Resilience in African Female Refugees and Internally Displaced Persons (IDPs) Living with Mental Health issues

by

Declan T. Amadi

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Faculty of Social Work

University of Manitoba

Winnipeg, MB, R3T 2N2

Abstract

Internally displaced persons (IDPs) and refugee problems are a global phenomenon (Virupaksha, Kumar & Nirmala, 2014; UNHCR, 2020), drawing much attention in the 20th and 21st centuries (Martin, 2014). Migrating to another country to seek asylum is a process which involves phases through which refugees must go. Often times, "lack of preparedness, difficulties in adjusting to the new environment, the complexity of the local system, language difficulties, cultural disparities and adverse experiences would cause distress to the migrants" (Virupaksha, et. al., 2014 p.1). Forced displacement is rampant in Africa; compelling people to abandon their homes and seek shelter elsewhere (Crisp, 2010). Female IDPs are the most vulnerable and endure variations of gender-based violence, sexual and physical, which consequently have detrimental effects on their psycho-social health (Adeyinka & Akinsulure-Smit, 2014; Gebreiyosus, 2014). This research sought to discover the abilities of refugee and IDP women to regain and maintain their optimal daily functioning despite their mental health issues.

This study adopted a general qualitative exploratory approach, guided by feminist and anti-oppressive (AOP) theories. Three refugees and three IDPs were interviewed. Data were transcribed verbatim and in-depth thematic analysis conducted, which enabled me to seek out overarching categories and themes that describe and interpret participants' views.

The result showed that uncertainty, trauma, family stress, unemployment, financial stress, racism and discrimination were major factors that contributed to mental health issues; while family and social support, religion and faith in God, sense of responsibility towards children, music future orientation (optimism and hope)**,** education, employment and volunteerism were resilience factors.

In conclusion, I discussed the implications of my research for theory, policy and practice; as well as further research suggestions. AOP and feminist theories may be beneficial in

understanding and improving the lives of refugees and IDPs. Cultural perspectives on resilience theory may illuminate the role of culture as a contributing factor to resilience, rather than as a risk factor. Policy wise, host countries are encouraged to enact policies that expedite family reunification; since family plays a very important role in facilitating recovery. Practitioners and service providers are encouraged to consider the perspectives of refugees on the mode of treatment and also explore the religiosity of their African clients in order to foster resilience.

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I also thank all my family and friends for being there to share in my highs and lows. To my sweet boys Jason Baba and Buchi (Declan Jnr.), thank you for giving me the strength and courage to tackle each day. You are the reason for my happiness; you are my everything and I love you two with all my heart. God bless you guys really good.

Dedication

In loving memory of my mother Mrs. Francisca Amadi.

You labored so hard to raise me well. May your soul continue to rest peacefully in heaven.

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Chapter One: Introduction

This research study aims to understand how female refugees and internally displaced persons (IDPs) of African origin maintain resilience amid their mental health conditions throughout the migration and settlement process. It seeks to explore the characteristics or factors which strengthen their perseverance and their capacity to withstand migration stressors and adversities.

Many countries in the continent of Africa have struggled under the burden of numerous social, political, and economic quagmires, including, but not limited to, poverty, famine, disease, and corruption (Adeyinka & Akinsulure-Smith, 2014). During the past four decades, fear of persecution, war, human rights violations, and other types of instability have led millions of people from many African countries to flee their homes and seek safety in foreign countries where they are likely to be isolated, and suffer through poverty and uncertain futures (Crisp, 2010; Stein, 1981; UNHCR, 2011, 2020). This mayhem has risen dramatically in the last two decades due to the explosion of armed conflicts and religious, ethnic and political tensions throughout the continent. The consequences of this havoc have been devastating for various African countries (Adeyinka & Akinsulure-Smith, 2014).

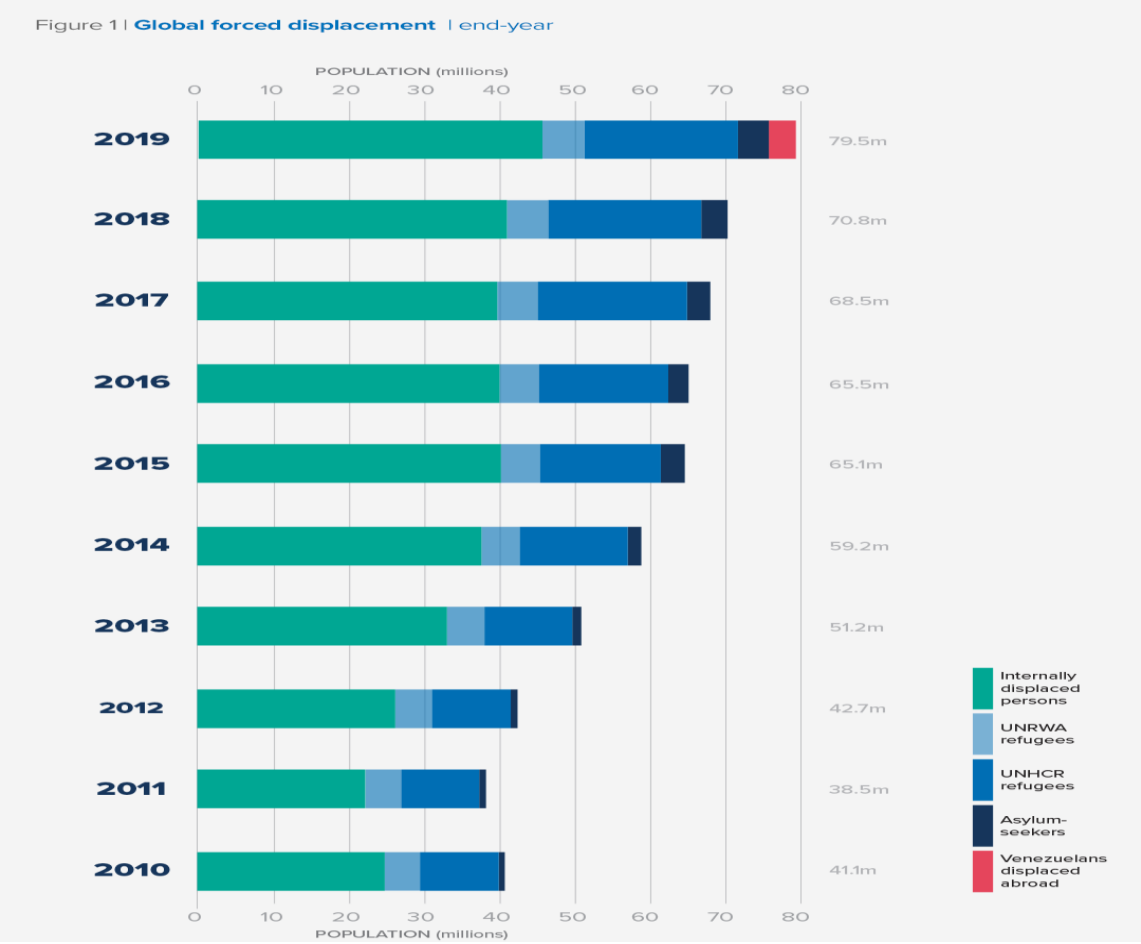
By the end of 2018, 70.8 million individuals were forcibly displaced worldwide as a result of persecution, conflict, violence or human rights violations (UNHCR, 2018). That was an increase of 2.3 million people over the previous year. This includes: 25.9 million refugees, 41.3 million IDPs; and 3.5 million asylum-seekers (UNHCR, 2018, 2020). One person becomes displaced every 2 seconds; that is less than the time it takes to read this sentence. This means that 30 people are displaced every minute. One in every 108 people globally is either an asylum-seeker, internally displaced or a refugee (UNHCR, 2020).

As of 2019, the number of displaced people rose even higher. The most recent figures released by UNHCR in June 2020 revealed a new high in the unending upward trend for forcibly displaced people worldwide. At the end of 2019 there were 79.5 million refugees, asylum-seekers and internally displaced people globally. This new high represents an increase of 8.7 million since the end of 2018 (Armstrong, 2020; UNHCR, 2020). Little wonder the UN High Commissioner for Refugees Filippo Grandi opined that the migration world is witnessing a changed reality in that forced displacement nowadays is not only vastly more widespread but is simply no longer a short-term and temporary phenomenon (UNHCR, 2020).

Currently, there are an estimated 24.2 million displaced people in Africa, an increase of 4.6 million since 2016. This includes 6.3 million refugees and 14.5 million IDPs; 52% of African refugees are women while 57% are children (UNHCR, 2020). The above statistics show that 34% of the world's displaced people, 24% of the world's refugees and 34% of the world's IDPs are Africans. Presently, Africa constitutes only 16.6 per cent or 1.3 billion of the global population of 7.8 billion, (Worldometers, 2020). Yet, more than a third of the world's displaced persons are African. Contrary to the popular belief that displaced people migrate to the Western world; research shows that developing regions hosted 86% of the world's displaced people (UNHCR, 2015). In order to throw more light on the preceding discussion so far, I will present a figure that describes the number of forcibly displaced people worldwide in the past ten years; 2010 to 2019. The figure visually represents the number of displaced people worldwide by year, population, and category (IDPs, Asylum seekers, and Refugees of various classifications such as United Nations Refugees and UNRWA refugees. UNRWA means United Nations Relief and Works Agency for Palestine Refugees in the Near East. It is a UN agency that supports the relief and human development of Palestinian refugees. I am not sure why it was necessary or significant for UNHCR to represent UNRWA refugees and Venezuelans displaced abroad differently from other displaced people.

Figure 1.

Number of forcibly displaced people worldwide by year (2010-2019)



Note. Figure one, number of forcibly displaced people worldwide shows the total number of displaced people globally. The numbers to the left represent the ten-year period from 2010-2019. The numbers, 0-80 at the top, bottom and to the right signify the population of displaced people in millions. The green color denotes IDPs, the sky-blue denotes the UNRWA refugees, the dark blue signifies other UNHCR refugees, the black denotes Asylum seekers and the red represents Venezuelans displaced abroad. From "Global Trends Forced Displacement in 2019", by UNHCR, 2019. Retrieved from (https://www.unhcr.org/globaltrends2019/). Copyright 2020 by the United Nations High Commissioner for Refugees, UNHCR (used with permission).

This thesis involves two different samples, refugees and internally displaced persons in two different settings. The refugees on the one hand, are already living in Canada and include three women who immigrated to Canada as refugees and are now Canadian permanent residents or citizens. On the other hand, the internally displaced persons include three women who were displaced by terrorist groups and herdsmen, and they live in an internally displaced persons camp in Nigeria. All the IDP respondents are Nigerian, while the refugees were from various parts of Africa. One of the reasons for choosing IDPs from Nigeria is because Nigeria has the largest populations of IDP'S and refugees in Africa, followed by the Democratic Republic of the Congo, Sudan, Somalia and Central African Republic respectively (Internal Displacement Monitoring Center, (IDMC), 2013). More so, according to the World Health Organization (WHO), as cited in Aljazeera News, (Oct. 2, 2019), Nigeria has Africa's highest number of cases of mental illness and ranks 15th globally, in the frequency of suicide. One in four Nigerians (about 50 million people) suffer from some kind of mental illness. Yet, there are fewer than 150 psychiatrists in a country of 200 million. It is estimated that fewer than ten percent of mentally ill Nigerians have access to the care they need (Aljazeera News, Oct. 2, 2019). Another reason for recruiting internally displaced persons from Nigeria is the ease of access. Since there are many IDPs in Nigeria, and also the researcher is from Nigeria, it was easier to gain access to IDP camps.

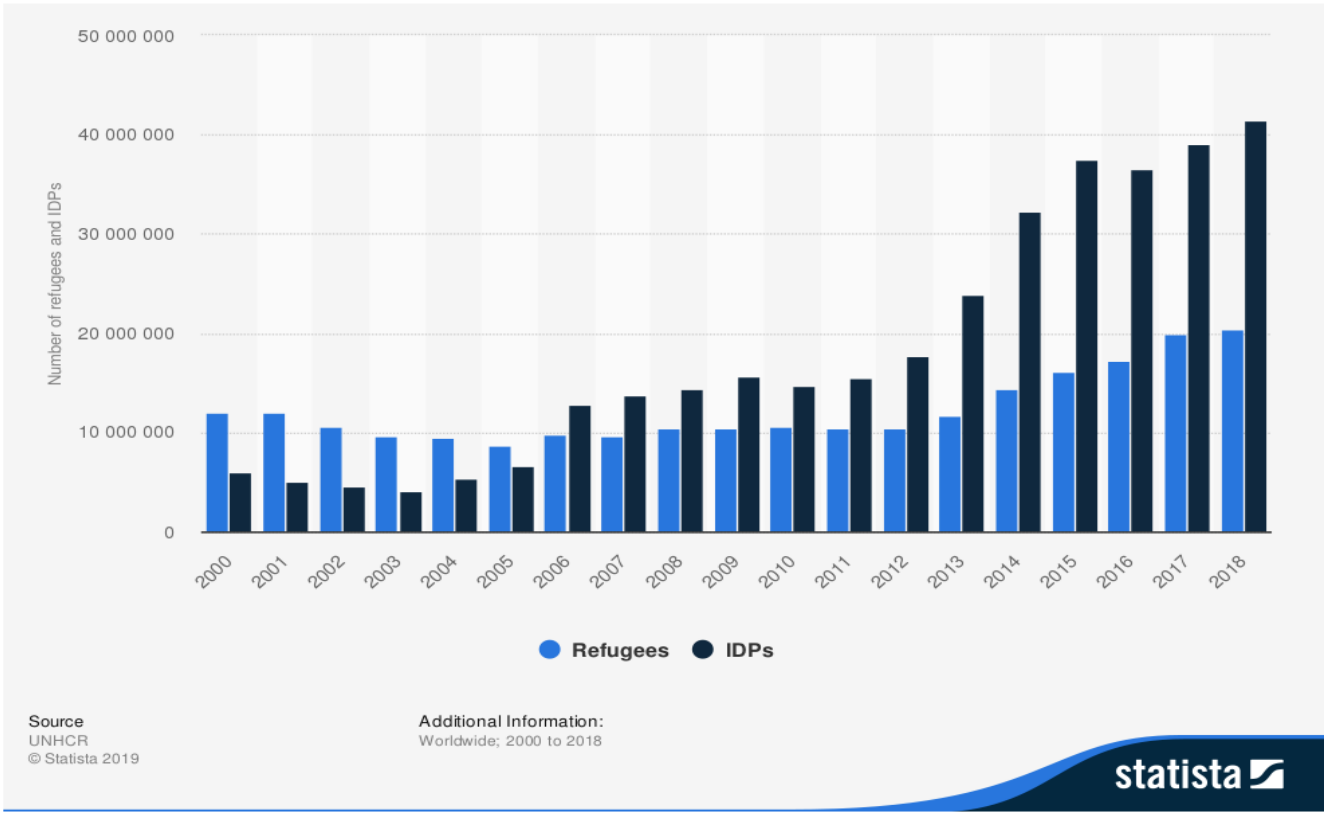
Various studies have found that prior to migration to Western countries, female refugees are often exposed to traumatic events, such as: loss of loved ones, torture, socio-economic violence, physical and sexual violence, including rape, physical injuries, discrimination, stigmatization, and denial of access to services (Gebreiyosus, 2014; Schweitzer et al., 2006; Virupaksha, et. al., 2014). These factors are usually interrelated and cumulative in nature and may put refugees at increased risk of mental health conditions such as Post-Traumatic Stress Disorder (PTSD), anxiety and depression (Abraham, Lien, and Hanssen, 2018; Beiser, 2005; Bhui et al., 2003; Grisaru, Irwin, & Kaplan, 2003;

Jeon et al., 2001; Li & Browne, 2000; Mitschke, Aguirre, & Sharma, 2013; Schweitzer, et al., 2006). Migration is a precipitating factor for mental illnesses due to the various barriers that people encounter in the migration process, as well as in the post migration period (Virupaksha, et. al., 2014). Research has shown that refugees experienced greater levels of stress and social difficulties than other migrant populations (McLennan, 1997). Refugees have high rates of risk factors for mental health disorders (Shawyer, Enticott, Doherty, Block, Cheng, I-Hao, Wahidi, & Meadows, 2014). There is greater emotional distress among refugees, and high levels of posttraumatic stress, anxiety and depression and, to a lesser extent, other mental health issues such as psychosomatic disorders and grief-related disorders (Silove, 1999; Steel 2001). The prevalence of specific types of mental health problems is influenced by the nature of the migration experience, in terms of adversity experienced before, during and after resettlement (Kirmayer, 2011).

In the next few pages, I will present some figures showing some statistics of refugee and IDP movement around the world and in Africa. The figures will help buttress the fact that forced displacement is more pronounced in Africa. They also show that statistically, IDP figures are on the rise more than refugees. The figures will also portray a clearer statistical representation and understanding of refugee and IDP movements. After looking at these figures, one can appreciate the reason why I chose to focus on Africa. Africa hosts over one-third of the world's forcibly displaced people (IDMC, 2019). Already, underdevelopment, poverty, unemployment, bad governance, environmental degradation, and insecurity have besieged the continent. Hence, this added and increasing level of internal displacement which has recently become the new normal for the African continent is an urgent concern that needs global attention.

Figure 2.

Number of refugees and internally displaced persons worldwide from 2000 to 2018

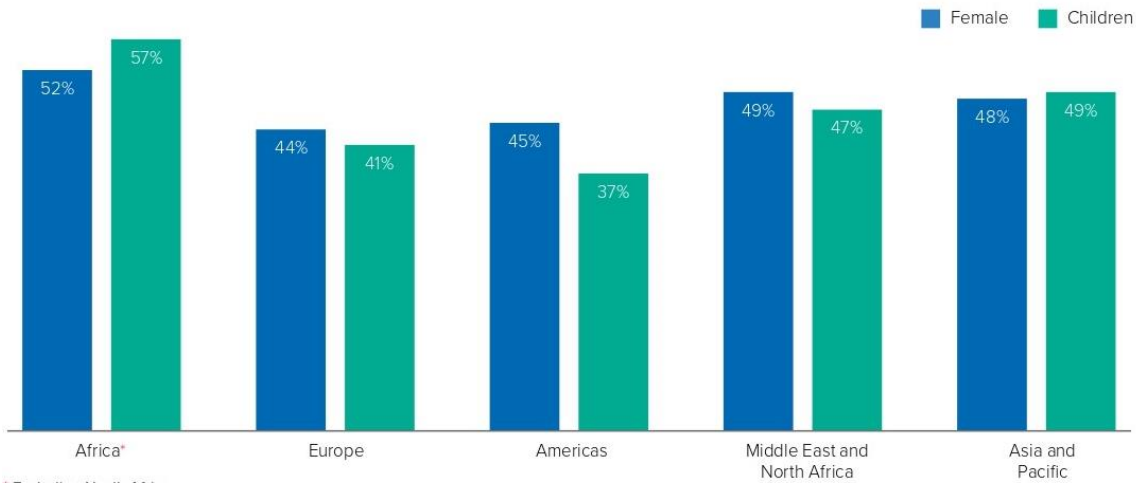


Note. This figure shows the number of refugees and IDPs worldwide from 2000 to 2018. From "Refugees and IDPs - worldwide 2000-2018" Published by Erin Duffin, Nov 8, 2019 (https://www.statista.com/statistics/268702/number-of-refugees-and-internally-displacedpersons-worldwide-since-2000/). Copyright 2019 by Statista (used with permission).

A critical look at this figure shows that from 2000-2005, refugees outnumbered IDPs; but from 2006 to 2018, the IDP population surpassed refugees. More surprisingly, IDPs remained under 20 million until 2012. By 2013, the IDP population not only surpassed 20 million; but grew exponentially, while the refugee population remained relatively logarithmic. This sudden surge calls for further research to understand the reason behind it. However, given that African hosts the majority of IDPs (IDMC, 2019); this sharp curve in IDP population places Africa as a critical security concern that needs urgent consideration. This is why my research on African refugees and IDPs is imperative.

Figure 3.

Demographic Characteristics of Refugee Population by UNHCR regions (2018).

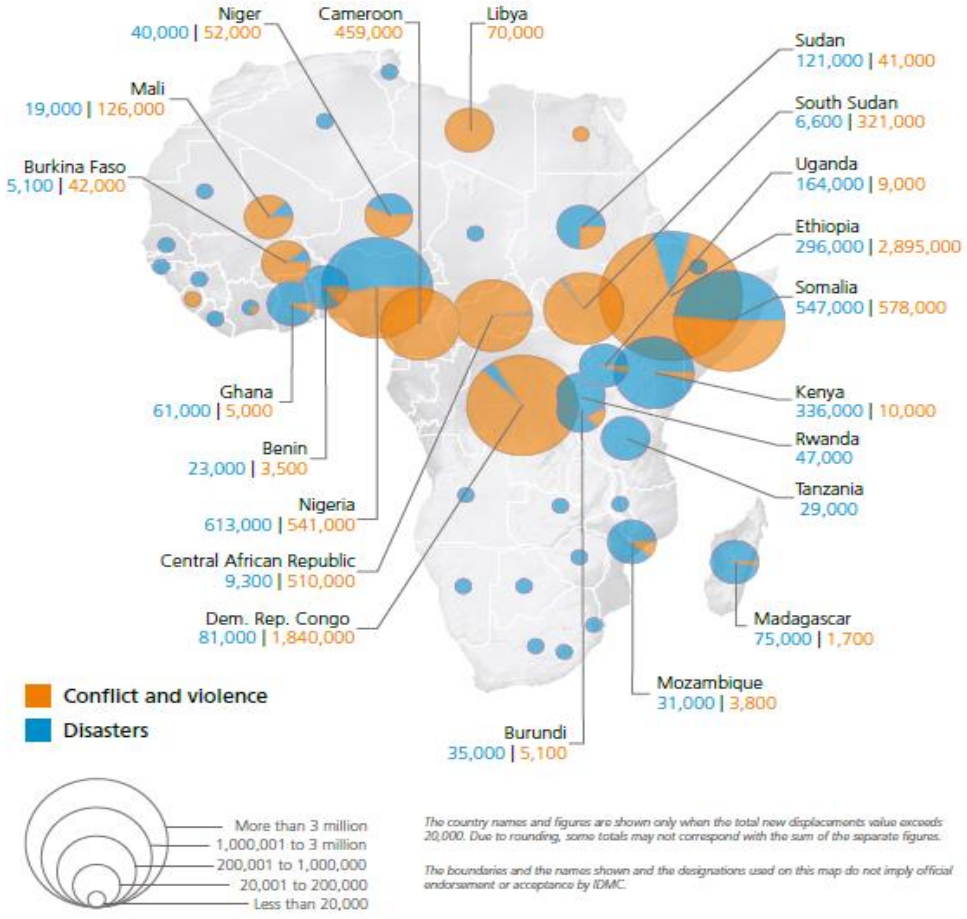


Note. Demographic Characteristics of Refugee Population by UNHCR regions, 2018 shows refugee population in percentage, per UNHCR region. From "Global Trends: Forced displacement in 2018" by UNHCR (2018). Global Trends: Forced displacement in 2018. Retrieved from: (https://www.unhcr.org/5d08d7ee7.pdf). Copyright 2020 by the United Nations High Commissioner for Refugees UNHCR (used with permission).

The green color represents children while the blue depicts women. From the figure, Africa has the highest percentage of refugee women and children. This supports the fact already asserted above that Africa has the highest number of displaced people. However, one critique about this figure from UNHCR is that it omitted the number of refugee men. Although research has it that women and children are the most displaced population (Adeyinka & Akinsulure, 2014); it would have been nice to compare the percentage of men, women and children refugees.

Figure 4.

Displacement by Conflict, Violence and Disaster in 2018.



Note. Displacement by Conflict, Violence and Disaster in 2018 shows the number of internally displaced persons in Africa by Conflict, violence and disaster in 2018. From "*Africa Report on Internal Displacement*." by Lennard, J. (2019, December*). Internal Displacement Monitoring Centre (IDMC).* Retrieved from: (https://www.internal-displacement.org/africa-report). Copyright 2020 by IDMC (used with permission).

Given that my research focuses on African female refugees and IDPs, and Africa is a continent; this figure serves to show the number of displaced people by countries. Nigeria, where all my IDP participants came from, has the highest number of displacements.

1.1 Pre-migration stressors

African female refugees are often forced to flee their home countries due to political conflict, persecution, genocide, famine, or other types of instability, and thus experience traumatic events which may result in psychological disorders, including depression, anxiety and PTSD (Abraham, Lien and Hanssen, 2018; Khanlou 2009; Silove, 1999). These traumatic experiences of refugees tend to be interrelated and generally cumulative, unlike single-event traumas, and have been found to have various impacts on refugees' mental health (Abraham, et al., 2018; Silove, 1999). Many refugees come from parts of the world where torture is still prevalent (Gebreiyosus, 2014; Virupaksha, et. al., 2014). Research shows that torture survivors, in general, who had exposure to severe violence often suffer from higher levels of depression and anxiety or PTSD (Zepinic, 2015). Refugees, in particular, who have had exposure to severe violence often have higher rates of trauma-related disorders, including post-traumatic stress disorder (Kirmayer, et al., 2011).

Numerous studies have found that African female refugees in refugee camps are vulnerable to different forms of gender-based violence; sexual and physical violence. including rape, and physical injuries, which consequently have short and long term detrimental consequences for their psycho-social health (Adeyinka & Akinsulure-Smit, 2014; Gebreiyosus, 2014). Violence against women and children, especially rape, child sexual abuse, coerced sex, and sex trafficking are found to be rampant in conflict and refugee settings and can impact the mental health conditions of refugee women and children (Jamieson, 1999; UNHCR, 1995; Weitsman, 2008). For instance, in Rwanda, between 100,000 and 250,000 women were raped during the three months of genocide in 1994 (Weitsman, 2008). In addition to being a psychological weapon, rape warfare was used with the deliberate intention of significantly diminishing particular ethnic populations (Jamieson, 1999).

According to the UNHCR (1995) and Jamieson (1999) women and children who are victims of rape may feel paralyzed by terror, experience physical and emotional pain, intense self-disgust,

powerlessness, worthlessness, apathy, and may experience an inability to function in their daily lives. In the worst cases they may experience deep depression leading to chronic mental health disorders, suicide, illegal termination of pregnancy, endangering their lives, or abandonment of their babies. Cases of infanticide of children born as a result of rape have also been reported (Jamieson, 1999). In fact, in Somalia, refugee families frequently cited rape or the fear of rape as a key factor in their decisions to seek refuge (Young, 2020; UNHCR, 1995; UNHCR, 2019).

In addition, female genital mutilation (FGM) has been identified as another factor that can contribute to why women and children flee their homeland to host countries (Mitike, & Deressa, 2009). FGM is a gender-specific violation of the rights of girls and women to physical integrity, and thus grounds for determining refugee status in Canada (CIC, 2011; UNHCR, 2009). It involves the cutting and removal of the female genitalia (Mesko, 2012; UNHCR, 2009). FGM is a traditional practice rooted in the political, social, cultural, and economic structures of the societies in which it is practiced (UNHCR, 2009). About 98% of Somali females aged 15 years and older had experienced FGM (Young, 2020). In fact, Canada was the first country to set out guidelines for considering the refugee claims of women fleeing their homeland due to gender violence of this sort (CIC, 2011). Although scientific research addressing the psychological consequences of FGM is limited, many researchers describe the psychological effects of FGM to include feelings of low-esteem, post-traumatic stress disorder, anxiety, depression, and memory loss (Mulongo, Hollins, & Mcandrew, 2014; Reisel, & Creighton, 2015; UNHCR, 2009).

1.2 Migration stressors

Most refugees flee from developing countries across the border to other developing countries (UNHCR, 2012). Many find themselves in refugee camps, which can be extremely hostile and frightening places, with shifting populations and little, if any, personal space (UNHCR, 2012). Refugees are exposed to a variety of stressors during their journey because of dangerous modes of

transport, the crossing of insecure borders, and the potential for being detained (UNHCR, 2012). They often have to travel arduous distances without food or water to get to the camps. Moreover, once the refugees arrive at the camps, they are often times challenged with serious threats to their welfare and restrictions on their human rights (Crisp, 2010). They are also confronted with adverse situations and ongoing stressors, which substantially impact their mental health (Khanlou, 2009). For example, poor quality of accommodation, restricted economic opportunity, uncertainty over access to food and water, physical and sexual violence are major psychological stresses or predictors of poor mental health (Khanlou, 2009; UNHCR, 2012).

