of the other three had been able to exceed what would have been their income assistance rate for their family size; that is, in only one case was the combination of employment earnings and child benefit payments enough to match her

household income with the refugee allowance rate. For all other families, reliance on a combination of employment earnings and child benefit payments meant they were earning anywhere from $100 to $500 less a month than the income assistance rate for their family size.

Given that all eight women participants and their families were living below the region's low-income threshold rate, it should not be surprising that all the women complained about economic insecurity. Women receiving refugee allowances were able to meet their families' most basic needs. To that end, the women had to use food banks on a monthly basis, could not afford transportation and childcare, and had to rely on clothing donations, but with such stringent budgeting were able to meet their families' most basic needs. These women receiving federal assistance were all extremely worried about what would happen at the end of one year when they lost their refugee allowance and had to begin looking for work. Even if they claimed income assistance, they knew provincial assistance was much lower than federal refugee payments, and they worried about how they could survive on these lower rates while having to pay for childcare and transportation while looking for work, and knew that if they were only able to find a minimum wage job their economic position would still not be much improved. Worse still, as these newcomers met with other African refugees who have been in Canada a while, they realized that ever after several years in Canada, they still might not be able to find full-time work, and at that point, they would be ineligible for income assistance.

Again, only one of the four women not receiving refugee allowance or income assistance in this sample had been able to find full-time work. Of the other three, only one had been able to secure part-time work at a minimum wage pay, one was unemployed and another had only been able to find casual work, also at a minimum wage pay. These three under- and unemployed women could not meet their family's daily material needs. These women and their families often went hungry, and could not afford basic Canadian household items like soap and toilet paper. When asked about the inadequacy of their household income, all each woman could say at first was, "It [the money] is not enough" (Int. 13, Int. 14. and Int. 19). The situation was almost unintelligible for them. It was for me as well. Here are two examples.

Example 1: 'My life in x. still follows me here.'

O. is 52 years old. She is the oldest woman participant in this study, and has been in Canada for 5 years. She has four children ages 27, 20, 17 and 7. All of the children are in school still and none of them are working; none of them had been able to attend school before arriving in Canada. O. and her husband insisted that they all complete their high school, otherwise, she told them, they would

have no future here. O.'s husband is ten years older than her and supports the family on earnings from a full-time minimum wage job. O. has not been able to find a job. O. tells me that her husband's health is very poor and that he feels so old, but that he forces himself to go to work because there is no government assistance for the family. While O. should still be entitled to receive a child benefit payment for her 17 year old, an error was made when he was first processed into Canada, and the Canadian government thinks he is 18 years old; Canada has refused to correct the error. Therefore, O. only receives one child benefit payment for her 7 year old, despite the fact that she has two children under the age of 18, and despite the fact that all four of her child are still in primary or secondary school studies.

The family of six survives on a monthly income of $1,400, including the one child benefit payment. Her rent is $780, leaving her $620 to pay for all other expenses. O. has never been able to find work, and speaks only a few words in English, although she has just recently begun attending an ESL class. O. received ESL schooling when she first arrived in Canada, but she was not able to pick up much of the language. She said her mind was like water passing through mud. O. told her story through the use of a peer translator, who speaks of O. in the third person:

> She tried to go to welfare to ask, cause her husband's working, get small money, and the same money, they supposed to pay the rent and they supposed to eat, for heat, to pay the electricity and everything. And she's not working. She's going to school. And she doesn't even have transport. You see, she tried to ask welfare maybe they can give her something small. [They said,] 'We can't give you cause your husband is working.'
>
> She said, when you stay at home, she used to think about the past, like you suffered in x., and you suffered again in y. And to her think, when she came here in Canada, she doesn't like to suffer anymore, like she suffered in x. and y. She know very well is coming to change her life, for another life, not like the same thing used to fall her again. But because no job really, you can't get job, is not easy, is hard to get a job—at least they [could have] something in the future, you can [imagine] you have your own car, you have house, you have job. This is to change the life, you see? But life comes again difficult again for them. And they are growing old, and the children are still in the way [i.e. still dependent]. They didn't arrive where they are going [i.e. have not grown up]. They didn't finished school. They doesn't have job. You understand? That's why is worried at home. She said, no, that life in x. is still follow me. I come live in y. is the same. I think in Canada, it will be the same life. She doesn't like that life again. She doesn't like the life. (Int. 19)

