The Forgotten Majority

Of the thirteen million refugees around the world today, the majority are women and girls — a "forgotten majority" who constitute three-quarters of the world's refugee population. However, the special needs of refugee women and the difficulties they encounter in adapting to a new way of life have only been lightly considered. To understand the struggle for refugee women in rebuilding their lives is a first step toward assisting them in the process of integration with Canadian society.

Since the Second World War, almost half a million refugees have settled in Canada, about half of whom are women. In the last decade, most refugees have come from the Third World — from South-East Asia, Latin America, and Africa. Many arrive in Canada with little or no ability in either official language. In 1986, nearly 40 % of all women immigrants 15 years of age and older claimed that they had no knowledge of either French or English prior to arrival in Canada. This figure was much higher for Family Class (43.9 %) and Refugees and Designated Classes (80.8 %)[1] According to the United Nations High Commissioner for Refugees, a refugee is any one "who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group or political opinion, is outside the country of his/her nationality and is unable, or, owing to such fear, unwilling to avail himself/herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence, is unable or, owing to such fear, unwilling to return to it."

Before arriving in Canada, a refugee may typically have spent months or years in transit from country to country. Particularly for those from the Third World, this flight to asylum may have been preceded by years of war, persecution, and torture in their homeland.

The far-reaching effects of a prolonged process of terror, flight, and resettlement have strong gender implications. The physical and psychological difficulties are pronounced for the refugee women, for whom the sense of cultural, religious, socio-economic, and sex-role dislocation is most marked. Notwithstanding the diversity of their backgrounds, refugee women share a commonality of experience — that of escaping from intolerable life-threatening circumstances, and being traumatically dislocated from their beloved family and homeland. Many are female heads of families, whether widowed, unmarried, or temporarily separated from their husbands and/or children. Some are young, unaccompanied minors. Others are elderly, homebound, or pre-literate.

During flight or while in camps (when physical sufferings and torture confront both men and women), sexual exploitation, enslavement and rape are prevalent for women. Often a woman is threatened or sexually attacked to humiliate or dishonour her husband, the male members of her family and her social group, or to punish her for involvement in political activities. The high incidence of pirate attacks against asylum-seekers in the South Seas involved brutal and sustained sexual violence. The most vulnerable are the youngest victims and the single women without family support. Unfortunately, there is also the "double back" effect in some cultures when the violated women are considered shameful and worthless. The family and community are not always supportive and relations with spouses can be strained.

BY CHRISTINA LEE

The results of torture can leave deep emotional scars. The American Psychiatric Association describes symptoms of disorder typical of torture victims as the "post-traumatic stress disorder." The symptoms include a re-experiencing of the event through painful, intrusive recollection; recurrent dreams or nightmares; feelings of being detached or estranged from others; loss of the ability to become interested in things which a person had previously enjoyed; and problems dealing with intimacy. These symptoms may emerge shortly after the trauma or may be delayed for years. Other symptoms observed are deep depressive states; social withdrawal; paranoia; feelings of dependency; incompetence; and nostalgic reaction, and suicidal preoccupations.

Psychological diagnoses often belie the lived reality and private experiences of the refugees. Cultural adjustment in the final resettlement country attests to these difficulties, most of which can be traced to the root causes in the refugee experience, some of which are compounded by the socio-economic and immigration structures of Canadian society. Often, the undeniable benefits of a safe political asylum, better health care and education are largely outweighed by resettlement difficulties. Lack of language and job skills, lack of access to information and services, and lack of positive reception from the host society, can have a debilitating impact on refugees. These external constraints are often compounded by the loss of extended family and supportive networks, the tremendous guilt of leaving behind loved ones, and decreased self-esteem in one's inability to cope with a new environment.