Furthermore, family loss or separation and death of loved ones are also predictors of psychological distress in the resettlement environment (Young, 2020; Rumbaut, 1991). The refugee family is essential to the successful integration of resettled refugees (Mayo, 2018). Additionally, the period between applying for refugee status and a decision being made varies among countries and ranges from a number of hours to a number of years. For many refugees, "displacement has proven to be a protracted experience, lasting for years and even decades on end" (Crisp, 2010, p.1). This is an extremely stressful and uncertain time when refugees are unable to make plans for the future and may be terrified of being returned to their home country (UNHCR, 2012). Some refugees cannot return to their country of origin because they will continue to be persecuted or confronted with violence and trauma (UNHCR, 2012). In such cases, the UNHCR helps resettle refugees to a new country. This period of waiting for a decision may be a time when refugees' extremely fragile psychological well-being may be compromised (UNHCR, 2012).

1.3 Post Migration Stressors

Unfortunately, the hardships that African female refugees endure do not end when they arrive in their country of resettlement. They still face difficult settlement barriers that have negative impacts on their mental health. It is well established that arrival and resettlement in a new country involve a

period of significant readjustment and stress (Fenta, Hyman & Noh, 2004). To this Kirmayer et al. (2011, p. 961) added that: “refugees and their families face enduring obstacles to advancement in their new home because of structural barriers and inequalities aggravated by exclusionary policies, racism and discrimination which negatively impact their overall mental health”.

Today, evidence shows that Canada’s active immigration and refugee policy has led to an increasingly culturally and ethno-racially diverse society; and each year significant numbers of African refugees who have fled famine, war, violence and persecution from their home countries enter Canada and begin the process of resettlement (Khanlou, 2009). While resettlement can be a positive and rewarding experience for African refugees, studies have shown that the psychological impacts of trauma experiences prior to resettlement, as well as post migration stressors while adjusting in Canada, can interfere with their day-to-day life and resettlement process (Baffoe, 2013; Khanlou, 2009). Some of these post migration obstacles that put refugees at risk of developing mental health issues will be discussed below.

The first issue is unemployment and underemployment. Many refugees experience a discrepancy between their social status prior to and after migration, which often leads to poverty (Baffoe, 2013; Brouwer, 1999). It is common for refugees to have lost many of their assets when forced to flee their home country (Crisp, 2010). Many lose important documents certifying their education, training and credentials, and this will eventually become a serious barrier to achieving employment (Baffoe, 2013). Thus, sustained periods of underemployment and unemployment are therefore common among refugees (Baffoe, 2013). Those who are employed may not be able to maintain their employment because of misunderstandings and differences in culture and practices arising at the new workplace. The foci of such differences include areas such as: teamwork, conflict resolution, communication style, working relationships with coworkers and supervisors, and misunderstandings at work (Brouwer, 1999; Khanlou, 2009). This is particularly true for those with

a low level of English communication skills. These factors make it very difficult for refugees to find and maintain employment, despite the fact that the majority of these new arrivals bring positive work habits and experiences to their new workplaces (Brouwer, 1999; Campion, 2018).

Moving on, refugee and immigrant women have borne the burden of the negative effects of a changing Canadian economy (Kazemipur 2004; Li, 2003). Studies have shown, although the majority of women immigrants are more highly educated than Canadian-born women (Boyd 2008; Chui 2011), they have difficulties finding jobs commensurate with their qualifications (Chen, et al. 2011). Many immigrant women are thus compelled to take up temporary employment or menial jobs (Fuller & Vosko 2008; Man, 2004; Wilkinson et al. 2006). Others struggle to upgrade their credentials in the hope of finding jobs some day (Adamuti-Trache, et al. 2011). Yet, some give up on their career aspirations and join the litany of women whose main duties involve caring and ensuring the success of their children's education and/or their husbands' careers (Creese, et al. 2008; Hardill, 2002; McLaren & Dyck, 2004). Both employment and unemployment can adversely affect the lives of immigrant and refugee women (Campion, 2018; Dion & Dion 2001).

Thus, unemployment and underemployment have been known to result in self-blame in many refugees, which can lead to feelings of inferiority, low self-esteem, helplessness, humiliation, anger, despair, and nostalgia that can negatively affect their mental health (Baffoe, 2013; Brouwer, 1999; Khanlou, 2009). In other situations, newly arrived refugees may be experiencing physical and mental health problems, including insomnia, anxiety, heightened emotions, worries, and re-experiencing trauma and flashbacks from the past that may contribute to negative settlement experiences, including employment difficulties (Baffoe, 2013; Brouwer, 1999; Khanlou, 2009). Despite the common employment barriers faced by both male and female refugees, many refugee women experience employment barriers more than their male counterparts regardless of their work experience, or the qualifications they had achieved in their home country and the considerable efforts

they had made to secure employment since arriving in their host countries (Tomlinson, 2010). Concerns are raised about the high emotional toll of racialized Canadian workplaces and the stress that some employed Muslim immigrant women report (Holtmann & Tramonte, 2014).

Further to unemployment are housing issues. According to experts, the successful integration of refugees into a new society is based on their attainment of several basic needs; one of the most important of which is securing affordable, suitable and adequate housing (Wayland, 2006). Housing affordability is important because it determines to a large extent who can afford what type of housing (Wayland, 2006). Unfortunately, many refugee women and children, especially single parents, have been found to experience poor and inadequate housing in Canada. Since housing is a central component of positive resettlement experiences for refugees in Canada, evidence has shown that a lack of affordable housing, or unsafe housing conditions, can have significant implications for the mental, physical and emotional wellbeing of newcomers in Canada (Wayland, 2006). A review of the literature by Access Alliance Multicultural Community Health Center (2005) as cited in Wayland, (2006) explored connections between housing, poverty, race-based discrimination, and access to health care, as social determinants of health. Housing can impact health in that high rent-to-income ratios mean that families may lack resources to access adequate food, medication, and other necessities of life. There may be mental health dimensions to housing experiences as overcrowded housing can have adverse effects on the mental health of refugee individuals and families (Wayland, 2006).

More so, insufficient language skills have contributed to the psychological stress of non-English speaking refugee women who find it hard to integrate into the Canadian community because there are not enough language support programs to accommodate various refugees from various language backgrounds (Baffoe, 2013). They find it difficult to form friendships with members of the community and also difficult to access required services in English. Women and seniors are at

heightened risk for isolation because they are more likely to be unemployed and hence spend more time at home (Baffoe, 2013; Khanlou, 2009). Goodenow and Espin's (1993) study on female immigrants identified English language learning as a barrier in their adjustment to the new country. Health Canada (as cited in Khanlou, et al. 2002) recognized refugees as likely to experience acculturative stress from language difficulties, which led to personal isolation that consequently could affect physical and mental health.

Inadequate medical care and extended health care coverage also contribute to the psychological stresses endured by refugees. In the past, refugee claimants with health issues were eligible to apply under the Interim Federal Health Program (IFHP) for assistance with emergency and essential health problems until their provincial insurance coverage started (Canadian Council for Refugees (CCR), 2012). However, in 2012, there was a drastic cut to extended health care for refugee claimants under IFHP, and many refugees were no longer eligible for coverage of necessities like medication, vision and dental care, and special devices like wheelchairs, prosthetics, and orthotics (CCR, 2012). Also, as part of the cuts to IFHP, coverage of psychotherapy for survivors of torture was also eliminated. This left deeply traumatized refugees, including those waiting for an appointment in order to make a refugee claim, without specialized support (CCR, 2012). Nonetheless, after much criticism, pressure and advocacy from interest groups and concerned Canadians, the federal government on April 1, 2016, restored the IFHP, which would provide health-care coverage, including basic, supplemental, and prescription drug coverage, for all refugees and asylum claimants (CIC, 2020). The Liberal government further promised that as of April 1, 2017, the IFHP would expand to cover certain services for refugees who have been identified for resettlement before they come to Canada. These services include coverage of the immigration medical examination, pre-departure vaccinations, services to manage disease outbreaks in refugee

camps, and medical supports during travel to Canada (CIC, 2016). This was a step in the right direction.

Thus, lack of immediate medical attention for an already vulnerable, traumatized refugee, can intensify existing or create new mental health issues, such as depression, anxiety and feelings of despair. Furthermore, Kirmayer et al. (2011) noted inadequate medical care as a major concern for the mental wellbeing of refugee women. Lack of knowledge about postpartum depression and treatment options, reluctance to disclose emotional problems outside the family, unwillingness to undertake medical treatment for what is perceived as a psycho-social problem, concern that maternal mental illness will burden or stigmatize the family, feelings of shame at being labelled mentally ill, and fear of losing one's children to authorities are great barriers to the mental wellbeing of refugee women (Kirmayer et al., 2011).

Another issue contributing to psychological stress among refugee women is racial discrimination. In a study that involved refugees in Toronto, Khanlou et al., (2002) discovered that cultural differences and discrimination are linked to isolation and alienation; which consequently are risk factors for mental health problems experienced by refugees. This is a complex social problem that has impacts at a number of different levels; from racial abuse or attack to subtler forms such as stereotypes in the media. Perceived discrimination impacts mental health through direct effects on an individual's psychology and self-esteem. In another study by Jibril (2011) on Somali refugees in Alberta, it was discovered that unfriendly reception and racism from community members create barriers to forging support networks with other people in the refugee's neighborhood. This, in turn, leads to feelings of not belonging to mainstream Canadian society and low self-esteem, which further created ripple effects on refugees' mental health. Mann et al., (2004) affirmed that poor self-esteem is associated with a broad range of mental disorders and social problems, including depression, suicidal tendencies and anxiety. Torres et al., (1995) found that self-esteem was significantly

correlated with mental health and safety aspects among older adolescents. Hence, low self-esteem can negatively impact the mental health of refugees.

Moving on, inadequate social and emotional support is another factor that could intensify the mental health issues of African female refugees. Africans, for instance, live in extended family and clan-based settings. The most powerful support systems for Africans are families, neighbors, clansmen, and religious organizations (Baffoe, 2013). When families live apart, it is difficult to build strong ties with neighbors (Baffoe, 2013). Many refugees have been separated from their friends and family in the migration process, and they may also experience the absence of similar ethno-cultural communities in Canada. Hynie et al. (2011) noted that refugees must rebuild social networks to obtain needed social support, but often face social exclusion because of their race, language, religion, or immigrant status. In addition, most have limited access to social, and community resources. Perceived support was strongest from family and close friends. Reports suggest that co-ethnic peer support networks may be overwhelmed in newcomer communities because of their limited size and resources. Perceived social support from refugees' ethnic community plays a significant role in predicting mental health outcomes (Schweitzer et al., 2006).

Further to the above issue is family disruption and reunification. For many refugees, one of the biggest settlement challenges is being reunited with their families (Wayland, 2006). Upon arriving in Canada, bringing the family back together is a top priority, especially if family members have been left in life-threatening situations (Baffoe, 2013). Unfortunately, Canadian immigration policies have been known to act as a barrier for family sponsorship or family reunification (Baffoe, 2013; Wayland, 2006). The prolonged separation from family members, the long years of anxious waiting combined with the sense of powerlessness, causes acute emotional distress and makes it more difficult for refugees to focus on their own integration (Baffoe, 2013; CIC, 2012; Wayland, 2006). Likewise, separation from extended family and concern about their family's safety in war-

torn countries of origin, or in countries under repressive regimes, adds to the accumulation of stress for refugees in Canada (Baffoe, 2013). Furthermore, family separation has been known to increase the severity of post-traumatic stress disorders often experienced by refugees, as well as depression and other mental health issues found among refugees from countries affected by war (Baffoe, 2013; Wayland, 2006). The Canadian Council for Refugees (as cited in Baffoe, 2013) noted that the barriers refugees face to becoming permanent residents, combined with the financial burden associated with family reunification, have worked directly to counter the assimilation and naturalization of refugees.

What is more, role change is also another factor that contributes to psychological stresses for refugee women. Evidence has shown that adjusting to a new culture can create additional family stresses, and families may not know where to turn for support, especially for psycho-social support. Kanu (2008) and Baffoe (2013) have noted that the roles played by parents and children may also shift in families that are adjusting to a new culture. Perceived loss of parental control in Canada, or dependence of parents on their children to help navigate a new culture or language can add new mental stresses (Baffoe, 2013). For instance, children who speak better English than their parents may be relied upon to deal with landlords, banks, and utility companies. As a result, refugee children and youth can experience a shifting sense of power, mixed with normal adolescent rebellion against parental boundaries (Baffoe, 2011; 2013). Hence, as the roles switch, some parents may experience powerlessness and hopelessness in their inability to raise their children according to their regular parenting styles, and this, in turn, escalates their mental stress.

Furthermore, some of the more challenging adaptation tasks for spouses in the family system are redefining roles and perceptions of competence and authority (Baffoe, 2013). Role changes and differential rates of acculturation can occur when, for example, the wife finds employment outside the family and the husband, whose traditional role was the bread winner, remains unemployed. Thus, role changes in refugee spousal relationships due to unemployment or low income have been found

to be strongly correlated with mental health, social and behavioral health problems, resulting in substance abuse, violence towards and abuse of women, depression and anxiety among refugee families (Baffoe, 2011; 2013; Kanu, 2008; Kirmayer, et al., 2011; WHO, 2005). So, with all these challenges experienced by refugees as enumerated above, there is a need to explore how African female refugees manage their mental health issues and are able to adapt well in their new environment amid their difficult and challenging migration experiences.

1.4 Purpose of the Study

As mentioned above, this study aimed to understand how female refugees of African origin maintain resilience in the midst of their mental health conditions during their migration and settlement process. It aimed to explore and better understand the factors or elements which strengthen African female refugees' and internally displaced persons' perseverance and ability to withstand migration stressors and mental health challenges. The study sought to unveil the conducive components that facilitate the abilities of these women to thrive and to regain and maintain their optimal daily functioning in the midst of their mental health issues and difficult migration experiences. The study aimed at discovering those resources that help African refugee women to effectively manage and minimize the hazardous effects of migration trauma and mental health disorders; and thus, be able to bounce back to their normal or, at least, positive functioning. The research allowed me to gather first-hand data on how these refugee and internally displaced women positively deal with their mental health issues in a way that fosters positive recovery in the face of their adversities and challenging migration and settlement experiences.

The main research questions for this study include:

1) How do African female refugees and IDPs with mental health issues stay resilient despite their stressful migration experiences, psychological and mental health challenges? 2) What are some of the reasons for which African female refugees and IDPs leave their homes to seek refuge elsewhere?

3) What are some of the tough experiences and stressful situations that these refugees and IDPs experienced or are experiencing during their migration and settlement? 4) What are their reactions and feelings about these experiences? 5) How can their resilience strategies be facilitated so as to enhance mental health services and intervention with these women?

1.5 Significance of Research

One question that I have been asked severally, that might easily come to the mind of my readers is: Why female refugees? Redwood-Campbell et. al., (2008) affirmed that refugee women have high rates of exposure to violence and post-traumatic stress disorder that often have not been addressed. Both African male and female refugees do endure various kinds and degrees of migration stressors that put them at elevated risk of mental health issues; yet research has shown that refugee men and women may face different issues, both pre-migration and post-migration (Ellis, MacDonald, Lincoln & Cabral, 2008; Gulden et al., 2010; Perera, et. al., 2013). Research on immigrants and refugees arriving in Canada in the last 20 years points out that the experiences of women differ from those of men in many contexts (Holtmann & Tramonte, 2014). Female refugees report more psychological symptoms than men (Porter, 2005); and they are at higher risk of gender-based violence, including rape, during armed conflicts, in flight, and in refugee camps (Hynes & Cardozo, 2000). Women reported more resettlement stressors than did men in a combined sample of Somali and Oromo refugees (Jaranson et al., 2004). African refugee women also have to confront and reconcile different gender norms between their more patriarchal culture and that of the Western world (Perera, et. al., 2013). In another study, Somali adolescent women described the unique challenges they faced in wearing the headscarf - a signal of their Muslim cultural identity, which is a target for discrimination (Ellis et al., 2010).

In other words, there is sufficient evidence to suggest that immigration and refugee experiences can contribute to negative health consequences, particularly for minority women

(Meadows, Thurston & Melton, 2001; Sethi, 2013). Migration has been shown to be a stressful process, especially for immigrant women confronting the multiple inequalities resulting from their ethnic minority status, nativity, and gender (Raj, Silverman, McCleary-Sills, & Liu, 2005). Refugee women find the migration experience more hostile and stressful than their male counterparts because of their social isolation, dependency on spouses, financial insecurities, and limited employment opportunities (Khan & Watson, 2005). Perera, et. al., (2013) found that refugee women reported more pre-migration, transit, and resettlement stressors than did refugee men.

Furthermore, studies on African female refugees have found that, although all members of displaced groups suffer greatly during the struggles and conflicts they experience; women and children remain the most vulnerable and constitute the majority of casualties (Adeyinka & Akinsulure, 2014; Sossou, 2006; UNHCR, 1998). During migration struggles, women and girls endure excessive suffering and they are often the targets and victims of ruthless acts of physical, sexual and emotional violence (McKay, 1998; Taback, Painter, & King, 2008; Ward et al., 2007). So, in many cases, women (and children) are more likely to be the innocent victims of circumstances during the migration odyssey. Given that African female refugees face the most stressful situations, there is a need to discover and foster their resilience skills in order to help facilitate their resettlement so that they can better adjust and maintain optimum mental wellbeing. More so, it is necessary to explore and foster the strategies with which female African refugees cope with their mental health issues because female refugees are among the most vulnerable groups to be exposed to diverse forms of gender-based violence and other adverse migration situations (Gebreiyosus, 2014).

Another reason why it is pertinent to discover how to foster effective coping among African female refugees is that in most African cultures (as well as some other cultures), women are seen as the caregivers while men are seen as the bread winners (Coley, Ribar & Votruba-drzal, 2011; Sethi, 2013). This is owing to the patriarchal familial relations existent in the refugees' home countries,

which naturally assign to women the cultural roles of care giving (Iredale, 2005; Merali, 2009; Shankar & Northcott, 2009; Sethi, 2013). Therefore, female refugees, after going through difficult times, still have to fulfil their care giving obligations by taking care of their children and attending to domestic duties and chores. This makes it even more difficult for them to deal with their mental health issues and at the same time take care of their children and domestic duties. Thus, migration stresses, challenges related to familial, societal and cultural expectations and responsibilities of caregiving may adversely affect the mental health of refugee women (Ahmad et. al., 2004; Martins & Reid, 2007; Rashid, 2011). Sethi (2013), in one of her studies, found that the female refugee participants with mental health issues indicated that they had the sole responsibility of childcare; and even though they were experiencing depression they were afraid to travel for counseling and other medical appointments with their toddlers. Hence, it suffices to say that refugee women may experience more difficulties and challenges owing to their positions in family and society; they face challenges both as refugees and as women (Rashid, 2011). Holtmann and Tramonte (2014), in a study affirmed that shouldering responsibilities for full-time care work at home leads to mental health problems. So, this research is very significant because it sought to discover the resilience strategies of these refugee women in order to help mental health practitioners to foster such strategies among these women. In other words, this study was geared to achieve a pair of significant and interrelated purposes. The first is to discover the resilience approaches of African refugee women regarding their post migration settlement and mental health rehabilitation. The second is to make recommendations on how to foster the discovered resilience characteristics among African female refugees in the context of community mental health rehabilitation. By acquiring information regarding factors that support these refugees' resilience, I hope that the study will help to increase the understanding of the mental health rehabilitation experiences of refugee women from Africa.

Chapter Two: Literature Review

This chapter will focus on a review of pertinent literature defining the main terms that I have used in this research. This will help provide the basis for understanding the concepts used throughout this study. The terms that will be defined are refugee, resilience, as well as the typical mental health issues of refugees namely: depression, anxiety and Post-Traumatic Stress Disorder (PTSD). In this chapter, I will also review some theories that have been used to explain resilience; as well as empirical research, specifically on the experience of refugees with mental health issues.

2.1 Definition of Terms

This section of the literature review will be dedicated to defining the key concepts that will be used throughout this thesis. The first term to be defined is refugee.

2.1.1 Asylum seeker. An asylum seeker is a person who moves across borders in search of protection, but who may not fulfill the strict criteria laid down by the 1951 Convention (UNHCR, 2011). Asylum seeker describes someone who has left his or her country of origin and applied for the protection of another country as a refugee, and is awaiting the determination of his or her status (UNHCR, 2011; Virupaksha et al., 2014). Whereas an asylum seeker asks for protection after arriving in the host country, a refugee asks for protection and is granted this protected status outside of the host country (UNHCR). One other concept that is sometimes confused with refugee is internally displaced persons (IDPs).

2.1.2 Internally displaced persons. This term refers to those who have left their usual place of residence in order to escape from persecution, armed conflict, or human rights violations, but who do not cross any international border; rather remaining within their country of origin (Crisp, 2010; Virupaksha et al., 2014). IDPs stay within their own country and remain under the protection of its government, even if that government is the reason for their displacement (UNHCR, 2020).

2.1.3 Refugee. The 1951 United Nations Convention relating to the Status of Refugees states that a refugee is a person 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 nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country (Lister, 2013; UNHCR, 2011, 2020; Virupaksha et al., 2014). Another concept that is almost always used interchangeably with refugee is: asylum seeker.

Regarding refugee claims, there are three durable solutions outlined by the international governing body for refugees, the United Nations High Commissioner for Refugees (UNHCR, 2012): voluntary repatriation; local integration in the country of first asylum; and third country resettlement. Resettlement in a third country is the least common durable solution (less than 1% of all refugees) given the high cost, resources and extreme financial burden placed on refugees and the host countries. However, it has been shown to be one of the most effective solutions in bringing protection to refugees (UNHCR, 2011; UNHCR, 2012). In Canada, refugee resettlement is an interesting component of our immigration system that is primarily based on humanitarian grounds (Immigration, Refugees and Citizenship Canada - IRCC (2020). Canada is a member of the United Nations and also is part of the 1951 United Nations Convention agreement relating to the Status of Refugees (Baffoe, 2013). Under this agreement, all refugee claimants in Canada are entitled to basic services such as education, financial support, language training and housing for up to one year upon their arrival in Canada (Baffoe, 2013; IRCC, 2020).

There are two categories to apply for refugee protection in Canada under the Canadian Immigration and Refugee Protection Act – (IRPA), (IRCC, 2020). The first category is the Claim Outside Canada, resettlement program called: 1) Convention refugee abroad class; and the next category is the: 2) Country of asylum class.

2.1.3.1 Convention refugee abroad class. People in this class: a) are outside their home country, b) cannot return there due to a well-founded fear of persecution based on race, religion, political opinion, nationality, or membership in a particular social group; for examples: gender, sexual orientation, etc. Convention refugees can be sponsored by: i) the Government of Canada - government-assisted refugees (GAR) ii) a group of people or an organization -privately sponsored refugees (PSR), or iii) a mix of both - blended visa office-referred refugees (BVOR). One can also be a Convention refugee if he/she has the funds needed to support him/herself and family after arrival in Canada. You will still need the UNHCR, a referral organization, or a private sponsorship group to refer you (IRCC, 2019). A claim for refugee protection made by a person outside Canada must be made by making an application for a visa as a Convention refugee or a person in similar circumstances. Refugees selected for resettlement to Canada have often fled their homes because of unimaginable hardship and have, in many cases, been forced to live in refugee camps for many years (IRCC, 2020). Canada works closely with UNHCR, as well as organizations and private sponsorship groups to identify and refer refugees for resettlement in Canada. People in this category are granted permanent residence (landed status) when they arrive in Canada and are classified as "resettled refugees". They may also receive financial aid from the government for a certain period of time, some of which has to be repaid (IRCC, 2020).

2.1.3.2 Country of asylum class. One may be in this class if he/she is a) outside his/her home country, or the country where he/she normally lives and b) have been seriously affected by civil war or armed conflict, or c) have been denied basic human rights on an ongoing basis. Country of asylum class refugees can be privately sponsored. You can also be in this class if you have the funds you need to support yourself and your family after you arrive in Canada. You will still need the UNHCR, a referral organization, or a private sponsorship group to refer you (IRCC, 2019). As per the Immigration and Refugee Protection Act (SC 2001, c. 27), a claim for refugee protection may be

made in or outside Canada (Justice Law Website, 2020). “A claim for refugee protection made by a person inside Canada must be made to an officer, may not be made by a person who is subject to a removal order” (IRPA, 2020 S.C. 2001, c. 27; 99(3). From January to December 2019, Canada Border Services Agency (CBSA) processed 29,370 in Canada asylum claims from all ports of entry, while the Immigration, Refugees and Citizenship Canada (IRCC) agency processed 34,680. The total number of Asylum Claimants processed by the CBSA and IRCC for this period was 64,050 (IRCC,2020).

2.1.4 Mental Health. The World Health Organization (WHO) defined mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2004). This definition moved away from understanding mental health as the absence of mental illness, to include the concepts of positive emotions and positive functioning as key factors for mental health.

However, the differences across nations in terms of values, cultures and social background may impede having a generally accepted definition of mental health. The definition is influenced by the culture that defines it. Nevertheless, despite cultural differences, certain universal elements have to be present (Galderisi, 2015). Three components of mental health have been identified as: emotional well-being, psychological well-being and social well-being. Emotional well-being includes happiness, interest in life, and satisfaction; psychological well-being includes liking most parts of one's own personality, being good at managing the responsibilities of daily life, having good relationships with others, and being satisfied with one's own life; social well-being refers to positive functioning and involves having something to contribute to society and feeling as being part of a community (Galderisi, 2015; Keyes, 2014).

For the purpose of this thesis, I prefer to adapt one definition that is more inclusive and less restrictive to culture-bound conceptualization of mental health. Galderisi (2015), in a more encompassing way, defined mental health as:

> a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium (pp. 231-232).

The above definition includes the three basic components of mental health, emotional, psychological and social. Internal equilibrium represents the emotional and psychological. Using one's abilities in harmony with universal values of the society and empathy for others represent the social aspect of mental health (social skills). Whereas the ability to recognize, express and regulate one's own emotions belongs to the emotional aspect of mental health.

2.1.5 Post-traumatic Stress disorder (PTSD). The next term to be defined is: Post-traumatic Stress disorder (PTSD). PTSD, as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V), corresponds to a situation in which a person has been exposed to a traumatic event and bears the marks of that experience; but has been removed from the actual event (American Psychiatric Association, 2013; Lacroix & Sabbah, 2011; Weine, 2001). Research indicates that victims of unresolved trauma usually exhibit intrusive recollections of the traumatic events, feelings of persecution, recurrent dreams, and reduced functioning (Williams, Zinner, & Ellis, 1999). Refugees escape war, move to refugee camps, and experience internal displacement and resettlement (Lacroix & Sabbah 2011). However, resettlement does not

necessarily bring relief to the numerous issues they faced (Eisenbruch, de Jong & van de Put, 2004). Research shows that mental health symptoms improve over time for the majority; but remain a significant risk factor for a minority in the long term (Beiser, 1998; Goldstein, van Kammen, Shelly, Miller & van Kammen, 1987; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Steel, Silove, Phan, & Bauman, 2002). Therefore, trauma may have indirect lasting effects by increasing the vulnerability of the traumatized individuals to future stressors (Schweitzer, Melville, Steel & Lacherez, 2006; Steel, Silove, Bird, McGorry & Mohan, 1999). A traumatized refugee, for example, who has been able to pursue normal daily activities after resettlement may, when confronted with severe stressors, develop symptoms of PTSD (McNally, 2003; Schauer et al., 2003). Research on the consequences of PTSD on refugee populations strongly suggests taking into account variables such as depression, anxiety, psychosocial dysfunction, unexplained somatic symptoms, the number of traumatic events and the severity of these events in the aggravation of the victim's PTSD (McNally, 2003; Schauer et al., 2003).