O. argues that the government should support families with dependents, until they finish growing up. She also contradicts dominant political discourses in Canada to suggest that her life is the same here in Canada as it was in the two countries she lived in overseas. O.'s peer translator had heard her friend's story before, but it moved her as well. The peer translator is a recent government

sponsored refugee herself. She said, “When you don’t have any support, me or you, is difficult. That’s why I when I hear this story, I know sometime after one year, I’ll be like her and start to cry. And I don’t like to be with tears again either.”

Example 2: ‘When you come here, you don’t have anybody to help you’

J. has also been in Canada for 5 years. She has four children, ages 18, 15, 11 and 4. J. works casual shifts, and her husband studies English full-time at college. He wants to be a teacher. Her husband works part-time, but all that money goes towards his college tuition and textbooks; he does not contribute to the household income. J.’s 18 year old son is just about to graduate from high school this year. Until this point, he has been focusing on his studies so he can get high enough marks for university admissions, and has not been working. However, her son will begin working soon to begin saving money for university. When J. arrived in Canada she did not speak English, and was unable to attend ESL classes in her first few years in Canada because of her pregnancy and then her childcare responsibilities with her infant. Now ineligible for free ESL classes, J. has still managed to pick up a fair bit of English from her work.

J. is currently earning $450 and $500 a month as a casual cleaner. She also receives $600 a month in child benefit payments, for a total of monthly income of $1,100 for a family of six. Her rent is $800, leaving her $300 for all other expenses. There was a time when J. was working a part-time job, but she became ill and was hospitalized for one week. She lost her job, and for the last three months has been unable to part-time or full-time work:

> I don’t like to talk about my life in Canada because it’s very difficult. Oh, what do I do to my rent, for me? It’s very difficult. The government’s stopped giving me money, make it very small for me and my kids. Where to buy food, where can I buy food for one hundred, and you have like four kids in home? It’s very difficult. How can you finish one month with only the food of one hundred [dollars]? Even if you find a job, it’s very difficult. Even full-time at eight dollars an hour is not enough. It’s not enough to pay rent. It’s really hard to live with this little amount of money. The government should not cut the money you get from them when you earn so little… If you get a nice job, you can pay the rent, no problem. You can buy food, no problem. You don’t have to take a loan. You can truly rest at home. After working, when you come home, you are happy. But, if you work a badly paying job, you ask yourself at work, when you get home, ‘What will I do, where will I find money?’ You ask yourself; it’s no good.
>
> The other thing is, in Africa, you live together, you have time to talk to people, you have time to play with the other person, you have time to laugh. Here it’s not like that. Here, you live to your own home, you stay there yourself, no talk to somebody. You are alone with your kids. If you stay home, you will start thinking, oh my family, oh I don’t have family, something like that. It’s a very hard. If you have someone come to your house, oh, you talk, oh you forget your loneliness. But here

> it's not like that. Here, your mind is not well. I'm looking for job, I'm going to work. I have to pay house. I have to pay food. I am the only one working. So much stress… As refugee [in Africa] you get all sorts of help. You have to think. There, you go hungry? No. They give you eight shillings I think. With that money, you can eat one month, and you pay house, and your kids dress up well. Now when you come here, you don't have anybody to help you. You have to think. (Int. 14)

J.'s rhetorical strategy, "You have to think," is quite effective. She is asking whoever bears witness to her story of suffering to think about the contradiction that she experiences more economic insecurity here than she did as a refugee overseas. She also wants the government to provide financial support to families who do not have enough to live on, especially if they are working.