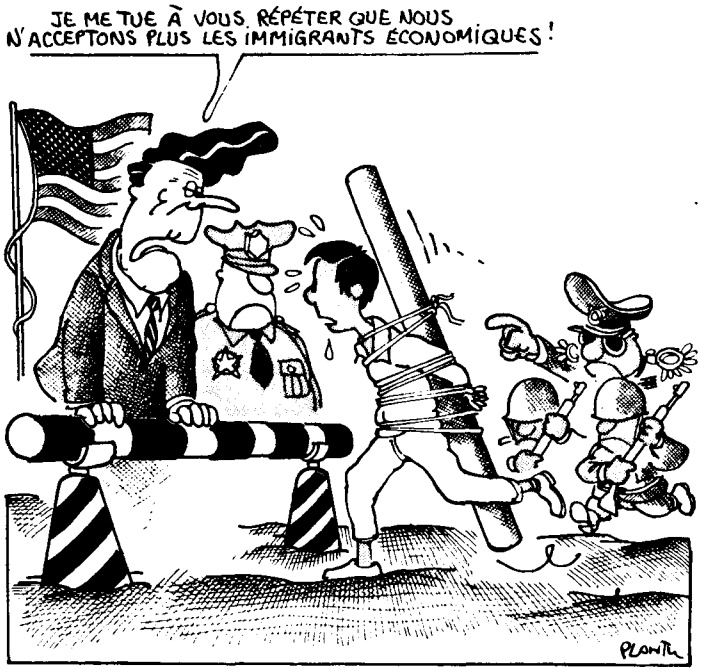
Refugee women are doubly disadvantaged by their gender and refugee status. They are constrained by their own traditional gender roles and the marginal status of their husbands in the new country. This situation is reinforced by the structure of our Canadian refugee applications: over 80% of applications are made by men,[2] thus perpetuating the dependency of women, legally, economically and psychologically.

Women's pivotal role in the family is well acknowledged. For the refugee families, the role of women is even more crucial upon arrival in a new country. Most of the rebuilding of the family depends on the women. Language and housing often emerge as the most urgent problems upon arrival, according to New Experience for Refugee Women (a Toronto-based agency assisting Latin American refugee women). Other problems include dealing with the climate, finding a job, transportation, and daycare. Due to the lack of language skills, non-verbal communication may be used to learn the most basic living conditions, such as turning on the hot and cold water, using the electric stove, travelling on the subway, etc. Culture shock and information overload tend to predominate the new life of the refugee.

As the family begins to settle into their daily routine, the problems of adjustment are greatly exacerbated by the acute dislocation of traditional family roles. For example, Vietnamese women in the United States have adjusted to the workforce more easily than the male members of the family, even though the women may say that they are not working in order to help their husbands save face. They may be employed in the secondary labour market, doing part-time and piecemeal jobs. Women appear to be less concerned than the men about "status inconsistency" and downward socio-economic mobility primarily because their occupational status at home usually was below that of the men. As a result of having to work several jobs outside the home, the women are progressively less able to fulfill their traditional duties as mothers and wives. At the same time, the men may be displaced from their traditional dominant role as family breadwinner.

Role change has profound implications for the refugee women. This conflict is heightened when the women come from extreme patriarchal cultures in which gender oppression is most extreme. The sharp contrast in the women's roles between Western and non-Western cultures can become very stressful when entry into the workforce exposes the women to values that are diametrically opposed to those of their culture of origin.

Despite their diverse occupational backgrounds, employment available to refugee women is often ghettoized in such jobs as cleaners, factory workers, and sewing machine operators. Refugee women can expect to spend the rest of their working lives in Canada in a workforce characterized by menial wages, shiftwork, health hazards, and layoffs. Economic necessity may compel refugee women to work in impersonal, industrialized settings or may force them to deal with the public more than their traditional culture would allow. The whole job-search experience can be traumatic. Latin American refugee women had never been in the position of having to market themselves and their skills to employers. Jobs at home were usually found through friends or relatives. In Canada, they are faced with job advertisements, interviews, application forms — all of which require a level of English and skills that the women do not have and a bureaucratic process they are not familiar with.[3] The threat of deportation makes the situation worse for illegal refugee women. Thus, the transition for refugee women, both at home and in the workplace, has been described as a "compressed modernization process."