2.1.6 Depression. Another term of importance is depression. The diagnosis of depression is defined in the DSM-V through a complex process of professional disagreement among psychiatrists (Davidsen & Fosgerau, 2014). There is no one definition of depression; rather the DSM-V has numerous classifications of depression from Major Depressive Disorder to unspecified depressive disorder, which respectively represent the levels and severity of depression (American Psychiatric Association, 2013). However, these various classifications are grouped under the general theme: Depressive Disorders. DSM-V noted that the common feature of all of these disorders is the presence of sad, empty or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. What differs among them are issues of duration, timing, or presumed etiology (American Psychiatric Association, 2013). Research has shown that the general symptoms of depression include: less appetite, weight changes, delusions, sleep problems,

mood disturbance, lack of interest, hopelessness, low self-esteem, functional impairment, lack of focus, and lack of concentration (Choe, Emslie & Mayes,2012; Kovacs, 1996; Luby, Heffelfinger, Mrakotsky et. al. 2003). Depression has been found to be prevalent among refugees given their migration experiences (Beiser, 2005; Bhui et al., 2003; Jeon et al., 2001; Grisaru, Irwin, & Kaplan, 2003; Li & Browne, 2000; Schweitzer, et al., 2006). Research has also found that post migration difficulties, such as unemployment, family separation and financial difficulties are associated with symptoms of depression and anxiety in resettled African refugees (Heptinstall, Sethna & Taylor 2004; Schweitzer, et. al. 2007). Furthermore, depression has been found to be common among African refugees who had been exposed to lack of shelter and water (Bhui et al., 2003). Another study of Ethiopian refugees in Canada also found that internment in refugee camps was associated with more depression (Fenta et al., 2004).

2.1.7 Generalized Anxiety Disorder. Generalized Anxiety Disorder is characterized by persistent fretfulness and uncontrollable worry that occurs consistently for at least six months (Stein & Sareen, 2015). The DSM-V defined anxiety disorders as:

> those disorders that share features of excessive fear and anxiety and related behavioral disturbances. Anxiety is more often associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviors. Sometimes the level of fear or anxiety is reduced by pervasive avoidance behaviors. (American Psychiatric Association - APA, 2013, p. 189).

Panic attacks are frequently associated with anxiety disorders as a particular type of fear response. Anxiety disorders differ from one another in the types of objects or situations that induce fear, anxiety, or avoidance behavior, and the associated cognitive ideation (APA, 2013). One important thing to note is that for an anxiety disorder to be diagnosed, it has to be persistent, lasting typically for up to 6 months or more; although the criterion for duration is intended as a general guide with

allowance for some degree of flexibility (APA, 2013). In other words, there have to be intense and prolonged feelings of fear and distress that occur out of proportion to the actual threat or danger. Also, the feelings of fear and distress must interfere with normal daily functioning (APA, 2013). Since individuals with anxiety disorders typically overestimate the danger in situations they fear or avoid, the primary determination of whether the fear or anxiety is excessive or out of proportion is made by the clinician, taking cultural contextual factors into account (APA, 2013). The symptoms associated with Anxiety Disorders include persistent and excessive anxiety and worry in various areas of life, restlessness, being easily fatigued; difficulty concentrating or mind going blank, irritability, muscle tension, and sleep disturbance (APA, 2013; Stein & Sareen, 2015).

2.1.8 Resilience. The next term to be defined is resilience. The term resilience is heterogeneous and dynamic and often defined by identifying its characteristics (Davydov, Stewart, Ritchie & Chaudieu, 2010; Toth, 2003). It suffices to say that no consensus on the operational definition of resilience exists as resilience is studied by different researchers from diverse fields of study (Davydov, et. al., 2010); and this multidisciplinary research in resilience is rapidly increasing (Herrman, Stewart, Diaz-Granados, Berger, Jackson, & Yuen, 2011). Various authors, therefore, have defined resilience in various ways; yet with intersecting features constitutive of common denominators. The definition is usually centered on how people withstand adversity without developing negative physical or mental health outcomes (Herman et al., 2011).

The American Psychological Association (APA) defined resilience as the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress. Resilience involves bouncing back from difficult experiences; it can also involve profound personal growth (APA, 2020). Resilience has been defined as an ability to recover from adversity (Wagnild, 2009). De la Rosa, Barnett-Queen, Messick, & Gurrola, (2015) defined resilience as the capacity to withstand life stressors, thrive, and make meaning from challenges. It is the capacity to “cope with

and bounce back after the ongoing demands and challenges of life, and to learn from them in a positive way" (Macdonnell, Dastjerdi, Bokore, & Khanlou, 2012, p.8). Resilience has also been defined as the ability to find meaning and purpose in adverse circumstances and to focus on what can be controlled (Ortberg, 2001). Losoi et al., (2013), saw resilience as a positive personality characteristic that enhances individual adaptation and moderates the negative effects of stress. Resilient persons tend to manifest adaptive behaviors, especially in the areas of social functioning, morale and somatic health, and they experience positive emotions even in the presence of stress (Tugade & Fredrickson, 2004).

Moving on, resilience has been defined in the context of mental health as positive adaptation, or the ability to maintain or regain mental health, despite experiencing adversity (Herrman et al., 2011). Yok-Fong (2014) defined resilience within the context of immigration as the adaptation process developed by immigrant women to regain and maintain their optimal daily functioning. Yok-Fong opined that the concept of resilience is characterized by the understanding of survivors' ability to regain control and thrive despite adversity. Resilience provides us with a theoretical and empirical basis for understanding the protective factors that buffer the exposure to risk for immigrant women facing numerous issues. The concept of resilience, however, does not imply that the survivors are free from the manifestation of any symptoms in this dynamic process; rather, it signifies the survivors' capacity to effectively meet the traumatic challenge by using personal resources to minimize future risks and hazardous outcome (Yok-Fong, 2014).

The above definitions have features and characteristics that are both similar and different from each other; although they all seem to include people's abilities to cope with difficult situations just as Herman et. al., (2011) pointed out. The first definition by APA, contained the features of one's ability to adapt well in the face of adversity. The definition by Wagnild, (2009) is probably too simple and vague, exhibiting only one component - recovery from adversity. The next definition (De la

Rosa, et al., 2015) contains the component about stress and challenges, but went further to introduce a new feature – meaning making from the experience. Moving further, the fourth definition (Macdonnell, et. al., 2012) depicted the two features identified above, but more extensively identified another important component – bouncing back to normalcy after the challenges have been overcome. The definitions by Ortberg, (2001); Losoi et al., (2013); Herrman et. al., (2011) and Yok-Fong, (2014); each has one or more of the components identified above, but also went further to introduce another basic factor that constitutes resilience - personality trait or characteristic which is suggestive of individual or personal strength and ability to deal with life's difficult situations.

So, in all these definitions and for the purpose of this study, I would prefer to adapt the definitions by Macdonnell et. al., (2012), Herrman et. al., (2011) and Yok-Fong (2014) as they contain four important components that better explain the understanding of resilience within the context of this research. Those four components are: a) coping with stressful, adverse and difficult life challenges b) making meaning, purpose and learning from such experiences c) regaining normalcy or bouncing back to a pre-stress baseline and d) positive attitude, personal resources and strength. Therefore, resilience for this study means the ability of African refugee women to positively cope with adverse migration challenges, regaining initial optimum mental health and learning from such experiences.

2.2 Resilience Theories

There are various theories that have been used to define resilience. Earlier resilience theories focused on understanding and hypothesizing resilience as a personal trait rather than a dynamic process (Bonanno 2004; Herman et. al., 2011; Losoi et al., 2013; Ong, Bergeman, Bisconti, & Wallace, 2006). Resilience was also construed as a durable personal resource (Fredrickson, Tugade, Waugh, & Larkin, 2003). This is a narrow understanding of resilience as it emphasizes only the selective strengths and internal resources and assets that helped people to survive difficult situations.

This view of resilience usually focused on single short-lived traumatic experience (Herman et. al., 2011). However, as time went on, the focus on short-lived trauma expanded to encompass negative life events across the lifespan, associated with adjustment difficulties or subsequent mental health disorders (Herman et al., 2011). As research progressed further, the study of resilience broadened to include the contributions of systems like families, groups, services, and communities to assist and facilitate people in coping with adverse situations (Herman et al., 2011). Subsequently, the understanding of resilience and resilience interventions incorporated "protective and vulnerability forces at multiple levels of influence, namely: culture, community, family and the individual" (Cicchetti, 2010, p.151).

Moreover, other resilience theories comprehend resilience more broadly as protective factors, processes and mechanisms that contribute to a good outcome despite experiences with stressors shown to carry significant risks for developing psychopathology. This understanding extends the view of resilience as an interactive system; a concept relating to resistance to environmental risks; a multi-dimensional characteristic that varies with context, time, age, gender, and cultural origin; as well as within an individual subjected to different life circumstances (Connor & Davidson, 2003; Hjendal et. al. 2006; Rutter, 2006). In line with this theoretical understanding of resilience, Davydov, et. al., (2010) construed resilience as an integrating multi-level biopsychosocial construct. This biopsychosocial model of resilience assumes the presence of numerous processes within and outside a person that help buffer the effects of adverse experiences. This approach assumes that in order to survive a psychological challenge, the system should have in-built mechanisms able to recognize and neutralize adversities and their related effects (Davydov, et. al., 2010; Hoge et al., 2007; Patel & Goodman, 2007). These authors opined that resilience theory in mental health research is presently inhibited by the lack of a unified research methodology and poor concept definition. Hence, their underlying assumption is that some other conceptual models, such as multi-level protection, which

have been developed for understanding resistance to some somatic disorders, might also help in the understanding of resilience in mental health. These authors think that somatic illness has received extensive attention regarding prevention and resistance while mental illness has suffered substantial neglect in this regard. They therefore recommend that a more extensive, multi-level biopsychosocial understanding is required in order to promote, prevent and regain mental resilience. Resilience for them is a mechanism involving numerous factors (Charney, 2004; Davydov, et. al., 2010).

Moving on, another important point to note in resilience theory and research is that resilience may vary according to age and it has been found to decrease when people are over 70 years of age (Rothermund & Brandtstadter, 2003). Resilience has also been found to be a product of genetic factors (Cameron et al., 2007; Charles & Almeida, 2007; Stawski, Sliwinski, Almeida, & Smyth, 2008). In retrospect, these definitions and theories of resilience all come to suggest that: 1) there are numerous factors and systems that come into play to constitute the meaning of resilience; and different individuals have different ways of remaining resilient. Hence, it is necessary to investigate how African female refugees remain resilient in the midst of their mental health issues.

2.3 Empirical Research on Refugee Mental Health and Resilience

My next task is to review salient empirical research studies on the mental health issues of refugees. The first review is a 2020 study which examined a total of 325 (143 males, 182 females) Congolese refugees, aged 18 and 65 years, with mental health issues, who recently moved to Uganda. Refugees who stayed in the settlement for at least a period of 1 month to 1 year prior to the day of the interview were included. Assessment included exposure to war-related traumatic events and focused on consequences of recent experiences of war and violence. The findings revealed that refugees, (particularly women) were highly exposed to different types of war-related traumatic events that produced high levels of mental illness symptoms, especially PTSD. The overall high prevalence of PTSD differed among women (94%) and men (84%). The highest conditional

prevalence of PTSD in women was associated with experiences of rape. Women, unlike men, showed higher PTSD symptom severity when experiencing low and moderate levels of potentially traumatizing event types. The study is suggestive that interventions focused on reducing mental health problems resulting from war should take into consideration, the context of gender (Ainamani et al., 2020).

Two critiques to this study include: 1). The semi-structured interviews were conducted in the Kiswahili and Kinyabwisha languages (spoken by Congolese refugees living in Nakivale refugee settlement), and then translated into English. As the saying goes; translators are traitors. Sometimes words could lose their original meanings from translations; and the translators may not represent the thoughts and expressions of the refugees exactly as they mean them. 2). Participants were compensated with a bar of soap and a package of salt each, for their time. This raises the ethical question as to whether the participants may have been compelled to participate in this study by the material gifts they received.

Another paper is Babatunde-Sowole, et. al. (2020). Resilience of African migrant women: Implications for mental health practice. This paper presented insights into African women's experiences of hardship and resilience. It used a qualitative strength-based storytelling approach with 22 West African migrant women (mostly refugees) living in Australia; to raise awareness about their resilience prior to migration.

Results of the study were captured in two major themes: "when the world falls apart" and "battered but strong" The former showed that most of the women were enjoying peaceful homes, relative wealth, social status, comfort and good health in their home countries until they were suddenly displaced. The later "battered but strong" included the women's experiences of living in refugee camps. The findings showed that despite having little or no access to basic amenities and living precarious lives the women were very resilient prior to coming to their host country. For many

years, they overcame the adversities associated with refugee camps and having to move from one camp to another. The findings further revealed that because these women are already resilient, some of them may not seek mental health help when they arrive in their host countries.

The authors encouraged healthcare practitioners to always be aware of the resilience of migrant women and incorporate this knowledge into providing appropriate trauma-informed care. They emphasized the need to focus on migrant people's strength to expedite their healthy re-settlement. Instead of looking at these women from a medical model lens, practitioners should look at them from a strength-based lens. Rather than focusing on problems and failures, practitioners should focus on individual, family, or collective strengths and the abilities of these women to adapt and become strong during challenging times. The study, however, failed to mention in what specific ways these women were resilient. It also did not provide the demographics and statistics of the various categories of migrants.

The next study for review is: "Determinants of Depression among Ethiopian Immigrants and Refugees in Toronto" (Fenta, Hyman & Noh, 2004). The purpose of the study was to determine the risk factors for depressive disorder in a representative sample of adult Ethiopian immigrants and refugees residing in the greater Toronto area in Ontario. The study used the Composite International Diagnostic Interview questionnaire (WHO, 2004), to measure depression. A random sample of 342 Ethiopians organizational members who were recruited through a snowball technique of locating organizations completed the structured interview. Using a snowball technique, the researchers identified all the possible Ethiopian ethnic, religious, political, and social organizations in Toronto and obtained membership lists from each organization. The resulting sampling frame consisted of approximately 4,854 households. From this list, 400 households were selected using a simple random sampling method, and one person 18 years or older was selected from each household. Ethiopians who had resided in Canada for less than 12 months were excluded from the study. A total of 342

people completed the structured interview. Sixty percent of the participants were men and 40% were women; the majority were married, and ages ranged from 18 to 59.

The participants reported a series of pre-migration experiences of traumatic events, such as difficult camp internment, being beaten or raped or seeing other people hurt or killed. Post migration stresses such as perceived discrimination, language barriers and racism were also recorded. Personal and social resources were also assessed. The data were eventually coded, and descriptive data analysis conducted. The results indicated a slightly higher rate (9.8%) of depression among Ethiopian immigrants and refugees than the prevalence rate in the rest of the Ontario population (7.3%). However, the rate among Ethiopian immigrants and refugees in Toronto was approximately three times higher than the rate (3.2%) estimated for Southern Ethiopia residents. The study also found that the prevalence rate of depression among men was higher than women. One possible explanation for this pattern could be that men in the sample were more likely to have experienced conditions associated with depression (such as: migration traumatic experiences and refugee camp internment) than females. Thus, Ethiopian refugee men compared with women are more likely to be exposed to adverse mental health consequences of migration and settlement stresses (Fenta, Hyman & Noh, 2004).

The data confirmed that the prevalence of depression in the participants was triggered by contingencies surrounding the pre-migration and resettlement experience that determine the risk of developing a mental health problem. Such contingencies include younger age, experiences of pre-migration trauma, refugee camp internment, and post-migration stressful events. The implication of the overall finding is that there is a need to develop mental health intervention programs, particularly for people who have experienced pre-migration trauma, refugee camp internment, and post-migration stresses.

One critique that could be made against this study is that it excluded Ethiopian refugees who had resided in Canada for less than 12 months before the initiation of the study, but the researchers did not explain why they did this. This exclusion seems contradictory to research findings which indicated that psychological and mental health stresses are more predominant among the most recent refugees and newcomers, because they have to cope with multiple and often chronic stressors encountered within the new environment (Berry, 2006; Castro & Murray, Kuo, 2014; 2010; Zheng, et. al., 1991). The Canadian Task Force on Mental Health Issues (1988) also found that pre-immigration traumatic experiences, such as internship in refugee camps, torture or witnessing violence, increases the risk of mental illness among refugees, particularly post-traumatic stress disorder and depression, in the first six months after arrival in Canada.

Furthermore, another study conducted by Perera, et. al., (2013) aimed at assessing differences in pre-migration, transit, and resettlement stressor exposure and Post- Traumatic Stress Disorder (PTSD) symptoms as a function of demographic characteristics (gender, ethnicity, age, time since immigration) in African refugees. It also examined the relationships between stressor exposure and PTSD symptoms. This study used data from a three-phase epidemiological study of Somali and Oromo refugees (Jaranson, et al., 2004, and Spring et al., 2003). The original sample consisted of a total of 1,134 adult Somali and Ethiopian refugees who completed the survey. The current analyses used data from a subsample of participants from the aforementioned study. This subsample consisted of 137 Somali men, 115 Somali women; 87 Ethiopian men, and 98 Ethiopian women. The age range of the sample was 18–78 years. Quantitative data were collected regarding pre-migration, transit, and resettlement stress and PTSD symptoms. The study used three separate multiple regression analyses with three stressor exposure scales (pre-migration, transit, and resettlement stressor scales). Analyses showed that resettlement stressor exposure generally was associated with higher PTSD symptom levels. It found that refugee women reported more pre-migration, transit, and resettlement stressors

than did refugee men. In one of its item level analyses, the study reported large differences between men and women in several specific stressors at the three time periods, including: authorities confiscating personal property during pre-migration (women = 68%, men = 27%), difficulty understanding host country's culture (women = 78%, men = 32%), and inability to speak English (women = 57%, men = 31%). The study also found differences in demographic characteristics. For instance, Ethiopian women and older refugees reported more pre-migration and resettlement stressors. Ethiopian refugee men reported more PTSD symptoms in regression analyses with other factors controlled. The result of the study underlined the importance of thorough assessment of trauma exposure throughout the refugee experience and cautioned against overgeneralizing between and across refugee groups (Perera, et. al., (2013).

This study can be applauded for being able to systematically analyze data from three separate studies in order to expand the understanding of the experiences of Somali and Oromo refugees in relation to mental health issues. However, one of the limitations is that it did not reiterate the original sample design and selection for the readers to clearly understand and appreciate the sampling procedure. Moreover, the study selected only 437 subjects for the sub samples out of the 1,134 sample from the original study, but, again, the researchers did not specify criteria with which the sub sample was selected.

Furthermore, Goodman, et al. (2017) did a qualitative study on trauma and resilience among refugee and undocumented immigrant women in the United States. They explored the multiple sources of trauma and stress that refugee and undocumented immigrant women experience and how they coped and adapted. The study used a phenomenological approach with nineteen immigrant women, of whom ten were undocumented immigrants from north, south and central America. Nine were refugees from Africa and the Middle East. The interviews were conducted in different languages based on the participants' preferences and language abilities.

The result revealed that these women endured premigration, migration and post migration trauma such as grueling years of journey filled with fear and uncertainty for the safety and survival of themselves and their children. They went through traumatic refugee camp experiences such as sexual assault and witnessing others being raped and abused, family separation, employment, economic and situational stress, and institutional betrayal trauma (wrongdoing by an institution upon which an individual relies). Most of the refugee women felt that they were made promises by government officials which were never fulfilled (Goodman, et al., 2017). These experiences, in turn, led to psychological symptoms such as posttraumatic stress, depression, and suicidal ideations. The women, however, developed external and internal methods to persevere, despite their stressful experiences. Internal processes of coping include beliefs in a better future, faith and religion; while external processes include family and social support, community and government resources.

The next longitudinal study worth mentioning here is "Tracking the Emotional Cost of Immigration: Ethno-religious Differences and Women's Mental Health" (Holtmann, & Tramonte, 2014). The study inter alia examined the influences of different pre-migration and post-migration activities on the mental health of immigrant women. The target population consisted of economic class, family class, independent immigrants, and refugees. Refugees constituted 6.2% (478) of the total population. Participants were interviewed at three different times: at 6 months after arrival, 2 years later, and then 4 years after landing in Canada. The first stage included data from 12,040 participants who arrived in Canada between October 1, 2000 and September 30, 2001 (Holtmann, & Tramonte, 2014).

The number dropped to 7,716 by the second stage and remained unchanged by the last stage. 50.5% of the participants are women and 49.5 % are men, leaving a sample size of 3,897 for analysis. Findings show that immigrant women's self-reported experiences of mental health vary at arrival and over the course of the settlement process because of the intersection of pre-migration and post-

migration factors. Challenges of the settlement process can give way to persistent feelings of sadness, loneliness and despair for immigrant women. This study did a huge analysis of the data while considering various demographics such as age, employment status, professions, and ethnic origins of the participants. However, it failed to enumerate the various types of mental health issues prevalent among these women and the degree to which they exist. It did not indicate the specific types of experiences that contribute to the mental health issues. It only indicated that pre-migration, post-migration and settlement factors influenced the immigrant women's mental health outcomes. The study also did not mention whether or not there are difference in outcome for refugee women or other classes of immigrants.

Akinsulure-Smith (2017) conducted a qualitative study titled "Resilience in the Face of Adversity: African Immigrants' Mental Health Needs and the American Transition.". The study explored key sources of emotional distress and coping strategies among West African immigrants. The focus group involved thirty-eight adult West African immigrants. The result showed that the participants' sources of psychological issues include racial and cultural discrimination, intimate partner violence, parenting, extended-family demands, and problematic immigration status. Their resilience was drawn from a range of positive and negative sources such as: humor and isolation, African cultural heritage, reaching out to family members back home, connecting with local African immigrant community, religious faith, substance use.

The authors concluded by encouraging healthcare practitioners to offer help to African immigrants outside formal mental health agencies; but within African community-based agencies, medical offices, social services agencies not specifically associated with mental health, and in some cases even within their homes. They also recommended developing partnerships between mental health service providers and African-serving community-based agencies and faith-based organizations. Leaders and trusted members of the community could receive basic mental health

training that would enable them to respond to mental health concerns within the community and collaborate with mental health agencies to provide culturally informed services.

One critique of this study is that the researchers failed to mention the types of substances being used by some participants to cope with their mental stress, and the degree or extent to which they are used.

Moving on, a study by Fazel, Wheeler and Danesh, (2005) conducted a meta-analysis on the prevalence of serious mental disorder in 7,000 refugees resettled in western countries. They searched for psychiatric surveys that were based on interviews of refugees with current diagnoses of post-traumatic stress disorder, major depression, psychotic illnesses, or generalized anxiety disorder. In order to avoid reporting and selection biases, the analysis excluded studies in which diagnoses were made solely on the basis of self-report questionnaires or that included refugees referred to clinical or other health-care services. Diagnoses were made solely on the basis of clinical interviews and most studies trained interviewers to make diagnoses using validated diagnostic methods, mainly with semi-structured interviews. They covered studies done from 1966 to 2002. In their review, 20 studies in 24 publications provided results for 6,743 adult refugees from seven countries: Australia (1,199 refugees), Canada (364), Italy (40) New Zealand (223), Norway (129), the UK (120), and the USA (4,668). Seventeen studies identified post-traumatic stress disorder, with data for a total of 5,499 adult refugees (mean age of 27) mainly from Southeast Asia, the former Yugoslavia, the Middle East, and Central America. Fourteen studies identified major depression, with data for a total of 3,616 adult refugees mainly from Southeast Asia, the former Yugoslavia, Haiti and Cuba. Only two studies of psychotic illnesses were identified, consisting of data for a total of 226 adult refugees. Five studies of generalized anxiety disorder were identified, with data for a total of 1,423 adult refugees.

Overall, research reported substantial data on comorbid psychiatric disorders, especially with ptsd and depression. The study concluded that the probability that these disorders overlap in many

people could be high. Five surveys identified 260 refugee children from Africa, the Middle East and Central America with ptsd. Overall, refugees resettled in western countries could be about ten times more likely to have ptsd than the age-matched general population in those countries. The study concluded that worldwide, tens of thousands of refugees and former refugees resettled in western countries probably have post-traumatic stress disorder.

This study did a good job in being able to analyze a sample size as large as 7,000. However, one of the limitations of this study is that the analysis excluded studies in which diagnoses were made solely on the basis of self-report questionnaires. It also excluded refugees referred to non-psychiatric clinical or other health-care services; thereby restricting the sample to only refugees who were clinically diagnosed in psychiatric settings. It would have been good to include refugees who self-reported as having mental health issues because many refugees with mental illness may still not be clinically diagnosed (Public Health Agency of Canada, 2006).

Another study, Udah, et al. (2019) was titled; “Experiences of vulnerability and sources of resilience among immigrants and refugees”. The article focused on the nature of, and factors contributing to experiences of vulnerability; and sources of resilience among immigrants and refugees of African background in South East Queensland, Australia. Participants consisted of 10 females and 20 males between the ages of twenty-two and sixty-seven years. Seventeen (56.7 percent) were refugees 13 (43.3 percent) were temporary residents.

The findings showed that their vulnerability and disadvantage emanate from being visibly different in white dominated country, coupled with other indicators like cultural difference, skin color, physical features, accent, dress, and religion (Udah, et al. (2019). Resilience was shown to be derived from going back to school, upskilling, and support from families and communities. The authors in the end called for change in society’s attitudes towards immigrants and refugees. Instead

of pathologizing them and focusing on their victims' stories, society should focus on their strengths and resilience.

The next empirical study for our consideration is Schweitzer et. al., (2006). The study examined the impact of pre-migration trauma, post-migration living difficulties and social support on the current mental health of resettled Sudanese refugees in Australia. The sample consisted of a total of 63 participants over 18 years of age, 21 females and 42 males, representing approximately 6.7% of the Sudanese population in Queensland Australia. Participants were selected via snowball sampling where two bilingual community liaison workers (one male, one female), who had strong links with the Sudanese refugee community, identified potential participants and approached them to participate in the study. They also invited participants to nominate further potential participants.

Hopkins anxiety, depression and somatization subscales (HSCL-37) were used for measurement. This scale is an extended version of the HSCL-25 that has been validated on a general American population (Winokur, Winokur & Rickels, 1984) and translated into various language versions that have also been validated (Mollica et. al., 1987). Reviews have attested to the transcultural robustness of the measure and its appropriateness when applied to refugee populations (Butcher, 1999; Hollifield et. al., 2002). Sixteen percent of the participants suffered from major depressive disorders and 13% suffered from ptsd according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), (Schweitzer et. al., 2006). However, 84% of the sample had experienced recurrent thoughts or memories of the most hurtful events, 62% had experienced recurrent nightmares, 59% reported trouble sleeping, and 71% reported avoiding thoughts and feelings associated with those traumatic events they had experienced. Worry about family back home (95%), limited employment opportunities (82.5%) and acculturation difficulties (73%) were the most commonly reported factors that contributed to the reported high levels of psychological distress among the participants. Other factors included: murder of family (62%) or

friends (68%), lack of food and water (59%) or lack of shelter (57%). Torture was experienced by 11%. The participants identified these factors as the causes of their mental health issues. One hundred percent of the participants reported that their families had also experienced trauma or had been tortured.

The results indicate that social support, particularly perceived social support from the migrants' ethnic community played a significant role in predicting positive mental health outcomes. The study concluded that the Sudanese refugees experience considerable mental health difficulties as a result of pre- and post-migration trauma and may constitute a particularly vulnerable group in terms of mental health outcomes. This study conducted a very good and comprehensive analysis of the impact of pre-migration trauma and post-migration difficulties on the mental health of resettled Sudanese refugees in Australia. It went as far as indicating to what percentage and degree each migration and settlement factor affected the target population. This wide-ranging analysis provides an in-depth understanding and knowledge of the experiences of refugees to even the novice reader.

Baiden & Evans (2020), also conducted a study titled; "Black African Newcomer Women's Perception of Postpartum Mental Health Services in Canada". The study focused on the sociocultural factors that impact African female newcomer' perception of mental health and service utilization after childbirth in Canada. Ten African women who gave birth in the past year were interviewed.

Results showed that Black African newcomer women rely on mental strength, nonmedical treatment options, spirituality, and spousal support for fostering postpartum mental health. Additionally, cultural beliefs, racial discrimination, and temporary immigration status impede their decision to seek postpartum mental health services. Without permanent resident status, they cannot utilize the mental health services for free. Some of them feel that the system is built to exclude them from utilizing such services, whereas many do not seek Western therapy on account of their cultural beliefs.