J.'s life as a refugee was not easy, and until she was able to get UNHRC assistance her and her family often went hungry. While J. describes the political violence in her country of origin as traumatic, she did not experience her dislocation as traumatic because she felt taken care of. Here in Canada, the isolation intensifies her worries about family, money and jobs, and that has manifested emotionally and physically as a form of trauma for her. J. is still severely traumatized by her memories of the political violence, however when the feeling of trauma takes over her mind and body, she thinks as much about how she is barely surviving here in Canada, as she thinks about others who did not survive the violence back home.

All of the women participants expressed that they felt it was the government's responsibility to provide them with employment if they would not provide them with financial assistance. They could not understand either how it was that the government of Canada would bring them here if they did not have the adequate resources to support them. The women participants used their life histories to demonstrate how the lack of support made them suffer again, even though they had already suffered enough in their lifetime and been resettled to Canada so they could live without trauma. The other women participants were struck by the same ironies and contradictions to which O. and J. spoke. Their struggles speak to a collective narrative which reads, "I want to forget what happened to me in x. But is the same thing here; we are not happy" (Int. 18)… "I am living the struggle again, because if you don't have work, you have no money. 'Why, why?' you ask yourself, 'why you came here for?' We don't have no help." (Int. 13)… "You need money to do everything here, and if you don't have it, it's a big stress. Money is everything here." (Int. 17)… "Why the government bring me here? Here they can give you other things, but for them to give you physical money, they cannot give it to you. We need help, we really do. We need to work. We need jobs" (Int. 12).

Sitting at Home and the Trauma of Isolation

The women participants in this study complained that they could not leave their homes because they did not have work, but also because they did not feel welcome; that is, they do not feel wanted, accepted or listened to. Working, of course, does not just get women out of the house; it also provides them with the economic resources to leave the house for social activities. However, economic constraints are only part of the picture. This research found that lack of inclusion negatively impacts women's sense of belonging and self-esteem, and thereunto, their willingness to leave the home. In this case, interpersonal racism plays a role, but the emotional fall-out which accompanies being in a strange country, which is turns out is more expensive than you could have ever imagined, and finding that the government will not live up to its resettlement obligations, leaves the women with a pressing sense of vulnerability and distrust; their sense of self-worth and human dignity is compromised. They cannot find jobs, they are often enough treated poorly at their jobs, on public transit, or in doctor's offices, and the government which brought them here demonstrates a lack of interest in their well-being and that of their families. How can they not but feel unwelcome here. As one service provider said:

> You try to look at the situation as if it is better here, that I am in a safe, free country. But you are always struggling. You are always looking at each other [your husband] thinking, 'What next? Is this the life that I came here to face?' You have so little money. You are so isolated, and so lonely. When there is an activity around you, that distracts you from the me; it's a healing process that gives you some other initiatives. But when you are idle, of course, what do you think about? The depression comes in, the self-beating, the anxieties. You know this life is not enough. Life is even more traumatizing here than when I was living in countries where gunshots were everywhere. You are so isolated. (Int. 6)

Accent can play a significant role too in the experience of social exclusion. Women participants typically did not raise the problem of accent in the interviews, but many service providers did. They related that their English-speaking clients often complained that Canadians could not understand their English. The problem of accents not only diminish refugee women's employment opportunities, as one woman participant found when she arrived for a job interview, but as one service provider commented, herself an African immigrant to Canada, you hear from someone that you can't speak once, and you become shy. You hear it again, and "you think twice. You say, 'Okay, for me, I can't talk again. I stay home. This is not my place here'" (Int. 7). She went on to add:

> Remember, when you are isolated, it comes from somewhere. It's not coming from nowhere. Nobody can say, 'I like to be isolated.' When you are isolated, to me that means something's wrong. And what is it? It comes from somewhere. I think the problem is how society treats newcomers. We need to try to help them, include them