Cartoon: courtesy *Le Monde diplomatique*

However, studies on the mental health problems among refugee women have been inconclusive. For example, Vietnamese women self-rated mental health problems were least frequent among respondents

with the least westernizing experience in terms of formal education and English.[4] It also appears that Vietnamese women of reproductive age had a higher incidence of mental health problems than any male age group; the higher stress scores could be attributed to increased demands of childrearing and job seeking.[5] A recent Montreal study reveals the sudden reversal of roles between husbands and wives and parents and children. Housewives and school children became the primary economic providers, while the husband-fathers were lamenting the loss of status and property. Their self-esteem eroded as a result of prolonged or periodic unemployment.[6] Domestic problems (such as conflicts between spouses and children and the threat of physical violence) can result.

Given the important role of women in maintaining the health, cultural identity, and general welfare of the family, assistance to refugee women is most critical in stabilizing the resettlement situation for all family members. However, refugee women tend to under-utilize the mental health, health and social service delivery systems, both preventive and remedial. Non-English-speaking refugee women have continued to turn first for aid to sources most familiar to them, for example, self-help, indigenous healing methods, or they may rely upon ethnic workers from community centres and immigrant women's agencies. Most women have little concept of preventive or Western medicine and they are reluctant to utilize general public health services except in emergency situation.

There are a number of barriers to seeking help for mental health problems. Many cultures attach a stigma to mental illness. Family pride and the fear of deportation prohibit the discussion of domestic and personal problems. Other concerns include a lack of information about available services and the skills to access these services. Most mainstream institutions (such as hospitals or clinics) have no multilingual counsellors or trained interpreters. The client can generally expect to receive little more than medication or custodial care. In the case of family violence, most transition homes across the country are developed for English-speaking clients, which again pose tremendous cultural and linguistic barriers.

"Those who work with refugees show relatively little concern for the refugee pre-immigration experience; their orientation... is that the refugee has no past, only future..." states Dr. Libuse Tyhurst, a psychiatrist well known for her work on Canadian refugee resettlement. As a result, resettlement has been perceived as "a unidirectional process" aimed at developing the optimal productivity of the refugees. Due to the lack of understanding of the refugees' past, most mainstream caregivers can not provide effective counselling, while ethnic professionals are overwhelmed by huge case loads and insufficient resources.

How can we begin to help refugee women?

- There is a dire lack of information on refugee women. Collecting data on the adjustment issues of refugee women, and identifying the facilitating and hindering factors in their resettlement process should be a priority in research and program delivery.

- Mental health, health and social services must address the access issues for refugees by developing active multilingual and community outreach.

- Appropriate assessment and referral methods should be culturally sensitive, for example, a resource directory with a network of professionals and experts on refugees and survivors of torture should be made available to community agencies.

- Staff development of service providers such as social workers, psychologists, and psychiatrists must include sensitization training and crisis intervention with refugees.

- Outreach programs must be created to educate the male members of the refugee community. These programs should aim at changing perceptions regarding the roles of women within their own families and communities, and at developing new ways of communication and conflict resolution.

- Refugee women must be involved in the planning and implementation of programs affecting them (for example, counselling, self-help support groups, educational and job training programs, health care, and prevention services).

[1]S. Seward & K. McDade, *Background Paper on Immigrant Women in Canada: A Policy Perspective* (Ottawa: Canadian Advisory Council on the Status of Women, 1988).

[2]National Action Committee on the Status of Women, *Refugee Women and Bill C-55*, 1987.

[3]The Report from New Experience for Refugee Women, Toronto.

[4]P.D. Starr, A.E. Roberts, R.G. LeNoir, T.N. Nguyen, "Adaptation and Stress Among Vietnamese Refugees: Preliminary Results from Two Regions." *Proceedings of the First Annual Conference on Indochinese Refugees* (George Mason University, October, 1979).

[5]K.M. Lin, L. Tazuma, M. Masuda, "Adaptational Problems of Vietnamese Refugees," (*Archives of General Psychiatry*. Vol. 36, 1979).

[6]K.B. Chan & D.M. Indra, *Uprooting, Loss and Adaptation: The Resettlement of Indochinese Refugees in Canada* (Ottawa: Canadian Public Health Association, 1987).

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