In retrospect, the authors recognized the urgent need for implementation of culturally safe interventions to meet the postpartum mental health needs of Black African newcomer mothers. Although this study is not specifically about refugees, it did provide insight into the coping strategies of women from Africa. Its findings on resilience are not very different from other refugee studies.

Another study by Pulvirenti & Mason, (2011), titled: "Resilience and Survival: Refugee Women and Violence" examined the ways in which refugee women can be seen to be resilient; and, second it explored the significance of understanding resilience within the context of environments, that is: as a process rather than an individual trait. The sample consisted of 18 service providers (women and men) who work with refugee women experiencing violence in resettlement. A snowball sampling method was used across two different states in Australia to ensure that sufficient services and a cross-section of agencies were included. Agencies were initially selected from publicly available government listings of services supporting refugee communities. Agencies were cold-called and invited to participate. All agencies, whether they accepted or declined to participate, were invited to refer other service providers who could be invited to participate. When an agency agreed to participate, usually through approval of senior management, consent was arranged with individual respondents. Respondents were given the option of full or part confidentiality so that eventually all names were withheld, but some roles and agency names were disclosed. Interview questions were semi-structured and covered four general areas: refugee women's experiences of violence; refugee women's survival strategies; refugee men's responses to refugee women's experiences of violence; and respondents' understanding of resilience.

Results from this study showed that service providers think refugee women are resilient. Many of the respondents described resilience as a "word that always pops into your head when you listen to stories or watch women go through settlement" (Pulvirenti, & Mason, 2011, p.6). The respondents believed that a word such as resilience only partially captures the qualities and

capabilities of refugee women to endure and survive. They thought that what refugee women have is so much more than resilience; it is better described as: courage, endurance, adaptability, selflessness, resourcefulness, and strength. When it comes to the ways in which refugee women can be seen as resilient, they believed that refugee women are resilient simply by having survived the journey out of their homelands and beyond refugee camps. They also thought that refugee women can be seen as resilient because of their ability to have coped with violence such as: conflict, trauma, loss of family, poverty, extreme conditions in refugee camps, and intimate partner abuse.

However, the study showed that naming refugee women as resilient risks diminishing other resources provided by the various sectors. Many respondents expressed concerns about the use of the word resilience. They thought that it is a term that locates the responsibility within refugee women and puts the onus on them to find a way to cope with extraordinarily difficult situations; instead of holding the community and government responsible to address those difficult situations. They expressed concern that the descriptions of refugee women as resilient could function as a rationale for assuming these women are able to fend for themselves and are therefore not in need of support from the government. The study also showed that resilience in refugee women is not automatic; rather, is built through support systems. The internal resilience of these women is built up through extended family or the community. Refugee women's resilience is closely tied to the degree and quality of support they receive. So, resilience is a process that is nurtured by external supports (Pulvirenti, & Mason, 2011). Material support regarding housing, employment and growing social capital were seen as material conditions necessary for supporting resilience.

In summary, the findings of this study provided substantial information that contributes to our understanding of resilience within the context of refugee women as a process that requires other supports. It also avowed the dangers of using the concept of resilience with refugee women. However, I do not think that the study accomplished its first task, which was to explore the ways in

which refugee women can be seen to be resilient. I think this may have been owing to the questions that the researchers asked the participants. They should have asked specific questions on the specific characteristics that make refugee women resilient. Additionally, when it comes to questions of resilience and to determine if refugee women are resilient, I would imagine that it is better to interview the refugee women themselves and not just their service providers. Another critique of this study is that the authors just mentioned that 18 people who were interviewed consisted of men and women; it would have been better to know the percentage of men and of women who participated in the study. More so, the study did mention that participants were given the option of full or part confidentiality; and eventually all names were withheld; but some roles and agency names were disclosed. However, the researchers did not explain why it was necessary to compromise confidentiality by revealing the roles and names of the agencies. I observed that the service providers were quoting and making references to information provided to them by some of the refugee women. Again, disclosing the agency names may compromise the confidentiality of some refugee women whose stories were re-told by these service providers. Finally, it was not clear how the third interview question: "refugee men's responses to refugee women's experiences of violence" would help the researchers accomplish their research goals.

Pannetier, et al., (2017), conducted a study titled: "Mental health of sub-Saharan African migrants: The gendered role of migration paths and transnational ties". The goal of the study was to understand the influence of migratory paths and transnational ties on the mental health of African women and men migrants living in Paris, France. This study used data from surveys conducted between February 2012 and May 2013, from a representative sample of 2468 migrants who visited healthcare facilities (including undocumented migrants). The age range of participants was between 18 and 59 years old. A face-to-face standardized life-event history questionnaire was administered to each participant.

The results demonstrated that mental health is related to the migratory path and the migrant's situation in the host country, with gender specificities. The levels of anxiety and depressive symptoms were higher in women (24%) than in men (18%). Among women, anxiety and depression were strongly related to having left one's home country because of threats to one's life. Whereas among men, residing illegally in the host country was related to poor mental health.

Age, length of time spent in France, relationship status and religiosity had implications for mental health prevalence. The likelihood of anxiety and depressive symptoms decreased among older and long staying migrants, those in a stable relationship, and those who frequently practiced religion (Pannetier, et al., 2017).

Additionally, cross-border (transnational) family connections and separation were associated with anxiety and depressive symptoms. The likelihood of having anxiety and depression was lower in women and men who had relatives and friends to rely on in both home and host country compared to women and men who had no one close to rely on. Social and emotional support from relatives and friends both in the country of origin and destination was associated with a lower level of anxiety and depressive symptoms. Transnational ties among sub-Saharan African migrants not only include emotional support, but also include financial support (Pannetier, et al., 2017). Although this study did a good job in portraying the impact of transnational ties; it, however, did not emphasize the impact of gendered roles on the mental health of African migrants.

Moving on, Amodu, et al., (2020) did a systematic review of literature on the health of conflict-induced internally displaced women in Africa. There was no limit to the scope of literature, but it included studies done up to the year 2020. Thirty-one relevant studies were included in the review. All of the 31 studies were conducted in various parts of Africa.

Results showed that violence, sexual and reproductive health, malaria, and mental health were identified as the major health issues suffered by displaced African women. Poor social and

economic conditions were found to predispose women to the above health conditions. Mental health was discovered to be a major health issue among others. Ten studies out of the 31 focused on the mental health of displaced women.

The study further revealed that numerous factors affect the mental health of internally displaced women in Africa. Sustained experiences of violence and traumatizing effects of prolonged conflicts resulted in mental health issues for these women. More so, excessive care-giving responsibilities, post-conflict gender role shifts, lack of financial and family support, family dysfunction, and men's chronic alcoholism were also other precipitating factors.

In conclusion, national and regional governments were encouraged to engage in institutional restructuring and improved funding allocations to culturally appropriate health interventions for displaced women. Such culturally appropriate interventions could include engaging religions leaders who serve as role models to these women, to help promote mental health and suicide prevention awareness. Government policies could also explore developing incentive-based home health intervention programs to significantly improve the knowledge, perception, and willingness of displaced women to take up available services. The study did a good job in identifying the causes of mental health issues among displaced African women. However, since mental health was a huge factor in their review it would have been good for the study to also explore how these women coped with their mental health challenges.

The next study by Siriwardhana, & Stewart, (2013) is titled: "Forced migration and mental health: Prolonged internal displacement, return migration and resilience". This was a meta-analysis that reviewed global research evidence on the impact of forced migration and prolonged internal displacement on the mental health of internally displace peoples (IDPs); and the role of resilience factors following situations of prolonged displacement.

The writers noted that evidence from the Internal Displacement Monitoring Centre (IDMC) estimates that currently there are around 27 million internally displaced people around the world (Siriwardhana, & Stewart, 2013). These data are now obsolete as the Internal Displacement Monitoring Center reports in its latest update, the number of IDPs at 38 million as of 2014 (IDMC, www.internaldisplacement.org, retrieved April 2, 2016). According to the authors, global research evidence suggests that many of these IDPs are at high risk for developing mental disorders (Siriwardhana, & Stewart, 2013). The analysis revealed that many IDPs have undergone acute stressors, (such as conflicts, abuses and violence), psychological and physical trauma before and/or during their displacement ordeal. However, it also noted that some IDP populations have had pre-existing vulnerabilities (socio-economic and health-related) that may act as precursor factors in developing mental health issues following their traumatic displacement (Porter, & Haslam, 2005; Thomas & Thomas, 2004). They opined that prolonged displacement can have even more detrimental impacts on physical and mental health of IDPs because of the trauma they undergo in the displacement setting (Porter, & Haslam, 2005). Crowded displacement camps, poverty, political, environmental, and socio-cultural determinants were found to contribute to the negative mental health outcomes of IDPs (Roberts, et. al., 2009). The researchers found that studies among IDP's have mainly focused on PTSD, potentially neglecting other mental disorders (Murray, Davidson, & Schweitzer, 2010).

When it comes to return migration and mental health, the researchers found that most refugees who were located in host countries with extremely limited resources compared to their country of origin may face some socio-economic challenges. In contrast those who lived in a relatively resource-rich, peaceful environment in the host country, may face increased levels of daily stressors and difficult experiences when they return to their areas of origin with limited resources. This may increase their risk of developing mental disorders.

On the role of resilience factors following situations of prolonged displacement, resilience was found to be a useful tool to identify and prevent mental health issues and to develop effective interventions among high risk populations such as IDPs (Siriwardhana, & Stewart, 2013).

Additionally, Morina, et al., (2018), conducted a systematic review of the prevalence of psychiatric disorders in adult refugees and internally displaced persons after forced displacement. The review undertook a database search using various search engines. The search was limited to systematic reviews and meta-analyses published after 1980 which focused on prevalence of common mental disorders among internally displaced people and refugees afflicted by armed conflicts in a war region or unstable country. Of the 915 articles selected, 38 were eligible and provided data for a total of 39,518 adult IDPs and refugees from 21 countries.

The results demonstrated that 75.3% of the population reported the prevalence of post-traumatic stress disorder, depression and generalized anxiety disorders. Other mental health issues identified include substance abuse, psychosis, suicidality, personality disorders, and other forms of mood and anxiety disorders. Internal displacement, protracted conflict conditions, and economic instability were shown to be strongly associated with poor mental health outcomes for displaced adults (Morina, et al., 2018).

The results of the meta-analysis were presented in a manner that is so direct and easy to understand. However, the articles were extracted from studies conducted in various countries that differ significantly in terms of population characteristics, race, culture, social traditions, religion, language, and even the duration of displacement and types of conflicts research subjects endured. It would have been better to present the findings separately for refugees and IDPs with common and/or similar experiences.

Another study conducted among internally displaced Congolese adolescents examined the impact of war-induced displacement and its related risk factors on the mental health of 819 Eastern

Congolese adolescents, aged 13 to 21 years old (Mels, Derluyn, Broekaert, & Rosseel, 2010). Respondents completed culturally adapted self-report measures of posttraumatic stress symptoms, using the Impact of Events Scale, revised version (Weiss, and Marmar, 1996). They also completed internalizing and externalizing behavior problems using the Hopkins Symptom Checklist 37, for Adolescents (Winokur, Winokur & Rickels, 1984). Data were compared to non-displaced peers. Results showed that internally displaced persons reported the highest mean scores for psychological distress, when compared to non-displaced peers. However, despite their traumatic experiences, mental health outcomes can be improved with resilience related attributes, such as coping (Mels, Derluyn, Broekaert, & Rosseel, 2010).

In retrospect, this literature review has demonstrated that refugees from every background residing all over the world undoubtedly do suffer various forms and degrees of mental health and psychological distresses that impair their functionality (Fazel, Wheeler & Danesh, 2005). The review has also specifically demonstrated that refugees from Africa, in particular, also face multiple mental health challenges (Schweitzer et. al., 2006). However, no study has specifically focused on the resilience strategies of female African refugees. So, the gap in research regarding female refugees of African origin needs to be filled. My research, therefore, aimed to fill in this gap and further contribute to the ongoing research on the mental health problems among refugees. It specifically focused on facilitating recovery for African female refugees by exploring their resilience strategies with the aim of making appropriate recommendations for theory, policy and mental health practitioners working with refugee women of ethnic minorities.

2.4 Contributions of this study

Mental health is a significant predictor of both physical health and quality of life, and good mental health provides individuals with a foundation for well-being and effective functioning (World Health Organization, 2005). Migration and its impact on refugees' well-being are a contemporary

issue. Although there is an attempt to understand the impact of migration on the mental health of refugees based on the studies conducted around the world (Virupaksh et al., 2014); there is limited Canadian literature that is focused on evidence-based interventions targeting the mental health issues of refugees in general (Wieling & Mittal, 2008); and African female refugees in particular (Hansson, Tuck, Lurie & McKenzie, 2010). A lot has been written on the many sociocultural risk factors and life experiences that make refugees susceptible to mental health issues (Morris, 2009). But the need to understand refugees' experiences, the impact on their mental health and the effectiveness of intervention, are extremely important (Hwanga et al. 2008). Limited research has focused on refugees and the factors that foster post migration adjustment (Schweitzer, Greenslade & Kagee, 2007). Moreover, refugee research has mostly focused on factors that make refugees more vulnerable for mental health issues; only a few articles have studied possible protective factors such as resilience (Arnetz, et. al., 2013). Based on my literature review, I could not find substantial empirical studies that focused on resilience and coping among African female refugees living with mental health issues in Canada. Most of the studies that dealt with African female refugees were on sexual and gender-based violence (Adeyinka & Akinsulure-Smith 2014; Gebreiyosus, 2014; Yok-Fong, 2014). I also found a study that focused on resilience among South Sudanese refugees dealing with unemployment (Wanga-Odhiambo, 2014). Schweitzer, et al., (2007), however, in their Australian study focused on coping and resilience among Sudanese refugees in general. Macdonnell, et al., (2012) focused on promoting resilience and the mental health of Canadian immigrant women in general. Lacroix & Sabbah, (2011) focused on a resiliency approach to intervention among refugees in general. There were also studies on Asian, Middle Eastern and Hispanic female immigrants and refugees (De la Rosa, et al. 2015; Bowen, 1999). However, there was no study that examined African refugee women living with mental health issues; yet there are a fair number of African female refugees in Canada. I then realized the need for empirical studies to unveil the resilience strategies of this group of people

in order to foster effective intervention and facilitate their quick re-settlement and recovery from psychological stresses.

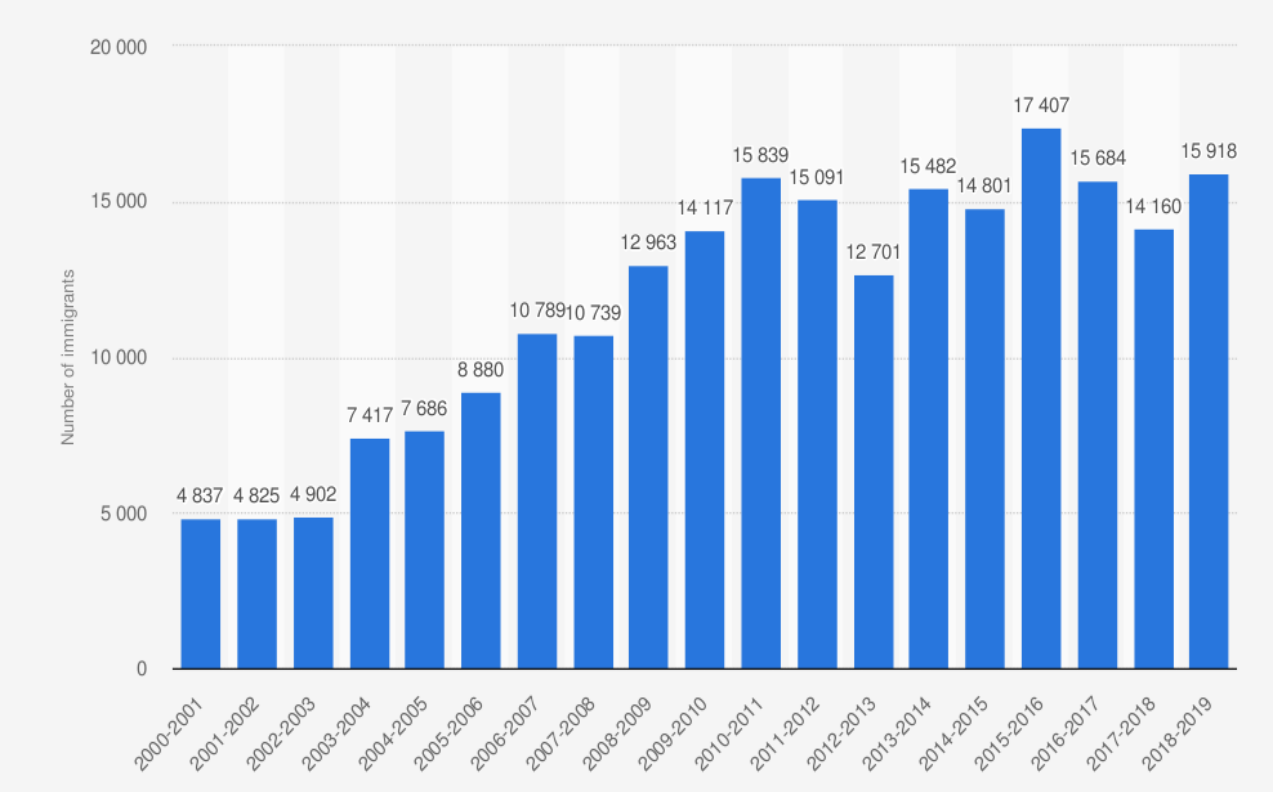
So, my study seeks to account for the gap in literature regarding African female refugee populations and their specific strategies that help them stay resilient amid their mental health and resettlement issues. It will help in understanding and identifying the specific strategies that African female refugees use in adapting to their new society and recovering from their mental health challenges. Knowledge of these resilience strategies will help mental health practitioners to formulate appropriate intervention plans geared towards reinforcing such resilience approaches, so as to promote their psycho-social wellbeing. In the past there has not been much consideration of the mental health needs and specific interventions targeted at this ethno-cultural and racialized group (Hansson et. al., 2010). There has been quite an increasing number of studies investigating mental health issues among refugees; however, when it comes to intervention strategies, these groups are often lumped together as one population (Hansson et al., 2010). This blanket approach to categorization of refugee groups may not be sufficient for the development of equitable services at a local, microcosmic and more appropriate level. There are major cultural, religious, historical, and language differences among various refugees from various nationalities, and these may be reflected in different needs at a service and/or intervention level (Hansson et al., 2010). Hence, there is a pressing need to enhance the availability and quality of mental health services provided to persons from historically disadvantaged racial and ethnic groups (Griner and Smith, 2006). Research proves that interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of clients from a variety of cultural backgrounds (Griner and Smith, 2006). In other words, what works for one group of people may not work for another, and, as such, various cultural groups may cope in various ways. When it comes to psycho-social rehabilitation of refugees, limited research has focused on African female refugees and the factors

that facilitate post-migration psychological adjustment. Understanding knowledge about their resilience and the capacity to overcome immigration stress and consequent mental health issues remains limited (Graham & Thurston, 2005). There is a dearth of evidence-based studies related to trauma, recovery, and interventions with refugee families that may help guide the development of intervention models (Wieling & Mittal, 2008). So, the present study aimed to address this empirical gap by exploring and delineating the themes highlighted by a sample of African female refugees as their resilience and adaptation strategies following their traumatic migration experiences. My research, therefore, focused on specific women from a specific cultural background in order to discover what works for them when it comes to resilience in the midst of mental health and migration issues. The study contributed to scholarship through alleviating the dearth of literature focusing on mental health intervention among African refugee women.

In the next page, I will present a table which shows the immigrant movement to Manitoba from the year 2000-2019. From 2006 to 2019, approximately, 15,000 immigrants per year found Manitoba as their new home (Statista, 2020). This number includes refugees and, thus, it is imperative to have services in place that would foster the mental health wellbeing of these new immigrants as they navigate their ways to settlement. Thus, the findings of my research contributed to the emerging Canadian literature, on policy initiatives regarding the mental wellbeing of our new immigrants on the macrocosm and refugees in the microcosm.

Figure 5.

Number of recent Immigrants in Manitoba, Canada (2000-2019).



Note. Table 1 shows the number of recent immigrants in Manitoba, Canada from 2001 to 2020. Between July 1, 2019 and June 30, 2020, there were 14,789 new immigrants to Manitoba. From "Number of recent immigrants in Manitoba 2001-2020" by Erin Duffin, Oct. 5, 2020. *Statista*. (https://www.statista.com/statistics/609175/number-of-immigrants-in-manitoba/). Copyright 2020 by Statista, (used with permission).

Through my research findings I hope to advocate for policy improvements in community mental health. I hope that my research will be able to instigate the enactment of policies that will foster tailored culturally relevant rehabilitation. Providing culturally informed, resiliency-focused mental health services to African refugee women as they rebuild their lives in a new sociocultural context has become a service imperative (Adeyinka & Akinsulure-Smith, 2014). My research, thus,

was focused on this strength-based aspect of rehabilitation as the resilience approaches that were explored are directly from the clients themselves, based on their inner strength and cultural values.

Furthermore, I also hope that my research may contribute to the development and formulation of theories of risk and resilience and the subsequent planning of resettlement services that can benefit refugee women of African origin. I hope that my research will contribute to the understanding of cultural perspectives on resilience theory by illuminating the role of culture as a contributing factor to resilience, rather than as a risk factor. There is an assumption that the cultural practices of refugee families are faulty and need to be remedied (Garcia & Magnuson, 2000). The host country might expect refugees to adopt its own cultural ideals and values; thereby undermining the refugees' own culture. Research has found that although the cultural values of ethnic minorities have been ignored in prevalent resilience theories; culture plays a very important role in understanding and maintaining resilience (Southwick, 2014). Eisenbruch (1991) found that immigrants who were able to participate in some of their traditional ceremonies and practices and were less pressured to conform to the host country's social norms were more resilient than those in dissimilar situations. Hence, rather than viewing these refugees' cultural values as risk factors, Garcia and Magnuson (2000) suggested that refugee families be studied and understood from the perspective of resilience rather than that of the risk framework. So, my research has unveiled the cultural aspect of resilience from refugees' perspectives that may contribute to the ongoing study and development of resilience theory. The more we learn about resilience, the more possibility there is for integrating relevant concepts of resilience, like culture, into the relevant fields of medicine, mental health and science (Southwick, 2014). Finally, my research contributed to the ongoing research in the mental health of ethnic minorities.

Chapter Three: Methods

There were an estimated 70.8 million individuals forcibly displaced worldwide by 2018 (UNHCR, 2018, 2020). Africans constitute 12% of the world's refugees and 50% of IDPs (Crisp, 2010). Nigeria has the largest IDP population; a whopping 2.7 million (UNHCR, 2019). More so, in the last 15 years, Canada resettled approximately 26,000 refugees per year and Africans constituted 10% of the total population of refugees (IRCC, 2020). 52% of African IDPs are women, and these women go through a traumatic migration process that exposes them to various mental health issues. Yet, there is limited Canadian literature that is focused on evidence-based interventions targeting the mental health issues of refugees, in general (Wieling & Mittal, 2008), and African female refugees in particular (Hansson, Tuck, Lurie & McKenzie, 2010). The above data represent the crux of the research problem that generated my interest to investigate how these women are able to stay resilient despite their traumatic experiences.

This chapter will focus on the theoretical foundation of my study, articulation of my research questions and sub questions, the study method (qualitative) and methodological procedures which include, an interview guide, sample size and sampling strategy, recruitment and data collection; as well as the rationale for the choice of method and procedure.

I received Research Ethics Board approval from the University of Manitoba psychology and social sciences research ethics board.

3.1 Theoretical Foundation

This research is guided by anti-oppressive and feminist perspectives. Anti-oppressive practice (AOP) is a framework which addresses social divisions and inequalities in service provision to clients. It is a person-centered framework that aims to provide more appropriate and sensitive services by responding to people's needs regardless of their social status (Dominelli, 2002). AOP is all about embracing diversity and difference in working with disadvantaged clients (Mullaly, 2010).

It is a methodology focusing on process and outcome; and a way of structuring social relationships between individuals that aims to empower service users by reducing the negative effects of hierarchy on their immediate interaction and work with service providers (Danso, 2009; Dominelli, 2002). The AOP researcher opens up discursive spaces in which individuals can develop their own interpretation of their experiences; it fosters and builds strength in people (Danso, 2009; Dominelli, 2002). An AOP research framework is anchored in the action-oriented and emancipatory approaches of social science research (Humphries & Truman, 1994). This type of research framework is oriented towards encouraging underrepresented and underprivileged populations to participate in the course of the inquiry process. Participants in this type of research are seen as experts on their own lives who are capable of self-determination (Strier, 2007).

African refugee women face a plethora of issues of oppression, marginalization and disadvantage at different stages and areas of their lives (Heaman, 2001). They face multiple jeopardy during their immigration and settlement process (Hampton, LaTaillade, Dacey, & Marghi, 2008; Guruge, Collins & Bender; 2010). Thus, an anti-oppressive research approach is aimed at promoting values of equality and social justice by challenging the power of oppression (Dominelli, 2003, Rogers, 2012).

This framework guided me to realize that since participants are experts in their problems; they are better able to disclose the strategies which keep them resilient in the midst of their mental health issues throughout their migration struggles. Thus, an anti-oppressive research framework promotes self-reflection on the relationship between the researcher and research participants (Strier, 2007) as researchers naturally occupy privileged status in contrast to participants (Korsnes & Noem, 2015; Healy, 2005; Heron, 2005).

Feminist research has undergone significant evolution and expansion since its inception, resulting in different versions of feminist research (Birch et al., 2012). However, despite its

metamorphosis, there are common overlaps in meaning between the various feminist research versions (DeVault & Gross, 2007; Miller, Birch & Jessop, 2012). The methodological focus of feminist research is to recognize and center the importance of women's lived experiences in order to unveil neglected or hidden knowledge (Aldred & Gillies, 2012; Olesen, 2011; Stacey, 1988; Westmarland, 2001). Feminist perspectives aim at empowering vulnerable participants and challenging the monopoly of knowledge claims by those in privileged positions; it brings to light the silent and subdued voices of women. Research from a feminist standpoint is purported to produce more complete, less distorted knowledge (Harding 1986; Westmarland). It is aimed at creating opportunities for women and other marginalized groups to share their experiences so that social knowledge is not based solely on the experiences of men or other privileged groups (Becker & Aiello, 2013). It is a legitimization of women's experiences (Wine & Ristock, 1991).

So, both feminist and anti-oppressive theoretical foundations helped me to discover and deliver the knowledge of resilience as it is understood and experienced by refugee women. Both frameworks helped me as a researcher to constantly realize my own privilege and advantage over the participants, and, thus, always to be conscious of my actions. This constant self-awareness enabled me to minimize the disempowering effects and consequences of power and privilege; thus, avoiding reproduction of oppressive social relations. For instance, during the entire process of recruitment and interviewing, I always allowed participants to make decisions based on their own convenience and personal judgment. I always made it clear to them that they were free to answer or not answer any of the questions asked and if they so wished to leave the interview sessions they could. I ensured that every answer they gave was freely given and not influenced in any way by me. If I observed that a participant was timid, nervous or frightened, I offered to switch positions with the person, where she sits at my desk and table and I sit at her own desk. This gave such a participant a sense of empowerment and feeling of being in charge of the session. These perspectives further allowed an

examination and interpretation of the data within the context of race, class, culture, and gender (Meleis, Sawyer, Im, Messias, & Schumacher, 2000).

3.2 Research Questions

3.2.1 Primary Question. 1) How do African female refugees and IDPs with mental health issues stay resilient and how are they able to manage their psychological stresses and mental health challenges despite their stressful migration experiences?

3.2.2 Sub Questions. 1) What are some of the reasons African female refugees and IDPs leave their homes to seek refuge elsewhere? This question is necessary for triangulation. It will help me to identify pre-migration stresses for my sample so as to corroborate such stresses with present research findings regarding the reasons why refugees are forced to leave their homes. The reasons why refugees leave their homes may impact the stresses they go through and the extent to which their mental health issues are affected. Also, the extent to which one's mental health is affected may affect the person's approach to resilience.