> in this society best we can. Otherwise, some will think, 'Oh maybe it was a mistake to decide to come here.' Some say that. (Int. 7)

F.'s experience of social exclusion is the most exceptional of all the women participants. F. arrived in Canada 9 months ago with three children, ages 7, 9 and 15, and her husband. She does not speak English, but her husband and her children speak a little bit of English now. F. would be attending ESL classes, but became very frightened coming home from school on her first day of class; F. got lost and could not find her way home. F. wants to study ESL at her son's school and is waiting to be registered for a class there. Since coming to Canada, F.'s children have been bullied at school. These children have also begun harassing her at home. Her family has phoned the police, and she has gone to the children's school with a translator, but nothing has been done. On several occasions F. has also been hit and spat on by the bullies. Again, when she complains, nothing happens. These circumstances are not the only exceptional aspect of F.'s narrative. F. seamlessly uses her trauma as critique. Her story is powerfully evocative of social justice as a moral discourse of trauma. Like O., F.'s story is told in third person through a peer translator:

> She said, difficult problem in Canada because she doesn't like to fight. She's tired, to her mind. You know? Your children can be like her children. Her children can be like your children. But the children come to fight her children. They come and start to fight. She doesn't know why. Maybe because she not [perceived] like human being. You understand? Maybe cause she don't know language. Now it start in her mind. She need her mind to be relaxed like other people. Her children must be happy like other people. Even her, she will be happy.
>
> But you must show her you love her. Don't show her that you don't love her. You see? Cause when you love her, she will grow, her children [will be] so happy. But when you show her you don't love her, maybe sometime you don't grow, and stress can make her die and leave them [her children]. You see? They are not happy. People show that they doesn't like her. You see, like this fight. They doesn't like her. When you phone police, police said, [we won't come] until blood come [physical assault occurs]. You understand? She went to the principle, principle said no. You see? Even someone, who is not from this country, and they are still new here, they doesn't know language, you must still show her love. You understand? It's very important. She needs people to show her. They must welcome her well. But now that they leave Welcome House, no one is welcome you. Now depression coming you. The children fight you. You're not safe. You just leave fight in x. You think, 'I am going to be in peace.' But when you arrive here, another problem to fight. Stress is coming again. Yeah. That's why it makes you sad. Her mind is so painful, because, 'Even I am here, they still doesn't like me. I'm not like human being.'
>
> She said, she think, she need a better life. And she needs peace. Peace is very important to her, all the people—when you have peace, you'll be happy. But when you don't have peace, you are not going to be happy. She needs to stay, to grow her children in good way. You see? That's why she thinks about the future, not to go back to x., or not to go back to struggle, or not to face a lot of problem. You

> understand? She needs a good future. She doesn't like to fight with anyone. She needs peace. She's supposed to be happy too. But she's not happy at all.
>
> Now, she's not going anywhere. She stay inside the house. She said, sometimes she's thinking a lot. When she is at home, she's thinking a lot, and used to be difficult for her. She says, it's so difficult for her. No one can understand her. And she doesn't know the language. Always staying inside the house. It's too difficult. (Int. 18)

Along side dominant medical and political discourses of trauma, F.'s interpretation and critique of trauma is provocative. She draws attention to the social origins of her trauma here in Canada, and while doing so frames both the root and remedy of her trauma in terms of human dignity and love.

F.'s post-migration experiences of violence and social exclusion disrupts the benevolent characterization of refugee settlement, and squarely locates trauma within a socio-political framework which takes into account her physical, emotional and social insecurity here in Canada and subsequent denial of peace and happiness. F.'s mind is painful because, in her own words, "I'm not like human being." F. also situates her socio-political critique within an interpretation of trauma as a continuum of suffering. F. wants "her mind to be relaxed like other people," but instead she continues to be traumatized by power inequalities, and loss of security, control and social connections, and like O. in Example 1, worries that her future will mirror her past. Staying at home compounds the emotional fall-out of social exclusion; rather than being a source of peace, F.'s home is a symbol of her exclusion, and the place where her life is made difficult from thinking too much about her problems.