2) What are some of the tough experiences that these refugees and IDPs went through during their journey from their home to the refugee camp? This question captures migration stresses. One cannot explain how he/she stays resilient without reference to the problems/issues he/she is facing. This is why I needed to know the issues that my sample experienced. This will help me understand in a clear manner their resilience approaches and to be able to relate such approaches to the issue being experienced. In other words, knowing the tough experiences that these refugees went through is like having knowledge of "the problem" while knowing their resilience approach is like knowing the "solution to the problem". So, both questions are related as one cannot know the solution to a problem without knowing what the problem is.

3) What are some of the stressful situations that the refugees and IDPs experienced or are experiencing since they arrived at the refugee camp/settlement house? These questions capture post-migration stresses.

4) What are their reactions and feelings about these experiences? This question is to know the participants' feelings and the extent to which the migration experiences have affected them.

5) What are the resilience strategies of these African female refugees and IDPs? This is the primary research question which seeks to discover the ways and approaches with which my target group stays strong and able to bounce back from their stressful experiences.

6) How can these resilience strategies be facilitated so as to enhance mental health services and intervention with this target group? This question is meant to gather the participants' own opinions on how the government, settlement workers and mental health service providers can assist in promoting their resilience approaches so as to help them stay stronger and recover faster.

3.3 Research Instruments

In this section I will discuss the instruments I will be using for this research, like the interview guide and assessment instruments. The first one is my interview guide, which contains some of the major questions for the participants. I used a semi-structured interview format for this research. My reason for choosing a semi-structured interview is because it gave me the flexibility to take the interview in the direction of each participant so as to get the whole picture and context of what her distinct approaches to resilience are. Hence, my interview guide served to prompt the right questions as well as guide, direct and remind me to always stay close to my research objectives when posing questions to my participants. So, there may not have been a strict adherence to the order of questions in the guide. The guide also contains such information as: a reminder to introduce myself and the purpose of the research to the participants, to tell them how the data will be used and who will have

access to it, and how long the interview will last. A sample of my interview guide is included in appendix A. Below are the sample questions in the guide and the reasons for asking those questions:

1. Could you please tell me about the reasons you left your home to seek refuge here? This question seeks to understand the causes of the respondents' displacement.

2. Are you married or living common law? This question is necessary in order to obtain the statistical characteristics and demographics of my sample.

3. Do you have kids, if yes how many are they? This question is important because research has shown that female refugees who have children are more vulnerable to developing mental health issues because they do suffer more severe consequences of migration experiences (Adeyinka & Akinsulure, 2014; Baffoe, 2011; 2013; Jamieson, 1999; Kirmayer et al. 2011; Sossou, 2006; Wayland, 2006; UNHCR, 1995; 1998).

4. How old are your kids? This question is also to obtain demographic information.

5. Are you here with other members of your family? Research has found that family is one of the powerful emotional support systems for Africans (Baffoe, 2013). Prolonged separation from family members can cause emotional distress (Baffoe, 2013; CIC, 2012; Wayland, 2006). So, it was good to identify the participants who are with their families and those who are not. Comparing the data from both groups may lead to some interesting discovery that may possibly either contribute to new knowledge in research or validate existing research findings. For instance, it was only one participant that did not have any family member at the camp. She had fewer coping strategies than those with their children or family members at the camp. She always referred to her family, stating that if her family members were with her, she would not feel as stressed as she was.

6. Tell me about some of the tough experiences that you went through during your journey from your home to this refugee camp? This question serves to gather and understand the participants' migration experiences before they got to the refugee camp.

7. What are some of the stressful situations that you experience since you arrived here at the refugee/settlement camp? This question serves to gather the participants' experiences within the refugee and IDP camps.

8. How do you feel about these experiences? This question is to know the participants' feelings and the extent to which the migration experiences have affected them.

9. How have you been affected emotionally by these experiences? This question is to ensure once again that the participants have suffered emotional issues from their migration experiences. The question is also meant to have them elaborate on their various emotional issues that they experienced.

10. Please tell me about how you are able to keep strong and manage your emotional stresses despite your tough migration experiences? This is the primary research question which seeks to discover the ways and approaches with which my target group stay strong and able to bounce back from their stressful experiences.

11. Are there other approaches, strategies or factors that help you to stay strong and keep up with life? This question serves to probe the participants to elaborate on their resilience approaches, in case they neglected to mention some of them.

12. You have told me a lot of things that keep you strong despite the challenges you are currently facing. In your opinion, what can the government do to enhance the mental health services that are offered to you so as to help you to stay stronger? This question is meant to gather the participants' own opinions on how the government, settlement workers and mental health service providers can assist in promoting their resilience approaches so as to help them stay stronger and recover faster.

13. Is there anything else you want to tell me regarding you're your ability to stay strong in this time of difficulty? Again, this question is the final reminder to get the participants talk about any relevant information they may have forgotten to mention earlier.

The semi-structured interview guide worked very well, and I did not have to make any changes to it. It allowed me to ask questions based on the directions of each participants. Sometimes I did not follow the guide chronologically, but I ensured all questions were answered by the participants.

3.4 Assessment Instruments

I used the Beck Depression Inventory (BDI- II) to measure signs of depression with the participants. It is the third and latest version of BDI, revised in 1986. The BDI-II is probably the most frequently used instrument among the many assessment tools that have been developed to measure depression (Sauer, Ziegler, & Schmitt, 2013). It is one of the most widely used instruments not only for assessing the intensity of depression in psychiatrically diagnosed patients (Piotrowski, Sherry, & Keller, 1985), but also for detecting depression in normal populations (Beck, Steer, & Carbin, 1998). It is a self-report tool which includes 21 symptoms of depression, each of which is represented by four items with increasing severity. Research has shown that the BDI has high levels of reliability and validity (Beck et al., 1988; Richter et al., 2000). Research studies focusing on the psychometric properties of the Beck Depression Inventory (BDI) with psychiatric and non-psychiatric samples for the past 25 years (1961-1986) were reviewed by Beck et al., (1988). The concurrent validities of the BDI with respect to clinical ratings and the Hamilton Psychiatric Rating Scale for Depression (HRSD) were high. The mean correlations of the BDI samples with clinical ratings and the HRSD were 0. 72 and 0.73, respectively, for psychiatric patients. With non-psychiatric subjects, the mean correlations of the BDI with clinical ratings and the HRSD were 0.60 and 0.74, respectively. BDI has been criticized for its lengthy nature, which may be overwhelming

for severely depressed clients, thereby reducing clinical efficiency (Schmitt & Maes, 2000; Valenstein, et. al., 2001 & Zimmerman et al., 2008). This has led to many versions of BDI. The correlations between the various forms and versions of the BDI were found to be very high (Beck, et. al.,1998).

3.4.1 Internal Consistency. Beck, et. al., (1998), reviewed 25 studies which have addressed the internal consistency of the Beck Depression Inventory for psychiatric and non-psychiatric populations. The meta-analysis of the BDI's internal consistency yielded a mean coefficient alpha of 0.86 for psychiatric patients and 0.81 for non-psychiatric subjects. For psychiatric populations, the nine coefficient alphas ranged from 0.76 through 0.95; and within 15 non-psychiatric samples, the range was from 0.73 to 0.92. The short form of the BDI appeared to have the same level of internal consistency as the long form.

***3.4.2 Content Validity*.** Moran and Lambert (1983) compared the BDI's content against DSM-III criteria and concluded that the BDI reflects six of the nine DSM-III criteria well, but that two DSM-III criteria are only partially addressed, and one is not included. The BDI asks about losses in appetite but does not ask about increases; some depressed persons actually experience an increase in appetite. A similar situation prevails with respect to diurnal sleep variation. The BDI asks only about sleep difficulty, whereas some depressed patients find themselves sleeping considerably more than normal. Moran and Lambert (1983) also noted the absence in the BDI of explicit items addressing psychomotor activity and agitation, which the DSM-III criteria include in the diagnosis of major depression.

However, Steer & Beck, (1985) noted that the absence of questions on the BDI about increased appetite, increased sleep, and agitation was deliberate. They found that the occurrence of loss of appetite was 72%, and the occurrence of sleep disturbance was 87 % in severely depressed patients. Because increased appetite and sleeping occur so frequently in normal life, their inclusion

would produce a high rate of “false positives”. They maintained that agitation, on the other hand, is a clinically observable sign which was not considered appropriate for a self-report instrument.

I used the original BDI II. When the tool became overwhelming or challenging for any participant, I made myself available to assist such participants by offering more explanations that did not diminish the meaning or quality of the instrument. Participants also had the option of stopping the assessment either to start at a later time or to take a short break and come back to complete it later. However, no participant found this instrument overwhelming. All versions of the BDI have been translated into many languages and have been used around the world, which suggests that BDI is culturally adaptable (Sauer, Ziegler, & Schmitt, 2013).

3.4.3 Discriminant validity. Wang & Gorenstein, (2013) reviewed 118 studies of the psychometric properties of the Beck Depression Inventory II. The internal consistency was described as around 0.9 and the test-retest reliability ranged from 0.73 to 0.96. Based on available psychometric evidence, the BDl-II was found to be a relevant diagnostic instrument, showing high reliability, capacity to discriminate between depressed and non-depressed subjects, and improved concurrent, content, and structural validity from the previous version BDI-1A. In order to identify discriminant and concurrent validity, the study further compared the BDI-II with BDI-1A and numerous other scales measuring depression. The convergent validity between the BDI-1A and the BDI-II was high, with Pearson's product-moment correlation coefficients (r) ranging from 0.82 to 0.94. This suggests that BDI-II is an instrument specific enough not to diagnose those without the disorder and sensitive enough to find those with the disorder; thereby reducing false positives and false negatives. In general, various studies reported a sensitivity of > 0.70. Sensitivity is viewed as the most important indicator to minimize the chance of false-negative diagnosis of depressive disorders. Its significant diagnostic accuracy was around 75% and higher.

For anxiety I used the Beck Anxiety Inventory (BAI). BAI is one of the most popular instruments to assess anxiety today and research has found it to have high internal consistency, test–retest reliability, good concurrent and discriminant validity and adaptable to other languages (Kagee, Coetzee, Saal, & Nel, 2015; Vázquez Morejón, et. al., 2014). Kagee, et. al., (2015) administered the BAI to 101 South African adults receiving HIV treatment. Internal consistency of the BAI and endorsement of items was verified. The BAI showed high internal consistency among the sample ($\alpha = .89$). The mean score on the BAI was 11.60 (SD = 10.15), indicating that, on average, the sample had mild symptoms of anxiety. In terms of severity of anxiety, 50.6% of the sample fell in the minimal range, 24.1% in the mild range, 19.5% in the moderate range, and 5.7% fell in the severe range.

Vázquez, Morejón, et. al., (2014) conducted a study to test the psychometric characteristics of a Spanish adaptation of the Beck Anxiety Inventory (BAI) in a sample of 918 outpatients being treated at a community mental health center in Spain. Results confirmed the high internal consistency ($\propto = .91$), substantial test-retest reliability at 8–10 weeks ($r = .84$, $p < .01$), and satisfactory convergent validity with the Anxiety ($r = .86$, $p < .01$), Somatization ($r = .81$, $p < .01$), Obsessive-compulsive ($r = .60$, $p < .01$), and Phobic Anxiety ($r = .63$, $p < .01$) dimensions of the SCL-90-R, and with the Anxious Thoughts Inventory ($r = .57$, $p < .01$). The BAI is a self-report inventory containing 21 multiple-choice items that rate the severity of various symptoms pertaining to anxiety and has proven to be an effective instrument in diagnosing anxiety symptoms among Africans (Kagee, Coetzee, Saal, & Nel, 2015).

For PTSD I used the PTSD Checklist. It has two major versions: the military (PCL-M) and the civilian (PCL-C), (Wilkins, Lang & Norman, 2011). The PCL-C is a 17 item check list that corresponds to the key symptoms in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), (Wilkins, Lang & Norman, 2011). It has been found to be one of the most commonly

used self-report trauma exposure and PTSD instruments with tested adequate validity and reliability (Briere, 2004; Elhai, et. al., 2005; Wilson & Keane, 2004). It has been found to work effectively across variations of populations, settings, and research methods (Wilkins, Lang & Norman, 2011). Cook, et. al., (2003), compared 2 primary methods of scoring the PTSD Checklist (PCL) in a sample of 504 non-treatment-seeking former WWII prisoners of war (POWs). The PCL's 17-items correspond to the DSM symptoms of PTSD. On the PCL, respondents were asked to indicate the extent of bother by each symptom in the past month from not at all (1) to extremely (5). The cut point method involves adding all the items to form a total score, with scores higher than the cut point suggestive of a PTSD diagnosis. The alternative mapping of diagnostic criteria or algorithm method requires a score of at least "moderate" (rating of 3 or more) for at least 1 re-experiencing, 3 avoidance/numbing, and 2 hyperarousal symptoms. A relatively high correspondence ([kappa] = .80) was found between the scoring methods. However, the algorithm method identified more former POWs as having PTSD than the standard cut point of 50. Receiver operator curve analyses revealed that a cut point of 42 distinguished optimally between the algorithm-defined PTSD and non-PTSD groups. These findings led Cook, et. al., (2003) to conclude that an optimal scoring method for older survivors of prolonged and severe trauma might use both cut point and algorithm, ensuring symptoms necessary for a diagnosis and sufficient severity. They concluded that there is evidence that PTSD can be reliably and validly assessed in older combat veterans and former POWs using the PCL. The PCL demonstrated adequate internal consistency (Cronbach's [alpha] =. 84) when used with older, trauma-exposed primary care patients who were screened for psychiatric disorders (Wilson & Keane, 2004).

Below are three screening questions I asked the participants before using the assessment instruments:

1. The purpose of this study is to gain an understanding regarding your approaches to

staying resilient amid your mental health issues. In this study, you are considered as an expert of your own life. In order for me to have clear knowledge of your perspective on this issue, could you please tell me what you understand as mental health issues? This question serves to ensure that the participants understood the subject of the study. It also helped me to have a clear knowledge of the participants' own understanding of mental health issues.

Overall, most of the participants were evasive about the word mental health. They preferred me using alternate words like psychological issues or stress. Most of them also did not fully understand the scope of mental health, but always related it to people who are dirty, homeless, violent, dangerous, and completely out of control. It was only one participant who immediately understood and provided answers relevant to the clinical understanding of the word mental health.

2. Based on your understanding of mental health issues, have you experienced or are you experiencing any mental health issues? Again, except one participant, the rest did not immediately agree to have experienced mental health issues. They preferred to identify with having experienced emotional or psychological stress.

3. If yes what are some of the symptoms of mental health issues that you experience? The second and third screening questions serve to explore from the perspectives of the participants, the types of mental health issues and symptoms they may be experiencing. Their answers showed they prominently suffered from depression, anxiety and posttraumatic stress disorder.

Because of the theoretical lens of my research, (anti-oppressive and feminist perspectives), I decided to ask these questions to my participants in order to give them the opportunity to define themselves as having mental health issues. So, whether or not the assessment instruments indicated that they have mental health issues; once a participant identified herself as having mental health issues, she was allowed to participate in the study. However, I first interviewed those who met both criteria of self-identification and screening tools.

Overall, the instruments worked well with my participants. They were straightforward and easy to understand. In one instance, participant number 4 asked me to explain the meaning of "irritability" in question number 17. I used two synonyms to explain it for her. I told her that irritability means "getting easily annoyed or angry".

There were two main screening criteria 1) self-identification and 2) screening tools. Self-identification has three questions that participants answered in order to determine if they identify as having mental health issues. Of the six participants, all the three refugees met both the self-identification and screen tool criteria. One of the refugees met the criteria for the three screening tools whereas, the other two met the criteria for PTDS and Depression. Among the IDPs, only one of the women met the self-identification criteria. The other two women denied having mental health issues but described feelings and symptoms consistent with mental health issues. When I screened them, they met the criteria for moderate to severe PTSD, anxiety and depression.

3.5 Qualitative method.

This research adopted a general qualitative exploratory approach. Exploratory research involves systematic data collection designed to maximize the understanding of the nature of the problem being investigated, based on descriptions and direct understanding of an area of social or psychological life (Stebbins, 2008). It is a flexible research design used to examine problems on which little or no previous research has been done (Brown, 2006). Exploratory research often includes descriptive data, social processes, belief systems, and experiences or circumstances normally found in the group under study (Brun, 2014; Stebbins, 2008). The research questions are open-ended and geared towards gaining knowledge about the process of intervention or to identify the need for new programs; the answers usually lead to improvement of services and knowledge development (Brun, 2014). Qualitative research has been said to present as a difficult term to define (Creswell, 2013; Morse & Richard, 2002; Weis & Fine, 2000; Yin, 2016). This apparent difficulty

is posed by the complex nature of a qualitative study, and, as such, many authors from different disciplines rather simply prefer to identify the features that constitute a qualitative study as it relates to their discipline (Yin, 2016).

Creswell (2013) offered a working definition of qualitative research as a method that begins with an assumption and the use of theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem. It studies the everyday lives of different kinds of people and what they think about, under many different circumstances; in other words, it studies the meaning of people's lives in their real world (Yin, 2016). It represents the views and perspectives of the participants, accounting for their experiential contextual conditions (social, cultural, institutional, environmental and more). This means that qualitative research acknowledges the possible relevance of multiple sources of knowledge rather than a single source (Yin, 2016). Qualitative methods rely on a small number of participants in gathering data and are intended to capture the complexities of human experiences from the perspectives of those who are in the situation being researched (Bouma, Ling, & Wilkinson, 2009; Patton, 2002; Van De Sande & Schwartz, 2011).

Data collection in qualitative research is done in various ways (interviews, observations, field notes and more) and is always sensitive to the people and places under study. The data analysis is both inductive and deductive and establishes patterns and themes. The written report reflects the voices of the participants and contributes to the literature or calls for change (Creswell, 2013). Interviews are usually open-ended so as to generate a holistic view of the problem of study (Patton, 2002). According to Kristensen & Ravn (2015), the qualitative method "provides researchers with in-depth and nuanced understandings of cultural domains" (p. 725). The rationale for a qualitative study is to provide the participants the opportunity to describe their contextual experiences of resilience and what the experiences personally meant to them. This study reflects the voices of my

participants themselves, since the issues being investigated are their exclusive issues. This method fostered the understanding of the meaning, as well as the resilience strategies for my target group as a qualitative study focuses on the real meaning of events from the participants' perspectives (Yin, 2016).

3.6 Sample Size and Strategy

Originally, I planned to interview five to eight people. The rationale for this small number of people is because the qualitative method uses a small number of people in order to allow for in-depth and manageable data gathering and analysis (Patton, 2002). My strategy for the selection of the sample was to be the redundancy principle (Lincoln & Guba, 1985). With the redundancy criterion, data collection may be stopped when little or no new information appears to be forthcoming from additional participants (Yin, 2006). This criterion serves to moderate data collection when redundancy sets in. Since the purpose of data collection is to maximize information (Yin, 2016), it suffices to conclude data collection when no new information is being derived from the interviews. Hence, I planned to interview five people at the first instance and as data became redundant, I planned to stop the interviews; however, if I kept obtaining new information from additional instances, I would continue to interview up to and including eight participants. In the event that data collected from eight people were not rich enough for analysis, I planned to interview as many more people as can generate enough data for analysis. Although, I ended up using this redundancy strategy, I interviewed six people in total and those six were able to generate sufficiently rich data.

Furthermore, the inclusion criteria for my sample included nationality, gender, age, refugee/IDP status, and duration for which the potential participants have maintained the said status. To be selected as part of the sample, the person had to be a) originally from Africa, b) female, c) within the age range of 25-45 years old (middle adult) and d) a refugee or internally displaced person. The rationale for choosing this age bracket is because research has shown that female refugees who

have children are more vulnerable to developing mental health issues because they do suffer more severe consequences of migration experiences (Adeyinka & Akinsulure, 2014; Baffoe, 2011; 2013; Jamieson, 1999; Kirmayer et al. 2011; Sossou, 2006; Wayland, 2006; UNHCR, 1995; 1998). So, women in the age range of 25 – 45 years are more likely to have children who are still dependent on them. The fourth criterion is to incorporate other specific characteristics for inclusion, such as: the participants must be refugees, or at least internally displaced persons (IDP). Choosing only refugees and IDPs will help me remain adherent to the purpose of my study – resilience of refugees. The fifth characteristic is that they must have left their homes to seek protection elsewhere for at least six months. The six months' criterion serves to facilitate the recruitment of people who are likely to have experienced migration struggles over a sufficient period of time to be able to witness a significant change in their mental and psychological state.

Additionally, the exclusion criteria were a) African female refugees who fulfil the inclusion criteria but do not speak English or any of the common native languages in Nigeria understood by the researcher (myself) or the research assistant (PhD student under the host University Professor who was helping me). b) African female refugees fulfilling the inclusion criteria, but who are in such a fragile psychological state that their mental health problems may gravely exacerbate particularly because of the questions they would be asked during the interview. This last group of people were initially identified by the agency (IDP camp) workers who would know some of the internally displaced persons whose mental health issues are severely and usually exacerbated by minor factors. In other words, those who are well known for frequent episodes of fragile psychological state manifestation. In addition, I also planned that during the screening or interview, if a participant is regularly and uncontrollably breaking down (crying) as she answers the questions, such a person will be given the option to voluntarily withdraw from the study. But during the actual interview; it was only one participant that became overwhelmed at some point, so she took a few

minutes break and came back to finish the interview. The agency worker (mediator) who helped to identify psychologically fragile potential participants was made to sign the pledge of confidentiality.

3.7 Recruitment

In retrospect, it suffices to mention that my initial purpose of the research study in Nigeria was to inform my Canadian research, which was to focus on African female refugees in Canada. I planned to do more interviews in Canada and then use the Nigerian data for comparison and triangulation. However, because of recruitment bottlenecks, I was unable to obtain as much data as I needed in Canada. I obtained the data equally from both Nigeria and Canada, three respondents each. So, I focused the research on African female IDPs and refugees living in Nigeria and Canada.

I hoped that the IDPs and refugees would be a mixture of women from Nigeria and other parts of Africa. For the IDPs, I hoped to recruit women from other African countries who re-settled in Nigeria, as well as internally displaced persons who re-settled in cities different from their states of origin. But in reality, all IDPs interviewed were from Nigeria whereas the refugees were from other parts of Africa. Because of access issues, I could not recruit IDP women from other African countries who re-settled in Nigeria. It was difficult for me to penetrate the IDP camps. Some sort of corruption played a role in inhibiting access. I visited three IDP camps and the authorities asked for money (bribery) in exchange for recruiting participants, but I declined. After three visits, the PhD student (research assistant) who is living in Nigeria told me that if I did not acquiesce to the bribery request, I would never obtain access to the camps; unless I knew someone at the management level who would facilitate the access. So, when we went to the fourth camp, the director also asked for some sort of incentive, one of which was buying food for the IDPs. I offered to buy food items but made it clear to him that I was not offering a bribe and also would not want the food to coerce IDPs into participating in my study. We agreed that the food be cooked for the residents after I was done

with my interviews. All the IDPs at this camp were from Nigeria; none were from other African countries.

The IDP participants were recruited through one agency (IDP camp), a charity organization that takes care of IDPs in Nigeria. Recruiting refugees through agencies in Canada was difficult. Most of the agencies cited privacy concerns and declined to help. Only one agency agreed to help deliver recruitment letters to their clients. But, after I sent the recruitment letters to the agency, the director emailed me saying that none of his clients agreed to participate. I requested that he simply gives the clients the letters so that interested participants would contact me. He replied again stating that he would not be giving out my letters because his clients were not interested. In my opinion, he was not really ready to assist me with recruitment, so I gave up on trying. I eventually recruited the refugees by myself through my friend and acquaintance circles. Two friends of mine referred one refugee each to me. Two colleagues referred one refugee each, and my thesis advisor also directed me to one refugee who he thought might also be able to refer other refugees to me. I got in contact with these 5 refugees via emails and telephone calls and was able to send out recruitment letters. Only 3 of them got back to me eventually and those three were interviewed.

Potential IDP participants in Nigeria were identified through mediators or gatekeepers (Kristensen & Ravn, 2015; Wanat, 2008). A mediator is someone who uses his/her formal or informal position and relationships to facilitate contact between a researcher and potential participants (Kristensen & Ravn, 2015). The rationale for using mediators was because the use of mediators has been found to be a very important, well-known and productive recruitment strategy in qualitative studies. They make the recruitment process less challenging and more successful for researchers (Kristensen & Ravn, 2015); especially when the researcher is not so familiar with the participants. My mediators in this case were to be the IDP agency workers, the PhD. student who was to assist me to collect data as well as the social work professor who supervised my work overseas. Since they

already had in some ways been in contact with the refugees, the mediators as key informants were to identify those refugees with psychological symptoms and mental health challenges. In this case, the mediators who identify potential participants were made to sign the pledge of confidentiality. They also obtained written consent from the potential participants so that their names and/or telephone numbers could be forwarded to me. The consent being referred to here is simply an indication of their willingness and permission for the researcher to contact them. It was not a consent to participate in my research. After I got in contact with the potential participants over the telephone and confirmed their interest in my research; one agency worker helped me to deliver the recruitment letters. I gave the potential participants one week to decide if they wanted to participate, and the recruitment letter clearly indicated that they should contact me to schedule an interview, if they wished to participate in my research. The actual consent form was signed when I met with them, prior to conducting the screening and interview.

My plan was that if the mediator strategy was unable to produce the number of participants needed for the study, I may also adopt the snowball technique in which research participants would be asked to assist identifying other potential participants (Goodman, 2011; Sedgwick, 2013). This strategy is a highly effective technique which is used to identify less accessible or hidden populations; and also, it is used in studies involving sensitive or private matters (Goodman, 2011; Sedgwick, 2013; Walters, 2015). The snowball technique resulted in recruitment of one IDP participant, while the mediator technique resulted in recruitment of two IDP participants. Initially, only 5 IDPs indicated interest in participating and gave their contacts to the mediators. So, in order to increase my chances of recruiting more participants, I randomly selected 10 more potential participants from among 20 IDPs who were identified as having mental health issues by the mediators - the graduate student and agency staff in Nigeria. I contacted those I selected and asked if they would like to participate in my study. I initially planned to give the entire 20 potential participants

recruitment and detailed study information letters by hand delivery, where they would be advised to contact me if they were willing to participate in the study. But following this random selection, I sent out only 15 letters in total. The recruitment letters contained the information about who I am, the purpose of the study, the criteria for eligibility of participants, confidentiality and ethical concerns, use, access, storage and destruction of data, contact information of the researcher and supervisor, the board that approved the research and other relevant information.

So, I eventually contacted some people from the pool of those who met the criteria of mental health disorders to set up interview dates. On the day of the interview, I discussed the research project with them and at this time the consent forms were signed. The Beck assessment instruments (depression and anxiety), and PTSD check list were used to assess the potential participants in order to establish an eligibility list. Prior to using the screening instruments, I had the participants self-identify themselves as having mental health issues. I asked them to tell me about the symptoms that they experienced which made them believe that they had mental health issues. In keeping with my research theoretical foundation, any participant who identified herself as having mental health issues was included in the eligibility list, even when she fell below the clinical screening cutoff score. When conducting the interviews, I first interviewed those who both self-identified with mental health issues and at the same time met the screening criteria. The initial plan was that those who fell below the screening criteria would be allowed to participate in the study if more people needed to be interviewed. But, I was able to recruit all my six interviews from those who both self-identified and at the same time met the screening criteria.

They were given the consent form by hand delivery and contact details of the principal researcher in case they had further questions. I went over the consent form with them. It contained the basic idea of what the interview was about, what their participation would involve, as well as such matters as: purpose of the research, research procedures and recording, risks and benefits,

anonymity, confidentiality, compensation, interview feedback/debriefing**,** dissemination, and destruction of the data. They signed the consent form and left them with me. None of the agency workers knew which potential participants have agreed to take part in the study. The initial plan was that the first five people to agree to an interview date would be scheduled for the interviews. But I succeeded in obtaining only three people scheduled for interviews. These interviews were conducted at the university close to the IDP camp with each participant's consent.

Out of the 15 recruitment letters sent out to IDPs, 10 actually refused to participate citing various reasons. Some said that they were registered in skills acquisition training in the city and do not get back to the camp until late in the night. Others refused to participate unless I pay them, but I informed them that the research is unpaid and voluntary. One or two people did not give reasons for their refusal. In total 5 IDPs were recruited; 4 were recruited through the mediators and 1 was recruited through the snowball technique; she was referred by her fellow IDP. Eventually only 3 IDPs were retained and interviewed, while 2 were rejected because they did not meet the criteria. Additionally, 5 refugees were given recruitment letters. Four were referred to me by friends and acquaintances, and the other 1 person was someone I knew. Only 3 of these got back to me and indicated interest in participating and all three met the inclusion criteria and were interviewed.

3.8 Data Collection Strategy

My study used a qualitative interview method to collect data. The interview was a one on one interview that lasted for about one and a half hours. I chose an interview because my research objective is to gain an understanding of the perspectives of the participants regarding their approaches to remaining resilient amid their mental health issues. I used a semi-structured interview format. A semi-structured interview allows people being interviewed to express their experiences, thoughts and feelings from their own point of view. It also allows the interviewer to use an interview guide with open-ended questions where the order of the questions will vary according to the flow of

the interview (Neuman & Robson, 2009). So, a semi-structured interview allowed me to explore unanticipated themes with the participants, given that I did not have to strictly adhere to the interview guide order.

The interview questions were open-ended questions. An open-ended question asks the affected individuals to describe their experiences according to what the experiences mean for them. Open-ended questions provide more opportunity for better collection of unanticipated answers (Van De Sande, & Schwartz, 2011). Mental health is an experiential reality that is very unique, so much so that even when two people go through the same issue, it might have different degrees of impact on and/or outcome for each of them. So, semi-structured interviews gave me the flexibility to take the interview in the direction of each participant. This, in turn, helped me to obtain the whole picture and context of the interview participants' different ways of expressing and coping with what they experience. The interview guide rather served to guide, remind and prompt the right questions (Yin, 2016).

In this research, I anticipated minor to no differences between stresses and mental health issues of African refugees migrating to Western countries, refugees migrating to Africa countries and internally displaced persons within a country. According to research, both refugees migrating to other African countries and those migrating to Western countries do experience similar stressful pre-migration and migration issues, which contribute to similar mental health issues (Adeyinka, 2014). While in refugee camps, both groups have to wait for decisions to be made regarding to which countries they will migrate (Crisp, 2010). Refugees who were unable to return to their country of origin because they would continue to be persecuted or confronted with violence would be re-settled to a new country (Africa or the West) as determined by UNHCR. Those who were determined to be safe in their countries were sent back to their countries (UNHCR, 2012). This is an extremely stressful and uncertain time when these refugees are unable to make plans for the future and may be

terrified of being returned to their home country. This period of waiting for a decision may be a time when refugees' extremely fragile psychological well-being may be compromised (UNHCR, 2012). The only difference I anticipated between these two groups of refugees is that: those who were destined for Western countries may have been able to deal with their mental health issues better than those who were meant to stay in Africa. My rationale for this expectation is that the hope and expectation of going to Western countries where the quality of life is better than in Africa would be a positive factor, which could help buffer refugees' mental stresses. Research has identified hope and expectancy as therapeutic factors that can lead to positive changes in people with mental health issues (Reiter, 2010). However, in the actual data collection, I was only able to interview internally displaced persons within a country. So, there was no need for comparison.

On the hand, I anticipated some differences in the migration experiences and consequently mental stresses of internally displaced people and refugees in Africa when compared to refugees in Canada. Both refugees and IDPs who remain within the borders of their own countries face similar pre-displacement and post-displacement factors that lead to similar mental health issues (Porter, & Haslam, 2005). Both groups of people have been forced to flee their homes as a result of conflict, situations of violence, human rights violations, natural disasters, or environmental degradation. They both exist on the margins of society and are vulnerable to significant abuses that can put considerable stress on them (Solomon, 2010). I expected refugees in Canada to have less stress and fewer mental health issues than their internally displaced counterparts, given that they are now resettled in a more peaceful and more developed country. The differences are discussed further in the findings chapter. The findings of my research shed more light onto the mental health experiences of refugees in Canada and IDPs staying in Africa.

Overall, the interviews went well both with IPDs and refugees. The participants were friendly and cooperative and very responsive to my questions. There were no language problems as they all

spoke at least basic English; so, we had no problems understanding each other. However, respondent numbers 4 and 6 had only high school diplomas and even though they spoke basic English, they intermittently switched between good English and pidgin English (the common street language in Nigeria). But this was not a problem as I understood pidgin English very well. Worthy of mention though was respondent 5, a 41-year-old female and a biology teacher. We quickly connected and got along very easily. We talked as if we knew each other before; she always addressed me by my first name, and she was a humorous person to talk to.

Nevertheless, the only time there was general hesitation to my questions was during the screening for eligibility when I asked if potential participants have experienced any mental health issues. This massive hesitation to the questions was owing to the cultural aversion to the use of the word "mental health". African female refugees preferred alternate words like psychological issues, stress or emotional problems. This aversion has to do with the stigma around mental health in Africa. I will discuss this further in chapter five. But it suffices to mention that this hesitation towards the use of the word mental health was strong among the IDPs and not refugees. I will assume that the reason is because refugees are already in Canada and are perhaps beginning to overcome the stigma around mental health.

During the debriefing, all the participants were happy to have spoken with me and they saw the interview as an avenue to talk about their problems; something they do not do so often because there is no one to listen to them. The interview, I would say was therapeutic, especially for the IDPs who were facing the most uncertain situations.

The length of the interviews are as follows: respondent 1 = 1hour, 15 minutes (1.25 hours); respondent 2 = 1hour, 22 minutes (1.37 hours); respondent 3 = 1hour, 33 minutes (1.55 hours); respondent 4 = 1hour, 45 minutes (1.75 hours); respondent 5 = 1hour, 38 minutes (1.63 hours); respondent 6 = 1hour, 18 minutes (1.30 hours). The (sum) total length of interview was 8hours, 51

minutes (8.85 hours). The (mean) average length of the interview was 1hour, 28.5 minutes (1.475 hours). The standard deviation is: 0.2.

During the interviews, it suffices to mention that my positionality in relation to the populations and issues of interest on the one hand facilitated data collection, and on the other hand posed minor challenges to data collection. Regarding the former, my position as a Nigerian and African helped me to understand and to record the interviews in detail. When I asked some questions for instance, some of the participants used gestures, symbolic or verbal cues to provide more clarification and more details to their answers. On a few occasions, a few of them used these cues to provide answers without verbalizing their answers in real English words. Symbolic and/or verbal cues and gestures are most often cultural; they are used and understood only by people from the same culture. Some of them also used our local pidgin English which is quite different from conventional English language and therefore incomprehensible to a researcher from a different culture.

On the other hand, my positionality as a person from the same country and culture posed a minor challenge to data collection. When asked questions, some of the participants would presume that I knew the answer just because I am Nigerian and African. They would say something like “you know already”, “you are one of us, do you really need to ask this question”. But I always clarified and let them know that they are the experts in this study and if I knew the answers, I would not bother to interview them. Additionally, because of my gender as a male, I encountered a minor difficulty in getting the IDPs to speak to me. These women came from a patriarchal culture where men have power, privilege and control over women and children. In my culture, when men speak, women and children are expected to remain silent. However, I overcame this challenge by being friendly, humorous, humble, and respectful. This created a conducive environment and made the women comfortable, and they spoke with me openly and freely.

Furthermore, the use of self-reflection helped to enhance my awareness and perceptions in data gathering. During the interview for instance, I was constantly aware that these women were coming from the place of oppression and marginalization, and hence, some of them had low self-esteem and confidence. I therefore always made sure that they felt comfortable talking to me. When one of the women came in for the interview, I observed that she was uncomfortable and nervous. In other to boost her self-confidence, I invited her to switch chairs with me. She sat at the office desk and chair while I sat on her chair. I told her that she was the professor while I was the student and I was there to learn from her. This made her smile and it was as if there was a transfer of power from myself to her. She quickly gained confidence and started talking to me courageously.

3.9 Method of data analysis

The interview was recorded with an audio digital device and was later transcribed verbatim by me. The initial plan was to have the student research assistant transcribe for me; but her first interview was substandard (only one and half pages and written in pidgin English). So, I had to exclude that interview from my data, and I did not trust her competence to transcribe my interviews since she could not proficiently transcribe hers. The entire data for this research were analyzed through thematic analysis, which enabled me to seek out overarching categories, themes, phrases and concepts that describe and interpret participants' views (Joanna & Jill, 2011; Morse & Richards, 2002). Thematic analysis has been defined as an interpretive process in which data are systematically searched for patterns to provide informative insight and enlightening descriptions of the phenomenon, without explicitly generating theory (Braun & Clarke 2006; Joanna & Jill, 2011). It is a means of bringing order, structure and interpretation to the mass of collected data by searching for general statements about relationships among categories of data. The step involves organizing the data, generating categories or themes, coding the data, testing emergent understandings of the data, searching for alternative explanations of the data, and writing up the analysis (Marshall & Rossman,

1999). Thematic analysis helped me to transition from a general to a more in-depth and higher conceptual understanding of my data by identifying and sorting out recurring themes, relationships, patterns, similarities and differences in my data. The nature of this initial coding has been referred to as: level 1 or open coding (Hahn, 2008). From this stage of coding, I then was able to progress to a higher level of coding - Level 2 or category coding (Yin, 2016). This is the level where I gained more insight into how my data relate to broader conceptual issues and phenomena and was able to code these data into categories. Finally, my analysis moved to the level of interpretations of the findings where I related my data to theoretical concepts based on the literature and previous studies; and then I was able to present conclusive recommendations as guided by the findings.

Furthermore, in my analysis, the demographic information that I gathered was reported in various categories, such as: marital status; level of education, those who have children versus those who do not, those whose children are below 18 years versus 18 years or over; those who are at the settlement houses with their family members versus those who are not. The categorization is expected to help my readers to better understand the data. The rationale for such categorization is also to enable me to engage in an easier and deeper interpretation of my data in order to seek comparable facts that may lead to new knowledge and understanding of refugee women; or possibly validate existing research findings. These groups of demographics are important because research has shown that female refugees who have children are more vulnerable to developing mental health issues because they do suffer more severe consequences of migration experiences (Adeyinka & Akinsulure, 2014; Baffoe, 2011; 2013; Jamieson, 1999; Kirmayer et al. 2011; Sossou, 2006; Wayland, 2006; UNHCR, 1995; 1998). Research has also found that prolonged separation from family members can cause emotional distress (Baffoe, 2013; CIC, 2012; Wayland, 2006). So, it was good to compare the data from both categories of participants. The comparison was consistent with existing literature on refugees and IDPs, in particular, and migrants in general. In this research,

refugee women with children were found to be more worried about their children's safety and welfare, and this puts much stress on them. Those who could not account for all members of their families either because they were dead or just got missing during the migration process were also under so much stress in their bid to gain closure regarding their families. Nevertheless, having children, as well as losing family members, had positive implications for the resilience of refugees and IDPs. This will be expatiated further in the discussion chapter.

Chapter Four: Findings: How Support, Responsibility and an Eye on The Future Empowers to Overcome Trauma

This is the data analysis and finding chapter. In the ensuing analysis, six respondents are being represented: three internally displaced persons (IDPs) and three refugees. Here, I will be discussing the research findings and themes from the data, participants' perspective on ways to facilitate refugee's resilience, relationships among the themes, and finally, the visual illustration of the themes presented in a figure.

In order to help my readers to stay focused to my research objective, it is important to recapitulate that my central research question is to investigate how African female refugees and IDPs with mental health issues stay resilient despite their traumatic migration experiences, psychological and mental health challenges. My major findings on resilience strategies include, but are not limited to social support, which is subdivided into family support and support from non-family members. Others are; religion and faith in God, future orientation, education and employment, music, responsibility towards children and community involvement. These and others will be discussed in detail in this chapter.

4.1 Description of Participants

For better understanding, I will provide a brief background description of each participant in the following few paragraphs. The refugees are represented with the acronym (Resp 1-3); while the IDPs are represented with (Resp 4-6).

4.1.1 Respondent One (Resp 1). She is a 46-year-old woman who arrived in Winnipeg in 2014, because there was war in her home country. She came through one of the churches as her service provider organization. She is married with three children: two sons, five and 18 years of age, and one daughter 21 years old. She is currently employed and lives in Winnipeg with her family.

Her interview was conducted at the University of Manitoba in Winnipeg. The interview lasted for one hour and fifteen minutes.

On the day of the interview, I arrived half an hour early to get the interview room ready. The interview was set for 3 p.m. At about five minutes to 3 p.m., I heard a knock on the door and as I opened it, the participant entered. She was a pleasant woman and was always laughing. Before I could offer her a seat, she already chose a different chair and sat down so quickly. When she realized that I was surprised she switched her chair, she laughed and said jocularly " I know you are from Africa and in Africa we don't wait to be directed by our host to take a seat; rather we make ourselves comfortable even among strangers". I laughed and we chatted a bit, went through the forms and she signed the consent forms and the interview started. Although she was for the most part jovial, personable and friendly; I observed that the first half of the interview was tough for her as she broke down a few times. We took a 15-minute break and debriefed, then came back and finished the interview successfully.

4.1.2 Respondent Two (Resp 2). She is a thirty-eight-year-old woman who arrived in Winnipeg in 2013, with her children and husband on account of war. She came through a non-government organization (NGO) (name of NGO withheld as per participant's request). She is married with two sons, and one daughter, all minors. One of her sons is physically disabled, not from birth but from the war in her home country. She is unemployed, but currently attending English classes. She was a teacher back home while her husband was an electrical engineer. Her interview was conducted in her home in Winnipeg. The interview lasted for one hour and twenty-two minutes. This participant is known to me, as I have interviewed her in the past for a class research project. Upon entering the participant's residence, her living room greeted me with this unique freshness of a cool, refreshing, sweet and clean aroma that pervaded the entire living room area. The air smelled as new and crispy as clean linen fresh from the laundry, yet with some lightly perceptible vanilla scent. Her

extremely clean and well-kept apartment immediately reminded me of my pleasant encounter with her in the previous year or two. She was sitting on her dark brown suede sectional sofa. Her dark brown highly polished and shiny rosewood center table with a concentric circle top held a long walnut scented and burning candle and her living room was not well lit; almost too dark for me. She greeted me and offered me a seat next to her. I asked if she could turn on the lights to enable me to see clearly, and she did. We went over the consent forms and she signed. I explained the purpose and scope of the interview to her, as was contained in the recruitment letter and we began the interview.

4.1.3 Respondent 3 (Resp 3). She is forty-nine years old, and arrived in Winnipeg in 2011, because there was war and political instability in her home country. She is married with one son, and two daughters and they all live together with her and her husband in Winnipeg. Both she and her husband are unemployed, but they have university educations from their home country. The interview was conducted in a fast-food restaurant of her choice in Winnipeg. The interview lasted for one hour and thirty-three minutes. When she arrived, she walked straight to me and said she knew it was me because I was the only black person there and she knew I am black. She wore a nice beach style dress well designed with colored flowers. She is soft spoken, has a calm personality and maintained a flat affect throughout almost the interview. She is a woman of few words and required so much prodding and probing before she could give detailed answers. I tried to engage her in casual icebreaking conversation before we could start the interview, but she was not forthcoming. So, we went straight into the interview after she signed the consent.

The next three respondents are internally displaced persons (IDPs). I interviewed the IDPs in Nigeria. My initial plan was to interview a sample of IDP women from various countries in Africa, but this plan was thwarted by lack of funds and the difficulties obtaining access to various IDP camps. So, all three IDPs interviewed are from one IDP camp in southern Nigeria. They were all interviewed at the office of one of the professors at the university close to the IDP camp in Nigeria.

4.4 Respondent 4 (Resp 4). The participant is a twenty-eight-year-old female IDP from the northern part of Nigeria. Her highest level of education is a high school diploma. She is single and has no children. She was displaced by the Boko Haram Islamic terrorist group who invaded her village and killed many people, including her family members (parents, two brothers and one sister). She was the bread winner of the family and made her living from selling clothes. She was away in the market when the killings happened. Her church helped her to escape from the village and come to the refugee camp in southern Nigeria for safety. She was recruited through the mediators (camp workers) who distributed the recruitment letter for me.

This interview lasted for about one hour and forty-five minutes. The location was at the University of Benin, Nigeria, at the office of one of the professors located at the east side of the campus. Because it was a Sunday evening, the university environment appeared so unusually uncongested, serene and peaceful – an atmosphere which was very agreeably conducive for the twenty-eight-year-old participant. The participant called me because she got the recruitment letter and wanted to participate in the study. So, we arranged to meet at the University and she voluntarily accepted to do so.

On the day of the interview, I was at the office waiting for the participant, and when I saw her from the window, I quickly recognized her for two reasons. First, the school was almost empty with only a few students sparsely present; so, as she walked from the gate towards the office building, I knew it was a purposive movement of someone who knew exactly where she was going. Second, her appearance did not smack of a typical Nigerian university student who dresses so flamboyantly and fashionably. So, I came out, introduced myself and led her into the office. The participant wore a long brown jean skirt, with a long-sleeve traditional African variegated textile blouse. Her dressing leaves a first impression of a person from the remote Yoruba villages – the tribes in the western part of Nigeria. However, her hair style was the traditional cornrow braids

typical of a country girl from Northern Nigeria, except that she was not wearing a hijab like most northern Muslim girls do. So, her costume got me confused and I did not know if she was Muslim or Christian (most people from the north are Muslims). Her hair was so unkempt, and one could tell that she has had this hairstyle for a long time; as I could see most of the threads used to tie her hair extensions stand out so slack, detached and unclasped. As she entered the office in such a sneaky furtive manner, I offered her a seat and she sat at the edge of the chair with her arms folded around her chest and both arms under the arm pits like someone who is cold, or frightened. Again, I introduced myself and the reason why we were there. I assured her of her safety and confidentiality; and she seemed a little more relaxed than when she came in. She was so soft spoken and talked in a low tone of voice. We went over the interview guide and consent forms and she signed. I explained to her the purpose and scope of the interview as was contained in the recruitment letter. We talked a little bit, (approximately 3-4 minutes)**,** about how easy it was for her to locate the office and then began the interview. The interview lasted for about 1 hour and forty-five minutes.

4.1.5 Respondent Five (Resp 5). This interview lasted for about 1 hour and thirty-eight minutes. The location was at the same professor's office at the University of Benin, Nigeria. It was also a Sunday evening and most of the students were away for the weekend. One can only see a few students sparsely present, who either came to attend church services or to read. This creates an atmosphere which was very peaceful for the interview. She is a 41-year-old female IDP (single mother with 5 children) from the north eastern part of Nigeria. She has a bachelor's degree in education and was a biology teacher until she was displaced three years ago. The youngest child is a four years old girl, the next in line is a boy six years old, then twin girls nine years old, and the oldest is an 11-year-old boy. Her husband was a religious fanatic who later joined the Islamic terrorist group but was killed in a battle with the Nigerian Army just a couple of years ago. She got the recruitment letter and called me, and we agreed to meet at the University at her own convenient time.

On the day of the interview, like I usually do, I was at the office waiting for her. We agreed to meet at 12:00 pm but as it was 12:40 pm already and she had not come, I went to sit under a tree outside the office because the weather was too hot and there was no electricity to use the air conditioner. As I waited outside, I heard a knock on the office door, so I went to check, and it was the participant. I introduced myself and led her into the office. The participant wore a long plain black habit, with a hijab (*the traditional garb which is particularly worn by Muslim women*) covering her entire head and chest area. Her garb was sweeping the ground and one could barely see her black shoes. As she entered the office, I offered her a seat and she sat down and relaxed with a heavy sigh. I asked if she was okay; she said she was okay, just that the weather was so hot, and she had to walk under the scorching sun. We talked a little bit about the hot Nigerian weather and lack of electricity and laughed over it**.** The participant presented as well coordinated, neatly dressed and well orientated. I informed her of the reason why we were there. I assured her of her safety and confidentiality. We talked as if we knew each other before; she addressed me by my first name, and she was a humorous person to talk to. We went over the interview guide and consent forms and she signed. I explained to her the purpose and scope of the interview as was contained in the recruitment letter; and then began the interview.

4.1.6 Respondent Six (Resp 6). She is a thirty-eight-year-old single mother with two children, four and five years old. The herdsmen invaded her village and clashed with the villagers, leaving many dead and injured. The ones who survived ran away from the village for safety. She has no university education, no job and no skills. She was a housewife and lost her husband when the herdsmen attacked their town. She was also recruited by the mediators (camp workers). She met me while I was visiting the refugee camp and indicated that she got my recruitment letter and would like to participate in my study. We agreed to meet at the camp.

On the day of the interview, we used one psychiatrists' office at the IDP camp, for the interview. The participant was wearing a long black gown and a black hijab. She appeared so calm

and soft spoken. Her facial expression was flat with little to no emotional expression on her face and general body language. I tried to introduce some jokes just to break the ice, but she seemed indifferent and did not react to the jokes, either in verbal or nonverbal ways. But she was still friendly and cooperative and very responsive to my questions. I also explained the purpose and scope of the interview to her, as was contained in the recruitment letter; and we began the one hour 18 minutes interview.

In the next page, I will present a statistical and demographic representation of the research sample.

Table 1.

Statistical Summary of the Research Sample

Respondents	Age	Marital Status	Number of Children	Education
Resp 1	46	Married	3	University
Resp 2	38	Married	3	University
Resp 3	49	Married	3	University
Resp 4	28	Single	0	High School
Resp 5	41	Widow	5	University
Resp 6	38	Single	2	High School
Median M:	39.5		3	
Mean $\bar{x}$:	40		2.7	
Minimum/Maximum #s:	28/49		0/5	
Standard Deviation SD:	7.3		1.6	

When it comes to the age of the research sample; based on the data collected and analyzed, it can be determined that members of this population had minimum and maximum ages of 28 and 49 respectively. The mean age is 40 years, median is 39.5. Regarding marital status, it can be inferred that 50% of the population are married, 33.33% are single and one respondent (16.7%) is a widow. In addition, the minimum and maximum numbers of children are zero and five respectively. The median is three, mean is 2.7 and the standard deviation is 1.6. Subsequently, 66.7% of the population have university education, while 33.3% have high school education.

4.2 Themes from the difficult pre-migration and refugee camp experiences

Themes under this category are from answers given by participants regarding their experiences in their home countries and refugee camps prior to their migration. These events and experiences were highly stressful and resulted in mental health difficulties for the respondents. In other words, the tough pre-migration and camp experiences provide the context and background for the development of mental health issues among the respondents. The pre-migration and camp experiences are therefore important in answering the research questions. They elucidate the situations of physical, emotional and mental suffering that made these women susceptible to mental health issues. Recounting those experiences helped me to understand their journey from their various homes to the refugee camp, the stressful situations that they experienced both while in transit and at the refugee camps, how they felt about the experiences, and the emotional impact these experiences had on them, and how they managed to pull through. The themes follow.

4.2.1 Uncertainty and Fear. Although fear and uncertainty are two different concepts, in this study, the two have considerable overlap. The respondents expressed uncertainty and fear simultaneously. Fear was for the most part a consequence of uncertainty. I combined the two because the experiences of uncertainty made the respondents fearful of their lives and future. Fear has been defined as an unpleasant, often strong, emotion caused by the anticipation or awareness of danger. It is a dysphoric reaction to an actual object, event or situation that is felt to be threatening. Fear warns us of impending danger and spurs us to take actions to avoid it. The actions could be in the form of actively fighting the object of fear or quickly escaping from it. This is a fight-or-flight response (Akhtar, 2014).

Uncertainty prominently featured in the data during the participants' stories of their pre-migration experiences. Uncertainty in this context was as a result of doubts, ambiguity and unpredictability of the future, current and imminent dangerous conditions, pain, threat, hazard, risks

and life-threatening situations in which the refugees and IDPs found themselves. The situations will be further disclosed in the next few paragraphs. The following are quotations from respondents, to elucidate the place of fear and uncertainty in their life experiences before migration.

While describing her story and journey from her home country to Canada, the forty-six years old refugee woman (Resp. 1) had this to say:

> My country had rebels. When they attack a city, you run for your life. I became homeless couple times. My family scattered, I lost properties, the gun shots are traumatic. We took turns while sleeping… they attack nighttime, so you must be awake because you don't want to be taken unawares. The rebels kidnap, rape and kill women. Corpses were lying in the streets. So, as you go outside, coming back to your hiding place was uncertain (Resp 1).

This refugee continued to explain how she ran to Gambia, but to register in Gambia, you must prove that you are a genuine refugee. It was very difficult for her to register. How do you prove that you are a genuine refugee, when you left properties and documents and ran for your life? Your future and life become uncertain and confused for you and you do not know what happens to you next. The above quotation clearly depicts a lived experience full of uncertainties at every stage. Given her account of her experiences, no one could predict what would happen the next minute to this participant. The gruesome rapes and killings undoubtedly explain why she was living in great fear and precariousness.

Another refugee, a thirty-eight-year-old mother of three (Resp 2), in explaining how she was displaced, recounted that the rebels came to their house, tied all of them up and set the house on fire. She was sleeping alone in her room while her husband was with the children. She managed to untie the rope on her hand because the rebels did not tie it well, and then she broke the window and jumped out. It was already too late to help anyone else, so she ran away, thinking she was the only one who

survived. She was faced with the worst confusion and fear and did not know what to do, where to go or where to start. She had no family, property or food. She thought that the best thing was to die, (Resp 2).

The above excerpt portrays fear of the unknown, uncertainty about her life and that of her family and their future. The suddenness and totality of the loss are important factors that contributed to her uncertainty and fear simultaneously. At this very crucial time, her urgent need was perhaps to take survival action before absorbing her loss and subsequently going through mourning and grieving. These characteristics of fear and uncertainty were not only expressed by refugees, but also by internally displaced people.

A twenty-eight-year-old single IDP (Resp. 4) narrated her story of how she and other IDPs had to go through dangerous and unsafe thickly forested areas for several days just to escape the wrath of the deadly Boko Haram Islamic terrorist group. When the Boko Haram attacked and displaced her community, she and a few members of the community ran in the same direction in search of protection. She narrated her fears in the following way:

> Because of the shooting in the streets, we didn't want to go out to the main roads for fear of safety. So, we slept in the bush for the second day without food or drink. We eventually got to the church but were still afraid because we didn't know if they (*terrorist group*) will come there and kill us. I could not sleep for many days. Eventually the bus came to take us to the camp, but nobody was sure if we were going to make it to the camp or not because these people (*terrorist group*) can strike anytime; everything is uncertain (Resp 4).

The above quotation depicts fear and uncertainty as experienced by the respondent and her cohorts. The many days spent in the forest without clear knowledge of what to expect, the starvation, the gun

shots, the unsafe forest and difficulty navigating the bush paths were all fear factors and valid reasons for the feeling of uncertainty experienced by the IDPs.

The next IDP, Resp 5 also narrated her experience of fear and uncertainty surrounding her migration. She stated that nothing is guaranteed, from food, down to her life and the life of her family. They lived every day in fear, worries and confusion. Before she came to the camp, they were living right in a village of the far north; no water, no food, the farmlands are dry and cold, food is expensive, and she had neither job nor money to buy food. She reported going days without food. The house they lived in was made with tree trunks and leaves, and when the wind blows hard, they automatically became homeless. She and her family lived life with nothing guaranteed, even in the refugee camp (Resp 5).

From the above extracts, some common features among the respondents' expression of fear and uncertainty include: a) precariousness about one's own life or what will happen next b) the possibility of death and evil looming in the participants' faces every minute of their life c) no guarantee of any form of security, including food security, water, shelter and safety of life d) living constantly in fear, with worries, confusion, and total resignation to the whims of fate and chance.