Associating home spaces with trauma and worry is perhaps counter-intuitive for many middle- and upper-class Canadians who equate home spaces with well-being as opposed to vulnerability and distress. However, in this study, the women participants were adamant that being at home is traumatizing. Consider the following three excerpts. Similar to O., J. and F.'s descriptions of the home as a site of worry (i.e. think too much), these next excerpts also demonstrate the intersection of traumatic memory, economic insecurity, isolation and family separation in ways previous examples have not. Rather than constituting clearly demarked events, these excerpts reveal how trauma intersects and overlaps in the home through the idiom of worry.

> If I am at home, I do think a lot of the suffering I endured in x., my father's death. I've started going to school, and I've started going to the community centre. I'm distracted there. If I'm distracted, I can't think about my past. Days that I'm home alone, even with my husband, I think a lot. Yes, I'm always at home. I can't leave. I'm always left thinking, 'How are we going to live, how will I raise my children, how will I find work?' I need to work. I have a daughter. I think a lot of my mom. How is she doing there? How badly is she suffering? Money? I think about all of that. And my mom? How will she leave? If I'm here, my mom should be well too. I

> should look for work. If I'm distracted the memories from back home don't come; I'm distracted. I just don't think about it. I feel good. I just disappears. But when you're home, you can't get out of your head. I get headaches, because you think a lot. It makes your head hurt. Because when you think a lot, you cry too. So it's painful. Suffering hurts. (Int. 16)

> How can I sit here? But most of the time, only I sit here, in the house alone. We not used to that in Africa. Africa we live one house with like fifty families around you in the morning, all them responsible for them [the children]. We eat together. We do everything together. Then we come here, the system change. You have to get house here alone. You stay alone. Oh my god. It hard. What can I do? But if I get work, among friends, or from the working place, it changes. That helping a little bit. But most of the stress again in this country is when we sitting here alone. We don't have no partner. We don't get nobody. And we not used to it, this population. It's a big stress. All African, nobody sit alone. Everyone sits with plenty family. So here, you come and see, just sitting alone, watching TV. You so sour. Sometimes you not want to be here. And even with a job, you work all day, and come home: you watch, you eat, you sleep. You don't even feel it. I sit here me alone. But if you not get anything to do, you sit here in this house. You think this, you think that, think this. You think, think, think, think, think. You think about the financial, you think about the back home. What can I do? I be here. My family? I sitting like this. There is no money, no financial. How can I help my family back home? How can I contribute to this country? I want to become useful. What I feel—I feel so bad, because we Africans no bad, really. We like people, and we just need the encouragement to live in this country, to feel like a human being. (Int. 13)

> If you've been busy in Africa, then you come here, you stay home the whole day, unless some days you look at the TV, but with that, if you don't have anything, you can't enjoy it, you put it off, unless the children are around. If you want to listen to music, you can't listen to music. The music will not sound good in your ears because you will think about the problems, the children's problems. So these are the things. Here I am sitting idly, doing nothing, until three o'clock and I go for my children. I don't like that idea. Just sitting down at home is not good. Because when the mind is not busy, you think about so many things, you see? Especially in the night. I want to be so busy working throughout the day, working for me. The government is supposed to arrange all these things. But likes sometimes you think, think, think, you have a headache, especially when you are lonely in the room. That's why I found these places [community centres]. But if you only stay at home, that's a problem. You think too much, about many problems. (Int. 12)

These three excerpts reveal the interconnectedness of traumatic memory, economic insecurity, isolation and family separation, and demonstrate how trauma is primarily experienced and expressed through the idiom of worry, and strongly manifest in the practice of being at home; to sit alone at home is to worry. Of interest, having husbands at home did not soften the blow of isolation: the women still feel alone. These excerpts also underscore the visceral nature of the women's new traumas in Canada, and how connected their present-day circumstances are to their traumatic experiences.