4.2.2 Starvation and Food Insecurity. Starvation and food insecurity were the next prominent themes identified in the data. Starvation is defined as "a severe deficiency in caloric energy intake needed to maintain human life" (Weiss, 2016, para. 4). It is the most extreme form of malnutrition. In humans, prolonged starvation can cause permanent organ damage and eventually, death. The basic cause of starvation is an imbalance between energy intake and energy expenditure (Chop et al., 2017). Food insecurity, on the other hand, is a more inclusive concept and exists when the "availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain" (Chop et al., 2017).

Both refugees and IDPs faced life without adequate food and potable water. The next refugee (Resp. 3), in narrating her life experiences in the refugee camp back in Africa, said that before she migrated to Canada, living in the camp was horrible. Sometimes, food would not reach everyone during meals. Everything was scarce, including rice and fufu (*local cassava flour*), and she became tired of complaining. Even when the food got to her, it was very small amounts or not well prepared or lacked the proper nutrients. From the above description, we can identify three components of food insecurity as reported by the participant: 1) insufficient food to serve everyone at the camp, which means that some IDPs will go hungry at some meal times 2) those that got the chance to be served food may not have enough to satisfy them and 3) even the food being served may not have been safely prepared and lacked required nutrients.

Another internally displaced person (Resp 4) also reported that sometimes food is limited, you eat the same thing all day, all week. If you complain the camp management will tell internally displaced persons that there is no money. They tell the IDPs that they are lucky to have access to some sort of food; that some IDPs in other camps do not see any food at all to eat. This IDP confirmed that this is true because she watched television and read newspapers on this issue. She read that many people died because of hunger at one camp in Ogun State (a *state in the west, very close to the former Nigerian capital city of Lagos)*.

Just as the previous respondent noted, another IDP also revealed that, not only is food insufficient; there is no variety in what camp residents were being fed. Sometimes they eat the same type of food for several days. She also discussed the high level of complacency and lack of concern on the part of the IDP camp management to improve their conditions. From my understanding, the management would rather want the IDPs to believe that they are being done a favor to eat improper and inadequate food because some IDPs do not have access to food at all. My interpretation of the management's attitude is derived not just from what this IDPs said, but also from my personal

knowledge of the corruption and embezzlement of funds pervasive amid the refugee and IDP camp management in Nigeria. The government usually gives them enough money, but most of the money ends up being embezzled. There is no accountability and no consequences for such actions. A typical example is the 2016 Nigerian National Assembly inquiry into the conditions of displaced people in North Eastern Nigeria. The report unveiled that about eight million dollars disbursed by the Nigerian government to the Presidential Initiative for the North East (PINE) was completely embezzled. This money was meant to cater for the shelter, food and overall wellbeing of displaced people in the North East. PINE was unable to account for the funds at the senate hearing. Until now, nobody has gone to jail for that embezzlement (Kazeem, 2016).

Furthermore, a 41-year-old internally displaced woman (Resp 5), in narrating her ordeals on her way to another IDP camp after being displaced from the first one, said:

> I had food that will last just one day for me and five children…We ended up staying 2 days in the forest without food because we felt safer there. I got used to hunger, it became normal for me, something I can live with. Honestly, being hungry was one of my least problems, when I have other big things like our lives and safety to worry about (Resp 5).

This response goes a long way to show the relative significance of the experience of hunger. The experience of hunger could usually be debilitating, but the enormity of her other problems, her natural struggle for survival and her strong sense of resilience helped her to rise above her hunger and face other immediate issues like safety and the struggle for survival.

To add to this, another IDP (Resp 4), while recounting her travails prior to making it to the camp where I interviewed her said that while she and other IDPs were in one of the churches waiting to be transported; they did not get enough food to eat, as they used to in the first church in which they were waiting. But, for her that was okay because their problem was not food but safety.

Everyone was more interested in staying safe than in eating. It did not matter to eat when you were not sure if you will live or die in the next minute (Resp 4). This IDP revealed important points to note: 1) insufficient food, and 2) the imperative of safety.

From the two responses provided above, it is obvious that the participants really had no choice between food and safety; rather their circumstances imposed only one option on them, that of fighting for safety. From an empathetic standpoint, one would assume that in the midst of displacement and suffering, the management of refugee and IDP agencies would at least guarantee basic necessities, like food and water. However, both refugees and IDPs suffered food insecurity. This ranged from no food at all, to insufficient food, or food that lacked proper nutritional contents, food that was not well prepared, no meal variety - eating the same food all day or even for weeks. Another surprising thing that can be deduced from this theme is that amid numerous challenges and lack of basic life amenities, the IDPs were forced by circumstances to prioritize necessities like food, water and the safety of life. In the scale of priorities, safety of life became more important than food and water. This is corroborated by comments made by refugees and IDPS, such as: “we ended up staying two days in the forest without food because we felt safer in the forest” (Resp 5). “being hungry was one of my least problems, when I have other big things like safety to worry about” (Resp 5). “we didn’t get enough food as we used to in the first church. But that was okay because our problem was not food but safety” (Resp 6). “Everyone was interested in staying safe than in eating. What are you going to do with food when you are not sure if you will die the next minute” (Resp 4).

Sadly enough, this is the reality of the majority of IDP women and children in Africa when compared to refugees in the western countries (Kazeem, 2016). Food insecurity is likely to disproportionately affect women because of global gender inequalities (Amin, 2015; Ivers & Cullen, 2011). Women are more vulnerable, given their lack of access to and control over resources, including land, employment and money (United Nations Department of Economic and Social

Affairs, 2015). Food insecurity has severe negative implications for women. It is related to poor mental health, such as depression and anxiety, increased risk of high-risk sexual behavior and staying in abusive relationships (Chop et al., 2017).

4.2.3 War and Conflict. Another theme that emerged from the data was the presence of war and conflicts as a precipitating factor for displacement. This ranged from religious and ethnic strife to conflicts between terrorist groups and communities, down to clashes between herdsmen and villagers or herdsmen and farmers. It is noted that on the one hand, in the bid to extort money from the government, Islamic terrorist groups will kidnap and kill vulnerable rural dwellers (most of whom are women and children) so as to induce the government to negotiate with them in exchange for huge amounts of money. On the other hand, herdsmen (livestock farmers) who have no food for their livestock will take their animals to farmland (belonging to crop farmers) where the animals will feed off of the farmers' crops. This usually ignites various forms of skirmishes between the herdsmen and farmers and often escalates to the community level, leading to a high death toll, destroyed residential houses and/or a complete wiping out of an entire community. Let us read what some IDPs have to say about their experiences of conflicts.

The first IDP (Resp 4), in recounting her displacement experience, said that she was away on a business trip (she was a small business owner) when the Boko Haram Islamic terrorists attacked her hometown. When she came back to her family house in the village, she looked through the entire house, but did not see anyone, only blood. Then a neighbor came and told her that her whole family was killed in the attack. The terrorists came and kidnapped people to forcibly join their militant group, but the village security men clashed with them. The terrorists killed many people and burned houses. So, the few surviving men in the village organized themselves and started guarding the village as security men, while the women and children left the village for safety. This IDP then ran to the church and stayed there for three months before she was brought to the camp (Resp 4). The

above experience represents how vulnerable people who live in the rural parts of Nigeria are to unwarranted violence. They are left to protect themselves because the government is unable to ensure the security of the people.

Moving on, another IDP (Resp 5) also shared her displacement experience during the interview. She said that she came to the refugee camp because of the problems with Boko Haram in the North. Her husband left her and her five children to go join the extremist Islamic sect because he was so fanatical about Islam. She was stunned that her husband could abandon his family just to fight for a terrorist group. He was eventually killed in one of their clashes with the Nigerian army (Resp 5). This goes a long way to elucidate the variety of conflicts that result in the displacement of IDPs in Nigeria. The respondent went further to elaborate how she and her children eventually were displaced through the instrumentality of the same religious strife. She stated that the Boko Haram came to the village with one boy they recruited in the past, to recruit the boy's brothers. His father resisted, they ordered him to shoot his own father in front of his siblings and he did. So, the village security ambushed the Boko Haram and killed some of them. They came on a revenge mission by the thousands, with guns and explosives; and almost wiped out the entire village. Those who survived left the village and ended up at the camps.

Another respondent (Resp 6), who is also an IDP, has this to say about her displacement experiences:

> I came here because of the killings in my town. The herdsmen killed many people because we refused to allow them to feed their cows on our crops and farmlands. We are farmers. So, we have no other means of livelihood and staying in the village was unsafe as the herdsmen kill and rape women and children indiscriminately (Resp 6).

The preceding quotation explains how horrifying the herdsmen's attacks on the vulnerable rural dwellers can be. The herdsmen are known to invade villages where they have their cattle forcibly

graze on farmers crops. The terrorist groups also operate in the rural areas where they kidnap men to join their group, and kidnap women and young girls who they will take into forced marriages, and subject them to rape and slavery. About this, the Council on Foreign Relations (CFR) noted that despite the efforts of the military to combat terrorism, the Boko Haram group: "retains control over some villages and pockets of territory and continues to launch deadly suicide attacks and abduct civilians, mostly women and children" (CFR, Feb. 2020). In 2014, 276 high school girls were kidnapped by the terrorist group, Boko Haram (Holpuch, 2018, para. 1). Also, in February 2018, more than one hundred school students were kidnapped by a faction of Boko Haram known as *Islamic State West Africa* (CFR, Feb. 2020).

The next few excerpts were from refugees who were displaced by civil and political war and conflicts. The first refugee (Resp 1), in narrating her migration experiences and her ordeals of war, said:

> I left my country because of civil war between the government and the rebels. The experience of war is horrible. You lose family, properties and lives. You have no future at all. When the war reached my city, we all had to find our way out and ran to Gambia. The Lutheran church helped me and brought me to Winnipeg (Resp 1).

Resp 2 was also displaced on account of war and conflict. She said that she and her family had horrible experiences of war. The insurgents came to their house and set the house on fire with all the family members locked up inside the house. She managed to escape, but thought she was the only one that survived because she was in a different room from everyone else. She was faced with the worst confusion and fear and did not know what to do, where to start or where to go. She later realized that her husband and children miraculously escaped, too. They ended up as refugees in Canada (Resp 2). So far, the two refugees both left their home countries on account of displacement occasioned by war and they both had bad experiences because of the war.

The next account is Resp 3's story. She added that her husband was a top politician in their country. When the war broke out, they became the first target of the opposition party. So, they escaped, travelling through Guinea and entered Gambia. They drove in her car, leaving behind all their property and luxury and ran for their lives. At some point the soldiers identified her husband and took him. His driver drove the rest of the family until they reached Gambia. She noted that it was a bad experience; they did not eat for a couple of days and slept inside the car for several weeks because they ran out of money (Resp 3).

From the foregoing, it is evident that both refugees and IDPs experienced war and conflicts in their home countries. While all the refugees in this study were displaced by civil war; the IDPs were displaced by terrorist groups and herdsmen. For the purpose of this research and based on its data, one can rightly say that war, conflicts and terrorism are directly related to loss of lives and properties. This takes us to the next related theme (loss of properties), which speaks about how the respondents suffered great losses of their homes, property and belongings.

4.2.4 Loss of property. As I mentioned earlier, based on the research data, loss of property among refugees and IDPs was a direct consequence of war and displacement. In this regard, one of the refugees said: "I became homeless couple times… I lost properties… left all properties and documents and ran for my life. I just took hold of my adopted daughter and ran from the rebels. I left everything else behind" (Resp 1). This refugee expresses how she left every material belonging behind in order to save her life and that of her adopted daughter. In times of war and unrest, the first thing that refugees and IDPs would think about is safety of life. They do not have the luxury or privilege to carry along any belongings.

Another refugee also narrated her ordeal and said: "When the rebels set our house on fire, I lost everything. No property, no food or clothes, except the most important thing – life. We lost all properties, but it didn't matter" (Resp 2). Again, this refugee indicated that she lost property. But,

one positive thing that can be deduced from her statement is that, even though she lost everything she had, she did not let that loss prevent her from realizing the positive aspect of her experience. She rather realized that despite the loss, she still had the most important thing on earth – her life. She prioritized her needs. For her, property did not matter as her life was the most important possession of all. So, she left every belonging and ran for her life. This is amazing because she focused on the positive, and that is a strong pathway to resilience. Another respondent (Resp 3), who is a refugee in Canada, opined "We left every single property and luxury and ran for our lives… My husband being a politician, had lots of money, houses and cars. But we lost all those things and became homeless suddenly" (Resp 3).

Furthermore, IDPs also expressed experiences of property loss. In this regard, one of the IDP women (Resp 5) explained that as they walked through the bush, she got so tired and one girl close to her abandoned her load and belongings and offered to help her with the children. She said that she had long abandoned her own belongings in the bush because she could not keep up with carrying them. It was as if the more they walked, the more tired they became and the more they threw away even the only water they had. This IDP talked about abandoning her belongings, but her main concern from my perspective was her children's safety. She had to continue walking, even though she was very tired. Her fellow IDP also abandoned her belongings to help out in carrying the IDP's children who had already become tired from walking. Another IDP (Resp 6) also explained that she left her home with her two children because when the herdsmen burned down her house to ashes, she and her family became homeless and could not afford to eat. They came to the IDP camp without a single belonging except the clothes they wore.

From the above experiences recounted by the refugees and IDPs, it is manifest that both the refugee and IDP respondents suffered loss of property. Another thing worth noting here is that whereas, both refugees and IDPs were displaced and suffered loss of property; most refugees

specifically talked about loss of property while IDPs focused more on the threats to, and security of their lives. Although they suffered various material losses, they always focused on the positive aspects of their experiences instead of their losses. I may not explain with certainty, the reason for this disparity, but I would suggest that it is because IDPs are still in their country of origin, where they still face similar traumatic experiences that displaced them. They are still living under additional and even worse traumatic experiences in the IDPs camps and have no access to necessities like food and water. Hence, they are preoccupied with surviving and living to see the next day; thereby ignoring other problems that are not immediately life-threatening. Whereas the refugees, on the other hand, are now living in their new settlement country (Canada) where they have access to all their basic necessities, are able to work, make money and acquire property. Food and security of life were no longer part of their immediate needs. This could be better illuminated with Maslow's Hierarchy of Needs (Simply Psychology, 2020), which is a five-tier model of human needs, often depicted as hierarchical levels within a pyramid. Needs lower down in the hierarchy must be satisfied before individuals can attend to needs higher up. From the bottom of the hierarchy upwards, the needs are: 1. Physiological (air, water, food, shelter, sleep, clothing and reproduction); 2. Safety (personal security, employment, resources, property) 3. Love and belonging 4. Esteem and 5. Self-actualization (Simply Psychology, 2020). Basically, the IDPs, in my view, are still at the first stage of human need; therefore, they prioritize life and physiological needs over property. Refugees, on the other hand, have gone past stage one needs and are probably on stage two and three. So, refugees in Canada have limited to no risks that threaten their lives. They may currently be at the needs level where they are more concerned with acquiring property and material things. Thus, they are able to quickly emphasize loss of property in their countries of origin.

4.2.5 Trauma and Rape Experiences. Most refugees suffer various forms of severe trauma during the process of migration, which leaves them psychologically vulnerable (Steel, et al., 2017).

Although refugee trauma experiences have been identified to be numerous; women, however, suffer most trauma from rape and sexual abuse (Forum on Global Violence Prevention, 2013). Rape is always followed by trauma. Behavioral science studies conducted on rape victims reveal posttraumatic stress disorder which follows the attack, known as Rape Trauma Syndrome (Alan, 1990). Rape Trauma Syndrome describes a cluster of physical and psychological signs, symptoms, and reactions which are common to rape victims. It can occur as a type of post-traumatic stress disorder involving an acute stress phase (Levesque, 2018). Rape trauma extends far beyond the actual assault (Emily, 2020).

In the next few paragraphs, I will examine what the respondents have to say regarding their experiences of rape and trauma. First, I will start with Resp 1, a refugee. While describing her pre-migration experiences, this respondent narrated the trauma she experienced, stating that the rebels attacked her and other people at the entrance of the city. Many women and girls were raped (*tears rolled down her eyes as she mentioned the word rape*). She recounted that hearing the gun shots was traumatic. Seeing dead bodies in the streets was a horrible trauma, also. According to her, "you never forget the feeling and horror of being raped. It is the worst thing anyone can experience" (Resp 1). As this refugee recounted her trauma experience, I asked her for clarification of what trauma means to her and she narrated how she still experiences episodes of posttraumatic stress, even without knowing she has PTSD. She said that one day she was standing at the bus stop; a car was passing, the tire exploded, and she unconsciously departed running. Loud sound brings back the feeling of war and all the traumatic experiences, like rape. Each time she remembers the rape experience she feels the need for safety. From this respondent's extract, one can see that even though the respondent may have experienced various traumas, she described rape trauma as the worst experience anyone can have.

Another respondent (Resp 4) told her story of trauma both before and within the IDP camp. She noted that "staying in the village was unsafe because the herdsmen killed and raped women indiscriminately. They raped women and children before their family members, and this leaves one with constant trauma that you cannot forget" (Resp 4). She continued to narrate her trauma at the IDP camp, describing how the soldiers at the camp maltreat and abuse residents sexually. She said that it did not matter if you did anything wrong or not. If the soldiers asked you for sex and you agree and meet them in the night, you will become their friend and they will be nice to you and allow you to go out anytime you want. But after that, one will live with the guilt and shame of giving out sex for favor. But if you disagree, the soldiers will maltreat you. Basically, the above citation refers to her traumatic experience in her hometown before coming to the IDP camp; as well as similar trauma she faced in the IDP camp. The horrible thing for this woman is that she left her hometown to escape rape and trauma, but unfortunately, she still faced similar ordeals in the camp where, technically, she should have been protected from such evil.

Moving on, another IDP (Resp 6) told her side of the story regarding her experience of trauma. She said:

> As a woman you are afraid and cannot go outside because if the rebels see you, you got abducted and gang-raped repeatedly. I have female relatives that live in the village who got abducted and taken away as sex objects. We constantly live in fear remembering the experience. Until now, the aftermath of the trauma and rape is still there even after so many years (Resp 6).

So far, the previous experiences narrated are largely about rape trauma. But, the following respondents did discuss trauma, but did not specifically mention rape trauma. Let us read what they have to say.

> Each time the fire alarm sounds, my son panics. He always needs someone to hold him when there is fire alarm. You know it sounds like there is another war, so you feel it is time to start running. The alarm reminds him of the sound of ambulance carrying the dead or wounded people in the streets. It is traumatic for him. (Resp 2).

From the above quotation, one may wonder why this woman rather preferred to talk about her son's trauma experience instead of hers. To put it in context, when I asked her to tell me about her trauma experience, she immediately seemed overwhelmed and distressed. I asked if she was okay, she nodded her head, wiped her tears and started talking instead about her son's experience. My speculation was that she may have suffered a lot of trauma or perhaps is still going through a high level of posttraumatic stress that she did not really want to talk about. Her high score in PTSD screening supports my assumption. Another reason might be that parents are always concerned and deeply affected by their children's issues. It could also mean that at this point in time her greatest stress comes from her son's problems.

Finally, the next IDP, while speaking about her traumatic experience, stated that sometimes she would wake up suddenly because she was dreaming that some strange creatures were coming to eat her children. So, she wakes up several times in the night to check her children to make sure they are okay. She said that she sees herself again and again in the bush and she thinks of the many bad things that could have happened to her children in the forest where they were hiding. Remembering all those experiences sometimes makes her feel sad and crazy (Resp 5). Coincidentally, the last two women that spoke about trauma did so in the context of their children. For this woman (Resp 5), her feelings of PTSD are escalated by her utmost love for her children, and her desire to ensure their safety. I can imagine a mother being in the face of death with her children whom she loves so much, and not knowing whether they will survive or not. It must have been very tough for her.

Overall, one common experience among most respondents on the issue of trauma and rape is the seeming inability to easily forget the trauma. This is the reason why most of them kept saying things like: "But you never forget the feeling and horror of being raped*"* (Resp 1). "After that (being raped) you live with the guilt and shame of giving out sex for favor" (Resp 4). "This (rape) leaves one with constant trauma that you cannot forget" (Resp 4). Another common factor is that it was tough for some of the women to mention the word rape. It always came with obvious hesitation or uncomfortable facial expression and body language or an outright emotional breakdown (crying). So, in this study, trauma and rape had a huge negative impact on refugee and IDP women from Africa.

4.3 Disturbing Post-migration experiences

In the next few paragraphs, I will be examining some of the themes that emerged from the post migration experiences of refugees and IDPs. The first one mentioned is family stress. Most of the respondents had various concerns that center on family attachments and relationships.

4.3.1 Family Stress. In relating her post migration experiences of stress, Resp 1 said that she was worried about her adopted daughter who is 21 because she is still back home. She cannot come to Canada because the participant does not have the adoption papers. So, she cannot prove the adoption, because the Canadian government requires the original adoption papers. Back home in Africa people do not do adoption officially for the most part. It is usually a family arrangement; you talk to the family of the child and adopt her. It is that easy. Even if she adopted her daughter legally, she may not be able to prove it because she would not have adoption papers; most of her family's important documents went missing in the process of displacement. She also said that her family was scattered because of the war, but when she came to Canada, she had to trace where everyone else was. Her adopted daughter was with her husband in another country and her aunt who lived with them died during the war. She still did not know where her uncle, her aunt's husband, was. She

concluded: “it is not easy for me, every day I think of how to reunite with my entire family. I miss the bond we shared, and it stresses me out” (Resp 1).

From the above, it is obvious that family reunification was very important to this refugee; not being able to reunite with her family contributes negatively to her worries and stress. It is important to note that in Africa the concept of family is very inclusive and expansive. It is not just one’s nuclear family, rather it outspreads to one’s extended families. This explains why this refugee is worried not just about her adopted daughter, but also about her aunt and uncle. To illustrate the broad African family concept, Makiwane & Kaunda (2018) said that African families are typically extended to aunts, uncles, grandparents, cousins and other relatives who form a family that functions in unison. In African cultures, the sons and daughters of one’s aunts and uncles are considered brothers and sisters, not cousins as in the Euro-American cultures. So, in Africa family is not limited to space and time; it cuts across generations, relatives living far and near, the living and even (the dead) those who have joined the ancestors, as well as the ancestors themselves who continue to play a role in the lives of the living (Lugira, 2009).

Another respondent, in expressing the scope of her family’s post migration stressful experience in Canada, talked about her son’s condition and how stressful it is to the family. She said:

> My son lost his left leg. The children laugh at him in school. They ask too many questions in school that he cannot answer. He is always sad. I and my husband are concerned about him. So, we don’t leave him alone in the house. He is only 12 years old and he cries a lot. This is too much for us (Resp 2).

She further said that her husband has no job, the money they get from the government is not enough, sometimes food is a problem, and she worries about her children’s welfare and wants her family to be happy. She is worried about her children’s education and whether or not they can deal with the language barrier in school because only her 12 years old speaks English (Resp 2). This refugee is

already in Canada with her family. One would assume that they would be living a less stressful life. However, they are still going through family stress. This goes a long way toward exposing how extensive and multifaceted family stresses could be for refugees and IDPs. Both those who live with their families and those whose family members are missing still have their various unique family stresses. For this refugee, her family stress stems from concerns about her children and their present and future wellbeing and happiness.

Respondent 3, a refugee, also narrated her story about family stress. She said that her daughter lives with a physical disability. They were told to always go outside when the fire alarm sounds. It sounds so often, so she has to carry her daughter downstairs from the fourth floor. She is eight years old and heavy, and this woman also has a three-year-old whom she needs to carry at the same time. It is so stressful for her and she mentioned that they need to live on the main floor, to make it easy for her to go outside when the fire alarm goes off. But, there were no available apartments on the main floor. So, it is hard for them. Essentially, her concern is about the same as the previous respondent – her children's welfare. Of course, parents care about their children's wellbeing, but given refugees' numerous negative experiences, family stress can put them in further psychological and physical stress. Not only does this respondent worry about her children; she also worries about her extended family. Thus, she further said:

> My mother is still back home, I didn't know where she was when we left. But now people have seen her, and she is sick. I want to bring her here, but they said I must start working before I bring her. I miss my mother every day. I don't know when I will get a job and it takes long time to bring her. I don't want her to die (Resp 3).

Family stress as one of the themes not only tells us the different levels and varieties of stress that refugees and IDPs go through; it also exposes the dynamics of familial relationships in the African context, which differs from the western nuclear family concept.

4.3.2 Credential Recognition Issues. Another important theme that emerged from the post migration experiences of refugees is credential recognition issues. When refugees come to their new homes in the host country their credentials back home seem not to be accepted by the host country, Canada. This constitutes another high-level source of stress for them. The following is what refugees have to say about their education credentials and the stress they go through because of their unacceptability. In narrating her story on credential recognition one of the refugee women said her credential was not recognized here in Canada. She studied business management but could not find a job. She took survival jobs, like working at a bakery, cleaning at a hotel, support worker, and so on until she went back to school to obtain a social work degree. She said this experience was tough and destabilizing (Resp 1). In the same vein, another refugee said:

> I was a teacher back home; they said I must go back to school here. My husband speaks good English. He was an engineer, making good money back home. Now they said his education is not good in Canada. He is 55 years old; how can he go back to school at his age? He now works with one of the factories that makes meat (Resp 2).

The first and second refugees seem to be describing similar situations. Their credentials were not accepted in Canada despite they and their partners having a university education. However, let us further look at the disclosures of a third respondent who revealed that her husband was a rich man back home. He had his own companies and did well in politics. He was a health commissioner and a doctor by profession. But, in Canada, he cannot practice with his medical degree. They said that he must go back to school and upgrade before he can take the board exam. He is confused and does not know where to start because it is a long and painful process (Resp 3).

Consequently, the credential recognition issues are exclusive for refugees only and not IDPs. Of course, this is simply because IDPs are still in their country of origin, whereas refugees are now living in another country, Canada. When refugees arrive in Canada, becoming integrated into the

workforce becomes hard even though they may be highly educated. This is owing to the fact that various professional bodies are not readily able to accept their international educational credentials. This leaves them frustrated and highly stressed; they end up doing menial jobs just to sustain their families. Others may be left jobless. This leads us to the next stress, unemployment and financial stress.

4.3.3 Unemployment and Financial stress. When foreign credentials of refugees are not accepted in Canada, the immediate consequence is unemployment, under employment and financial stress. The next few paragraphs will explore respondents' views on the impact of unemployment on their wellbeing and how it contributes to psychological stress on refugees. Regarding the impact of unemployment one of the refugee women lamented that it was like you have to know someone before you find a job. Her credential was not accepted, so she had to go back to school. Even after that, employers looked down on her resume when they identified her as an immigrant, because her work experiences were outside of Canada. Employers need Canadian experience, but how can refugees obtain Canadian experience unless they become employed in Canada. Sometimes this refugee could not feed her family due to financial constraints (Resp 1). Another respondent opined:

> We were sponsored by the government. We are paying back every money that the government spent on us. There are consequences if you don't pay back, and there is interest on the money too. You file tax they take it from your returns, they can also send you to collections and spoil your credit rating. How can you pay debt with no good job? This is so stressful, and I am worried about our financial needs (Resp 2).

Apart from the stress that emanates from not having a job, this respondent has mentioned another factor that escalates her family's financial stress, having to pay back to the government the money that was spent in bringing them to Canada.

Further to this, the next refugee also expressed concerns relating to unemployment and financial stress. She noted:

> You know the government pays for your flight and you have to pay them back. I make eleven dollars per hour as a cleaner, the money is not enough at all, so when do I finish paying this money back to the government? They cannot forgive the money; people think the government is helping us for free, but they are not. I am grateful I am in Canada, but I pay for everything (Resp 3).

The third respondent also raises concern regarding the financial stress of reimbursing the government for the expenses paid on her family's behalf to bring them to Canada. Contrary to the popular belief that the government favors refugees more than Canadian citizens, refugees are burdened with the immediate financial stress of paying back the government for all the travel expenses it spent on the refugees. For the refugees, unemployment and underemployment are factors that contribute to financial stress.

IDPs have their own concerns as well when it comes to financial stress due to unemployment. Respondent number four disclosed: "It is hard to get a job. Someone in the street will promise to help you but when you come, they want sex. If I have job and money, I will not feel bad or depressed, I will feel better" (Resp 1). IDPs also go through employment challenges, like refugees. Resp 5 added:

> I want to be able to work again. I cannot live forever to depend on people's donations for my survival. I am a very hard-working person, but there is no job. I need to work and take care of my children like I used to. Once I get a job and be independent, I will be fine. Not having money is the reason why I am stressed out emotionally (Resp 5).