That home spaces are so clearly associated with traumatic experiences has significant implications for the role of social programming and community participation for black African refugee women in the GVA. For instance, this research found that when the women participants did seek out resources in the GVA, they wanted to engage in pragmatic activities which lent to informal socializing and the development of genuine social relationships. Individualized clinical counselling might very well provide women with some skills on how to cope with panic attacks and flashbacks, and indeed, a few of the women participants were open to developing therapeutic relationships with service providers who practiced home outreach in addition to individual counselling in their own language, but the women were clear that neither of these services would assist them in addressing the trauma of their isolation. Rather, the women overwhelmingly wanted to be given opportunities to *do* things with other women, and in the process, *talk*.

The women participants were very interested in participating in information sessions, parenting workshops, English classes, and community cooking and sewing projects. Some of the women were open to the idea of group therapy, but most wanted the opportunity for less structured peer support. The group of women participants were equally divided on their desire to share their life history, including pre-migration and migration traumas, in a social setting or any environment for that matter. However, all the women wanted an opportunity to talk about their struggles in Canada, and in the process share ideas, and potentially in the process have their struggles acknowledged by people in positions of power, such as government decision-makers, who could change the social structure of their daily lives.

Locating healing in the social, as opposed to domestic or therapeutic sphere, is consistent with the women participants' socio-political framing of trauma which interprets trauma in light of its social origins and political context. The women do not experience trauma so much with respect to their past, as they do with the social and economic inequalities and insecurities of the present. Locating their trauma along a continuum of lived experience, the women posit the resolution of their trauma not through a medicalized mode of therapeutic intervention, but through a social lens of social and economic equality, human relationships and moral responsibility. Their idioms of worry and social justice reflect these central values of equality, relationships and responsibility.

Conclusion

What pulls together all these women's narratives are common themes of loss of security, loss of control, loss of social connections and power inequalities. These are the very qualities that are legitimized as traumatic within dominant medical and political discourses in Canada so long as such

traumas are geographically and temporally fixed in such a way as to circumscribe the embodied moral and political critique of contemporaneous forms of suffering in Canada. The women participants contest such a depoliticized interpretation of their suffering here in Canada, and claim the economic insecurity and isolation they experience in Canada as new forms of trauma. To further underscore the social origins and political context of their trauma, the women emphasized their suffering through an intimate language of worry and a moral discourse of social justice.

The question we need to ask ourselves now, after having borne witness to these stories of suffering, is how we, in good conscience, could ever continue claiming that trauma does not run in parallel; that is, given the autobiographical authority of these women over their own lived experiences, how could we dispute their claim that trauma is in fact a cumulative continuum of experience? These narratives should cause use to rethink our conceptualization of trauma's borders, and the impact of everyday suffering. The power of stories to evoke change is exactly what M. had in mind when she closed her autobiographical storytelling with me:

> It's very nice for you to know some of these things, because we don't have people to talk to, to explain our problem to. So I'm very happy that you are coming out to know, so that even though you are a student, you are doing the research, but I know this will go to the government. Sometime they will know what's going on. They must see on paper, 'Oh this is happening. Okay, let's help.' You know? We must give our own experience, so from that, they will know what to do. Because the government don't know what's going on. They don't know. Canada is not a bad people, but they don't actually know our needs. They don't know what's going on. We tell our stories to UNHRC and that's it. When we come here, nobody knows what we experiencing here, not like you now, asking me so many questions. (Int. 17)

While M.'s conviction that the government of Canada is ignorant to the suffering of black African refugee women in Canada is a more generous reading of the situation than I might be want to offer, her faith in the transformative potential of stories is one I share. The government of Canada and its citizens have a responsibility to address the economic and social roots of black African refugee women's suffering here in Canada.

Programmatic and Policy Recommendations

Both service providers and women participants were asked to make suggestions on what should be done to address the trauma and suffering of black African women refugees in the GVA. The following recommendations represent the most common recommendations put forward by both sample groups.

Extend Refugee Allowance from One to Two Years

Federal Refugee Allowance payments are significantly higher than provincial welfare payments and offer refugees more economic security while they adjust to life in Canada. Black African refugee women are not ready to enter the labour market after one year in Canada. They need more time to study English and potentially begin college training. At present, black African refugee women in the GVA are only able to access minimal employment opportunities, most predominately as casual and part-time cleaners and care aids.

Eliminate Two-Year Time Limit and Increase Earnings Exemptions for BC Income Assistance, and Introduce Extended Benefits for Low-income Earners

In my sample of women participants, only one woman's combined family employment earnings and child benefit payments exceeded the income assistance rate. For all other families, loss of income assistance meant they were earning anywhere from $100 to $500 less than the income assistance rate for their family size. Families living on one minimum wage salary require at a minimum extended assistance with daily transportation costs for all family members, and their children's school costs. Given the predominance of part-time minimum wage employment this population would also benefit from increased earnings exemptions on casual and part-time wages. Finally, the two year time limit has been particularly devastating for black African refugees in the GVA. Without any recourse, these families are supporting themselves on casual and part-time minimum wage jobs. The extent of their economic suffering is intolerable.

Defer or Eliminate Repayment of Travel Expenses

The fact that refugees arrive in Canada already in debt in the upwards of $8,000 in air transportation costs seriously contributes to their experience of economic insecurity, and also seriously deters refugee adults from taking out student loans for college training or upgrading until they have paid back their initial debt to the Government of Canada. The government needs to seriously reassess their policy which obliges UNHRC refugees to begin full repayment of their air transportation costs to Canada within six months of their arrival.

Extend Welcome House Orientation and Provide Funding for Periodic Follow-up

Currently, all refugees to the GVA receive two weeks' free accommodation and orientation at a Welcome House, run by Immigration Services Society. Refugees are unable to absorb much of the information presented to them during this time, and during that time they also need to search for a house without the staff assistance. Refugees make frequent phone calls and visits to their settlement

counsellors in the first few weeks after they leave Welcome House, asking for help on the very issues covered in the two-week orientation. After this initial flurry of contact, settlement counsellors and clients lose touch as settlement counsellors are not required, nor do they have the time, to conduct any follow-up with their clients. This lack of follow-up contributes to a sense of abandonment, especially because Welcome House was their first 'home' in Canada, and a tremendous opportunity for policy and programmatic development is lost as no follow-up surveys or interviews are conducted.

Local, Integrated Services

ESL classes, job search and job training programs, social programming, and if possible trauma counselling, should all be provided in one location, and preferably in or near their child(ren)'s elementary school. African refugee women are more likely to access such services if they coincide with dropping off and picking up their young children from school, and if there is continuity in service provision and staff.

Social Healing and Increased Funding of Social Programming

Engaging in pragmatic social activities, such as information sessions, parenting workshops, community kitchen and craft classes, and ESL classes, were all desirable services for the women participants in this study, because of the way it allowed for unstructured talk and the development of genuine social relationships. Social programming benefits black African refugee women in the way it addresses the trauma of isolation, allows for the development of concrete skills, and also establishes a context for social healing. The prioritization of women's practical needs and opportunities for informal socializing is in part what distinguishes social programming from other group- or peer-based counselling therapies. The emphasis on practical needs resonates with the women's experience of trauma as a continuum of suffering into the present, and in creating opportunities for informal socializing, social programming readily accommodates multiple interpretations and meanings of trauma through spontaneous, participant-driven conversation.

Interestingly, of the many service providers who had been able to carve out niches for group- or peer-based therapies within their practice, found that the quality of emotional and social support and healing generated within more pragmatic and informal settings rivalled (and some argued exceeded) that of more formal therapeutic environments. These service providers had also found that social programming had more potential to be less hierarchical, to normalize traumatic responses, and to emphasize the strengths of each woman. These service providers argued for a more balanced approach. Individual and group counselling can successfully assist women in coping with their most distressing and incapacitating traumatic responses. As such, service providers argued that African

refugee women need better access to linguistically appropriate and culturally sensitive individual and group counselling. But service providers also argued that social programming is an essential, effective and appropriate model for addressing the mental health and settlement needs of African refugee women precisely because it allows women to establish social connections outside of an explicitly therapeutic environment where they are more apt to speak freely and express their own points of view. For these reasons, service providers suggested that social programming and counselling should be considered of equal importance, if not complementary. Indeed, women participants agreed that they would be more likely to access individual or group therapy if their other, more pressing needs were being addressed, and if they had time to develop a relationship with a service provider before engaging in an explicitly therapeutic relationship with that same staff member.

The proposal to staff social programming with mental health workers, however, is problematic and deserves serious reflection by policy makers and programmatic administrators. On the one hand, women participants and service providers are pressing for greater opportunities for social healing which would provide for continuity of service providers and take the continuum of their trauma seriously. However, staffing social programming with professionals trained in western psychiatric traditions risks supplanting non-hegemonic discourses of trauma with a medicalized framework of trauma which prioritizes intrapsychic healing as opposed to social healing, and consequently may marginalize the socio-political worldview of black African refugee women and their social, collective and moral resolutions of trauma generated from a socio-political perspective.

Part of the solution to this tension is to recognize that refugee women who experience trauma are knowledge producers in their own right regardless of the public venue (i.e., social program, or individual or group therapy). Rather than limiting black African refugee women to one particular framework of trauma, service providers ought to prioritize the lived experiences these women, and follow the lead of women who understand and experience their trauma not in terms of their individual culpability or subjective perception as a western might be more wont to do, but rather in terms the social, economic and political context of their trauma.

Universal Childcare

Lack of affordable and safe childcare severely curtails refugee women's employment opportunities. Women with preschool age find it virtually impossible to afford part-time and even full-time work because of their low-wages and the cost of childcare. Full-day childcare for a preschool aged child costs approximately $800 a month in the GVA. That would leave mothers working 40 hours a week at minimum wage less than $480 a month before tax to pay for rent, food,

utilities, clothing and transportation. Large family size can take the ease off childcare costs if teenaged children are available to baby-sit younger school aged-children, however teenage children often cannot assist in the supervision of preschool aged children because such duties would conflict with the times they are at school.

Safer, Less Crowded and More Affordable Housing

Black African refugees in the GVA typically find housing in neighbourhoods with low-cost apartment-rental complexes. Most of the women participants and service providers expressed concern about the visibility of violent assaults, drug abuse and small property crimes in their residential complex. Standard apartment sizes are also inappropriate to the size of many African refugee families. It is common for families with 4 children or less to live in one or two bedroom apartments, and families with 5-6 children are living in two to three bedroom apartments. African refugee women also have difficultly convincing prospect landlords to rent to a family with more than 2 children.

Employment Assistance

While most service providers were more apt to argue that black African refugee women experiencing pre-migration and migration traumatic distress should be exempt from having to look for work, most women participants argued that they wanted to work as a way to keep their mind busy and to get them out of their home. The women participants also argued that after one year, employment assistance was economically essential as most of them had been unable to find full-time employment, even after having been in Canada for several years. All the women argued the government should be responsible for helping them find work so long as the government refused to offer them income assistance. The women participants offered no specifics in terms of how the government should negotiate such complex issues as the type of work—day-time, night-time, casual, part-time, full-time—and the amount of remuneration.

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