Nevertheless, there is a slight difference between the data from refugees and that of IDPs, although they both worry about their finances. Refugees discussed unemployment and the financial burden, as well as some other factors that intensify their financial stress such as paying back government

loans. They emphasized the burden of the requirement to pay back a huge amount of money to the government. IDPs, on the other hand, discussed unemployment, but emphasized their need and desire to be employed. The IDPs are of the opinion that once they have a job, all other problems will be taken care of. For them, lack of finances is the major issue that creates their psychological stress.

In retrospect, it suffices to say that, not recognizing refugees' credentials leads to unemployment and underemployment; unemployment and underemployment lead to dire financial stress, and financial stress intensifies psychological issues for refugees and IDPs, as well.

4.3.4 Racism and discrimination. This is another theme that emerged in postmigration experiences. However, this theme is exclusive to refugees. Refugees feel that they are being discriminated against in Canada on account of their status as immigrants. They feel that employers do not judge them by merit; rather they presume that being a refugee makes one incompetent. The first refugee narrated the story of how racism played a role in her inability to obtain a job. She said:

> They think because you are from Africa or refugee, you don't know anything. Getting a job was hard until my professor who was in charge of CFS branch emailed me for a job. I have applied three times, but he said my application didn't cross his table. He then hired me. Being a refugee screens you out of job competitions (Resp 1).

She was recounting her experiences looking for jobs in Canada as a refugee. In her opinion, employers seem to treat you differently and look down on your resume if you are a refugee. She applied for the same job three times, but her application never reached the top decision makers until her professor, who knew her abilities, decided to hire her. Her professor, who is now her employer, was surprised that her resume never got to his desk, even though she was qualified for the job.

Another refugee woman said that her coworker put an update on social media saying that the natives are not taking up taxpayers' money, but immigrants and refugees do. She replied to her coworker and reminded her that she (the respondent) was a refugee and had been working and paying

her taxes. She does not live on taxpayers 'money. Nothing is free for refugees. According to her some refugees even pay more taxes than Canadians because they work hard and do two to three jobs. Racism and discrimination are seen as results of ignorance. People do not realize refugees and immigrants take care of themselves (Resp 2). This respondent was talking about the public perception of refugees as those who extort and abuse government social services. But, what the majority of people did not know was that refugees pay taxes like every other Canadian. All the more so, respondent 2 disclosed that most immigrants take up two or more jobs and eventually end up paying a huge amount of taxes. She believes that people like her coworker who discriminate, do so on account of ignorance. She revealed that after educating her coworker, this coworker apologized, stating she never knew immigrants work that hard for themselves.

Moving further, Resp 3 told me a story of how she has been in Canada since 2011, took English classes, went to school, but could not obtain a good job. She stated that a lady who worked in human resources (HR) for one company in Winnipeg told her about employment equity, whereby she could declare as a minority or refugee. It was designed by the government to help disadvantaged people obtain jobs, but some employers use it to screen out immigrants. She said that after the HR employee told her about this, she stopped declaring as a minority and she was invited for an interview. The refugee woman said: "once they see that you are an immigrant, they won't hire you. They prefer to hire Canadians. But I didn't declare as an immigrant this time, and I did so well in the interview, so I was hired" (Resp 3). She was narrating her experiences in which she was treated differently just because she is a refugee. She even believes that rather than using the employment equity declaration positively, some employers use it to discriminate against immigrants by screening them out of job pools and not inviting them for interviews. This refugee feels that she was not given equal opportunities with Canadian counterparts until she stopped declaring as a refugee and minority.

The aforementioned were the themes from pre and post migration experiences. In the next few pages, I will discuss resilience themes, in other words, how refugees and IDPs manage to stay resilient in the midst of their mental health issues.

4.4. Resilience Themes

Resilience within the context of immigration has been defined as the adaptation process developed by immigrant women to regain and maintain their optimal daily functioning (Yok-Fong (2014). The focus of this research was to explore how female refugees and IDP women of African origin remain resilient in the midst of all their struggles. Participants were specifically asked to speak about how they are able to stay strong and manage their emotional stresses despite their tough migration experiences. The following are the themes that emanated from the above question.

4.4.1 Social support. This represents a support network of friends, acquaintances, peers, family members and the community. Social support is a general theme which is further subdivided into three subthemes, namely: Family support, Support from non-family members and Community involvement.

4.4.1.1 Family support. In discussing the things that keep refugees and IDPs strong in the midst of difficulties family support was raised as a strong resilience factor. The first respondent said: “My family is a big source of strength. We don’t believe in therapy. Therapy is your family, their encouragement, and help. My family is what keeps me going” (Resp 1). For her, the most powerful means of dealing with emotional issues and staying strong is her family connection and support. Again, this relates to the previously discussed idea of the African family. For refugees, families are united together and fall back on each other for support, both emotional and financial. The depth of family support is best appreciated by recapping what this respondent said above “We don’t believe in therapy. Therapy is your family, their encouragement, and help” (Resp 1). The implication is that with appropriate family support, there may not be any need for therapy or counseling.

Moving further, another refugee woman described her idea of family support in the following way: “My family is everything. I live for them; we live for each other. We cry together, laugh together and encourage each other. My husband and children, we support and stay strong for each other. They don’t like to see me cry”. Her words demonstrate how family ties can be a source of strength for refugees. Family members at every moment are conscious of the need to be there for each other. Although refugees may be going through tough times, they try to stay strong for the sake of one another. So, this need for family members to support one another against all odds is a clear sign of altruism at its best. Strong family ties not only featured in refugees’ data, but also in IDPs’ data.

One IDP woman also portrayed family support as a huge resilience factor for her. She said that one of the things that has kept her strong is her family. Even though they may be dead, she still hopes that they are alive. So, she wants to stay strong and be able to someday find her family alive. She wants them to know that she did not give up, despite the numerous troubles. Family is very important for her and she wants to represent her family and make sure that her family’s name will live on, generation to generation. So, this determination to keep her family’s name alive makes her strong and hopeful (Resp 4). Just to throw more light on this respondent’s comment the Boko Haram Islamic terrorist group invaded her village and massacred many people while she was away. She did not see her family members’ corpses but was told they were also victims of the massacre. So, it is possible that some of her family members may still be alive somewhere since no one saw their dead bodies. But, given the nature of the massacre, her entire family is presumed dead. In her extract above, she revealed an interesting and novel idea about family support. Although her family may be dead, she still believes strongly that they are alive, and she must stay strong so that her family will not be disappointed in her if eventually they are found alive. This expresses a deep sense of commitment, family value, reciprocity, and a high level of trust and selflessness. More importantly, this IDP believes that even if her family members are dead, she still must be strong. As the only

surviving member of the family, she feels the need to procreate and maintain her family lineage. Therefore, whether one's family is dead or alive, one who is connected to familial relationships needs to always stay strong and committed to her family. This IDP expressed a very positive way of dealing with her life situations; regardless of her circumstances, she tried to stay positive and optimistic.

The second IDP, while speaking about the importance of family support said:

> When you meet the right people, who are able to support you, then you see the next side of family. Family is not just your immediate family, but anyone that gives you support like your own sister or brother or children would, is your family (Resp 5).

This goes a long way toward expressing the importance of family as a source of support. It further expressed the expansive and inclusive idea of family in Africa. Because family represents the strongest support system anyone who supports you is considered a family member in the African setting. In all, family has been expressed as a huge resource for resilience for African refugees and IDPs. In this context, anyone who is helpful, dependable and trusted is considered a family member.

4.4.1.2 Support from non-family members. The impact of social support in the overall mental wellbeing of individuals cannot be overemphasized. Although there are disparities in psychosocial rehabilitation strategies; social support has been found to promote better psychosocial adjustment (Watson et al., 2016; Koelmel, 2017). Social support means feeling loved and cared for, and having a network of family, friends, neighbors, co-workers, and community members who are there in times of need (Public Health Agency of Canada - PHAC, 2016). Adults with strong social support are more likely to report "being happy, have high psychological well-being, report high life satisfaction, report a strong sense of belonging to their local communities, report their mental health as very good or excellent" (PHAC, 2016). In this research, IDPS and refugees have also identified social support from friends, acquaintances and others as a source of resilience. One of the IDP women, during the interview on resilience strategies said:

> I learn new and exciting things when I hang out with people. I learn their culture, language and different positive perspectives about life, that encourage me. When I am outside the camp, I associate with people who are better than me and that renews my hope for a good future. Life in the camp makes you lose hope, especially when you look at the sad faces of everyone (Resp 4).

Ultimately, social support was an important factor that helped this respondent to stay resilient and maintain her hope and optimism for the future. Going out to meet people who are more stable served as an expectancy factor that gave her the courage to anticipate a future better than her current situation.

In line with this, Resp 5 recounted her story of the benefit of social support. She said that she goes out into the community and meets new friends, and it seemed like she was starting to feel human when she meets friends from her computer class because they are so supportive. They take her out to eat and do other things together and attend cultural festivals. She said that her connection with friends in the community makes her forget all her problems. Her roommate also goes out to meet her friends outside the camp, and when coming back she brings food and shares with her and her children. According to her "this is a good experience that gives me courage and hope". For this IDP woman, social support from her friends and acquaintances outside the IDP camp have given her the strength she needed to face the future.

Moving further, the next IDP said that her social support system is based inside of the IDP camp. She stated that she has good friends at the camp, maybe one or two people. For her, these people make her feel like they are her family members. She stated: "I have enough support from my friends here at the camp. I feel happy because they take care of my children and spend time with us. So, that helps a lot" (Resp 6). While the previous IDPs identified their social support outside of the camp, this respondent identified her source of resilience within the camp. Finally, social support was

largely featured among IDPs, although it was not exclusive to them. One of the refugees also said that her source of strength is her friends in Winnipeg. She opined: “we console and encourage each other. Some of my co-workers have the spirit of God. They talk to me when they see that I am too sad. The overall support from everyone is encouraging, Canadians are nice people” (Resp 1).

As I mentioned earlier, there are differences in individual psychosocial rehabilitation strategies. This is evident in the extracts from the respondents. Overall, the respondents’ social support systems range from friends and acquaintances to families and coworkers and even total strangers. For refugees and IDPs, social support is associated with resilience and mental wellbeing.

4.4.1.3 Community involvement. Community involvement has been demonstrated to offer benefits both to communities and to the volunteers, themselves, especially volunteering that is not required, pressured, or controlled, rather volunteering that is intrinsically motivated like that of refugees and IDPs (Stukas, et. al., 2016; Weinstein & Ryan, 2010). Resp 1, while discussing community involvement as a way of promoting resilience, said that getting involved with community members gives her strength and helps her face her fears. In her opinion, not being connected to people makes your situation worse. For instance, you may not know where and how to access various community services, social services and medical facilities. For her, mixing with her community and socializing is a healing experience. She revealed that relating with those who came to Canada before her helped her to gain the knowledge of services and how to navigate the entire system. In the same vein, Resp 4 stated that going out of the camp and connecting with the community was a positive experience for her. She opined that interacting with community members motivates her to want to leave the camp and join the community in order to live a better life. Relating with members of the community strongly gives her the will to want to fight harder and change her life for better.

So, community involvement from the foregoing embraces the ideas of resilience, normalization, information support, and social support. Respondents reported to have leveraged

community and human resources to support themselves, increase their knowledge of services and navigate the system in their entirely new world. Community involvement was a motivating factor to strive for success.

4.4.2 Religion and Faith in God. Africans are among the most religious people on earth (Igwe, 2010). In everything they do, religion and faith in a supreme being comes into play. The religiosity of the African person has been credited to various factors, such as: family upbringing and early religious indoctrination, the failure of human rights, rule of law and educational systems; social and political pressure, and bad governance (Igwe, 2010). Hence, there is no alternative for a better life than to believe in God as the only hope. This describes the importance of religion and faith in God in the lives of Africans.

The following are excerpts from refugees and IDPs as to how they stay strong through the help of religion. An IDP woman recounted:

> We don't eat well at the camp, but I am religious, and the church gives me food when I go there. The sisters at the church buy fruits and groundnuts and eggs for me, and I will take them back to the camp to share with the women who live with me. So, for me the church is a safe haven and gives me hope and strength (Resp 4).

For this woman her religiosity and encounter with a religious organization is her support system and source of resilience. So, when the refugee camps are not able to feed residents, the church is always available to help her. Another IDP said: "the church members brought food for us and it didn't matter if you were Christian or Muslim. I thank the church that helped me to come here. So, ultimately, Allah is the source of my strength because he made all these possible through people" (Resp 4). In the two quotations above, religion, church (through its members), and God are the entities that help the IDPs stay resilient. There is yet no mention of faith. But, in the next extract, faith comes into play.

Another IDP woman, in explaining the role of religion and faith in her ability to stay strong, stated that there is a religious sticker that she bought and on it was written 'if not God'. She put it on the wall close to her bed and every day she looks at it and it gives her courage and hope. Looking at the religious sticker gives her the assurance that God is always there to help her get through things in life. This assurance, according to the IDP woman, makes her happy. For her, God is at the center of her survival and resilience. She concludes that "If not God, who knows if I would be dead. I thank God every day that I am alive. I have always prayed a lot. I live every day because of my hope in God" (Resp 5). Here, faith in God is made manifest. The IDP owes her life to her prayers to and belief in God.

Furthermore, another IDP woman noted that she attends the church's fellowship once a week. Through the fellowship she met many people who encourage and support her. According to her, the support from brothers and sisters in the church is different from the support she experienced from anyone else in the street. She sees the church as a family, and everyone supports you with their heart and no strings attached. She revealed that the church members help in an honest way, and if not for the church's support, worse things may have happened to her (Resp 6). This IDP introduced some important elements regarding the impact that God and religion plays on resilience. She noted the concepts of 1) church as family, 2) social support within a religious setting as different from social support in the community.

Having looked at what IDPs had to say about religion and faith in God as sources of strength, I now examine refugee women's thoughts on faith and resilience. For the first refugee woman (Resp 1), prayers to and faith in God are the foundation for being alive; it is the guarantee for her future. Regarding the role that religion and God played in her ability to stay resilient, she said: "I have learnt how to hold God tight and pray well. Without God, we are nothing. With him, there is hope for future and there is reason to live. I must be thankful to God and give him all the glory". She maintained that

she found so many churches and African communities here in Winnipeg and got involved with churches. According to her, she draws her strength through her association with the church and its members.

Furthermore, Resp 2 is a Muslim and she acknowledged the role of religion and Allah in making things better for her. She said that when her family came to Canada, they were always lonely, but after some time, they were introduced to the mosque. Since then, things have become better. Praying with fellow Muslims has kept them going. She goes to the mosque every day to pray. She carries her problems to the mosque and comes out empty and happier. The people at the mosque have also been very helpful; they encouraged her and gave her food and clothes and showed her where to buy Halal meat. So, for this woman, faith in Allah, going to the mosque and help from religious members contributed to improving her situation. Going to the mosque was a source of social support to her, and her family and the mosque members were also sources of material support to them.

Moving on, another refugee woman (Resp 3) added that her ability to be strong can only be tied to the omnipotent being. When I asked for more explanation regarding what she referred to as the omnipotent being, she said: “whether you call it God or nature… some call it Allah, some call it Karma. I don’t know what it is, but it is real” (Resp 3). She continued to say that based on her experience, there is a supernatural power that controls the universe and has a way of sorting out everyone that remains upright (Resp 3). Amazingly, the third respondent was not so forward and outright like others in acknowledging religion, faith and/or God as her source of strength. In other words, she did not sound as religious as other African respondents. Rather, she talked about an omnipotent being which she described loosely to perhaps represent God (for Christians) or Allah (for Muslims) or Karma (for the non-religious and humanist). So, this respondent went outside of the norm to present her views in a non-religious, but humanistic, way.

Overall, the concepts of God, faith, religion and a supreme being have helped both IDPS and refugees to cope with their physical and psychological struggles. The next theme that emerged from the data is social support.

4.4.3 Sense of Responsibility towards Children. In addressing the question on how they stay resilient, respondents have traced their strength to their strong and natural sense of responsibility towards their children. In the midst of all challenges, they chose to be strong so as not to fail in their parental obligation to take care of their children and provide for them. To buttress this point, one IDP woman (Resp 5) said: "when I was diagnosed with mental health issues, it took a long time before I agreed to go for treatment, but I had to do it because of my children. I must be strong for them. I am their pillar and I cannot show my weakness". All the more so, another IDP opined:

> One thing that keeps me going is the need to be there for my children. It is tough for everyone, but amid all these, my children look up to me when they are hungry, sick, or sad. I don't have to give them excuses. So, in order to be there for them, I must be strong. I feel happy when my children are happy (Resp 6).

This strong sense of responsibility towards once's children is not exclusive to IDPs; refugees equally feel obligated to be strong for their children. One refugee revealed that one of the biggest reasons why she has been resilient and hardworking is the connection between her and her adopted daughter, who is still in Africa. She said: "I feel she looks up to me for a better future. I want to bring her to Canada. I don't want to disappoint her. She is my source of strength and has given me reasons to keep pushing harder" (Resp 1).

Another refugee woman stated that her children are ultimately the reason why she is strong and will continue to be strong for them. She said that if she gives up or worries too much and ends up in the hospital, her children will suffer because there is no one else to take care of them. In a more fascinating way, she stated: "the more I realize that they depend on me, the stronger I become" (Resp

2). Finally, Resp 3, (a refugee woman) stated that her children are her source of strength. She does not want them to see her cry because they will be disappointed. She rather prefers to be the shoulder on which her children cry. They look up to her; so she has to be to be strong for them. She believes that for her to be strong and provide for their needs, she has to be healthy emotionally and physically.

So far, almost all the refugees and IDPs interviewed in this research, revealed that they found resilience in their determination to provide for their children. This is not surprising because, naturally, mothers have the innate inclination to protect their children, in the same way that we all have the natural instinct for self-preservation and defense (Lowe, 2016).

4.4.4 Music. Music was another theme that featured in this research as a source of resilience. Studies have revealed that music is an effective tool for coping with stress, challenges, or adverse conditions, and thus an effective way to help a person be resilient (The National Conference on Undergraduate Research (NCUR), 2015; Fletcher & Sarkar, 2013; Pasiali, 2012). But, surprisingly, in this research, only two respondents discussed music as a source of their resilience. I am not exactly sure what the reasons for this are.

In recounting her resilience strategies, one IDP woman said that she listens to all types of music because they help her sink into the spiritual world and forget the physical world. She stated: "when I listen to music, I forget my sorrows and forget the present situation. Music gives me hope for a better future, it is like magic" (Resp 5). In line with this, one of the refugees, also said; "One other thing I do which has been helpful since day one is listening to Christian music. There is nothing that gives me meaning and purpose to life than music (Resp 1)". So, one IDP and one refugee identified music as one of their sources of resilience, although with individual variations. On the one hand, the first woman relates to listening to all types of music, while the second woman, on the other hand, alludes to listening, specifically, to Christian music. All the more so, while speaking about what music exactly does for them; the first woman said that music takes her to the spiritual world,

thereby facilitating her forgetting of the physical world and its problems. Music also gives her hope for a better future. The second woman, on the other hand, discussed a deeper meaning of music and resilience. For her, music gives a sense of meaning and purpose to her life.

For me, the idea of music giving purpose and meaning to life transcends physical and temporal coping mechanisms. It is more spiritual and goes deeper into shaping the refugee woman's fundamental, theoretical and practical outlook over life's difficult situations. Having a clear sense of the meaning and purpose of one's life, in my opinion, would mean knowing and understanding the ultimate purpose of one's life and following the right steps to achieve that purpose. It translates into not letting difficult times deviate one from pursuing his or her life's purpose. In other words, and also interestingly; this refugee may be living life at a high level of constant consciousness and awareness of purpose in life. In my opinion, all this may be linked to her deep religiosity as a Christian, which may have predisposed her to a more spiritually inclined understanding of life; as well as adopting a Christian perspective to challenges and suffering.

4.4.5 Future Orientation (Optimism and Hope). Research has linked greater future orientation with improved health and educational outcomes (Johnson et al., 2014). It has been identified as an important predictor of adolescents' ability to overcome adverse environments (Ostaszewski & Zimmerman, 2006). A greater future orientation indicates that an adolescent has clearer goals, a better ability to plan, and a stronger ability to overcome obstacles to their future. The power of future orientation to influence adolescent behavior is based on expectancy-value theory, which posits that individuals modify current behavior based on their judgment of future outcomes (Johnson et al., 2014). Thus, in this research, future orientation is directly linked to, and almost synonymous with, hope and a sense of optimism as a way that refugees and IDPs remain resilient. Below are some of the responses that featured hope and a sense of optimism.

Resp 5 noted that staying positive all the time is the key to her resilience. She stated that she tries to stay optimistic and hopeful all the time no matter what the situation is. In her opinion, if you cannot change the situation the only alternative is to believe and live with the hope that everything will be alright. For her, the fact that her present condition is better than some people's and the fact that she is alive and physically healthy gives her the reason to stay strong because many people in the same situation died because of hunger and neglect. In her words:

> If God considered me worthy to be alive, it means he has a purpose for me and my children. I have to be resilient, in order to live and see that purpose fulfilled. The hope that the future is bright, makes me strong and keeps me going and not relent (Resp 5).

Further to this, Resp 2 said "although things are not quite the best they could be, I look forward to a greater and better future. This hope for a better future keeps me believing everything will be okay". All the more so, Resp 3 said that staying strong for her means adopting a positive outlook. Each morning, when she wakes up, she tries to live positively and make herself happy with the things she has rather than thinking of the things she lacks. She would dress up every day in her best clothes and be positive about life. She believes we all have problems, but the magnitude and weight of our problems depends on how we look at them. In her words: "I look at my glass of water as half full, not half empty. This way I can live with the hope that my glass will soon be full in the future. I make friends with positive people; I listen to positive music" (Resp 3).

From the forgoing, while Resp 2 is more future oriented and stays resilient because of the hope for a better future; Resp 3 was all about optimism and a positive outlook. A few features are evident in their account on optimism: 1) the respondents seem to focus on being content with the good things they already have, instead of focusing on their immediate problems. 2) they try to measure and compare their achievements and positive life situations against other people who may have been ill-fated or are experiencing worse conditions. By so doing, they come to the realization

that they are better off than some people. This is a positive reality check which keeps them strong. 3) For the respondents, the hope for a better future yields a positive attitude and a positive attitude yields resilience. In other words, hope and expectancy for a purposeful future motivates the need to live and insure that the forthcoming purpose is fulfilled. In order to see to the end of the fulfillment, one must have to stay strong. Hope and expectancy enhance optimism about the future; they build resilience.

4.4.6 Education. Having sufficient education is another theme that emerged from the data as a factor to have enhanced resilience. Education relates to the preceding theme we discussed, including a future orientation and optimism**.** Being well educated is seen as a guarantee and security for the future. Regarding education, Resp 1 opined: "going back to school opened new doors for me and confidence for a better future. I meet successful people whose mentorship give me hope and assurance for greener future. Education is a huge source of resilience for me*"*. In the same line of thought, Resp 2 said: "Starting school will make me feel better. I want to become a teacher and there is no other way to do it than to go back to school". She maintained that if she starts school, she will not have time to think about other negative things; rather she will just concentrate on doing well in school. For her, when you are busy, you do not have time to think about problems.

Finally, Resp 4, who is a refugee, also spoke on the importance of education in facilitating resilience. She stated that some of her friends wanted to go back to school to obtain degrees. She also wanted to go back to school because she has only a high school diploma. However, she does not want to stay in school for several years pursuing a degree. She rather wanted to obtain formal computer training and education so she could start working. She insisted that without education or some training, you cannot be independent.

Basically, for these respondents, education is not only a guarantee of future security; it also boosts one's confidence level and facilitates resilience. It is a positive avoidance strategy as

witnessed in the response of Resp 2, who mentioned that education makes her focus on her studies and avoid negative thinking about her problems.

4.4.7 Employment. In this research employment can be said to improve resilience, independence and self-worth. Resp 1, in speaking about her resilience strategies, said: “Having a job, makes me to forget all my worries, even the hope that I will get a job after school encourages me to stay strong. It gives me a sense of independence”. While talking about employment as a resilience factor Resp 4 stated that the reason why she was still focusing on feelings of sadness is because she has no Job, and no money. She said that once she obtains a job and is able to provide for her needs, her feelings of sadness will reduce to the barest minimum. For her, even though bad things happen, good things can overshadow them; so, if she gets a job, she will forget all her problems. Another IDP, (Resp 5), while stressing the importance of having a job, said that she does not want to depend on people’s donations for survival because she is a very hard-working woman. She stressed that she needed to work and take care of her children by herself, and so being able to obtain a job would make everything else fine. She believes that having a job would make her independent and being independent would improve her self-esteem and overall happiness.

Looking back, one can see a clear link between the three previous themes discussed (future orientation, education and employment) and their role in enhancing resilience. Based on the above data, being educated enough is seen to guarantee future job security, having a good job leads to enhanced self-image and independence for the refugees and IDPs.

4.4.8 Volunteerism. Volunteering featured as a theme that enhances resilience. It represents a deep sense of reciprocity as demonstrated by the refugees and IDPs. Resp 1 said that she volunteers with refugee agencies in order to give back to refugees, and it makes her happy. She said that when she remembers that she was once a refugee who endured much hardship and is now stable, she is motivated to give her time and energy to improve the lives of refugees through volunteering. For her,

being able to work with refugees makes her realize how lucky she is now, and how much her life has improved. So, she is always grateful and cannot but stay strong as there are refugees whose conditions are worse than hers. Again, she indicated that she spends a lot of time volunteering because giving back and volunteering is satisfying. Resp 2 added: “I go out every day to help in the mosque, clean and do other volunteer duties. This makes me forget my worries, instead of staying at home and think about them”. Also, Resp 6 expressed that “sometimes she serves food in the IDP camp. She enjoys serving others because it gives her a sense of usefulness. She maintains that the feeling of responsibility and usefulness keeps her strong.

Based on the above excerpts, refugees and IDPs have found volunteering to be a satisfying and positive source of fulfilment and self-worth. Volunteering is largely self-willed, self-motivated, and a non-mandatory act of service that refugees and IDPs have found to be therapeutic and gratifying. This goes a long way in portraying how committed they are to giving back to the community in mutual reciprocity. They are not compelled for any reason to volunteer; rather the desire comes from deep within their hearts and represents a deep sense of purpose and resilience for them.

4.5 Alternative Resilience Strategies

This refers to other forms or approaches by which the refugees and IDPs cope with their daily challenges and life struggles. These are literally unconventional behaviors adopted by the respondents to remain resilient. Initially, I wanted to name them ‘negative resilience strategies’ but on second thought I decided to use the word ‘alternative’ rather than negative. This is because, even though the strategies may be negative behaviors, they still help participants to positively divert their attentions from debilitating psychological issues to more optimistic and beneficial behaviors.

4.5.1 Prostitution. The first alternative strategy adopted by refugees is prostitution. Research has found that the lack of assistance and support was the primary reason that nearly every study on

urban refugee livelihoods observed negative coping strategies, including crime and prostitution (Buscher, 2013). In my research, Resp 6 mentioned this term while speaking of her experience of coping at the IDP camp. She said that the soldiers that guard the camp and the employees were taking advantage of the IDP women and children. The soldiers pay them money to have sex with them. They always told the women to "use what they have to get what they want", meaning that they should give in to sex in exchange for money. She referred to this as prostitution. In her words, "if the soldiers want my body, they get it. If the workers want my body, they get it and they give me what I want, money" (IDP 6). This woman revealed that initially she was refusing to sell sex for money, but the soldiers still forced her to do it. So, she decided to give the sex and use the money to change her life and that of her children. She said: "it makes me strong knowing that I will not watch my children starve since I can get money from sleeping with them. I am young, and men still want my body in exchange for money and favors".

Although society may regard prostitution as a vice; the goal here, however, is not to pass moral judgement, but to understand the role that prostitution played in the resilience of a few refugee and IDP women. As concerning as it may sound that a young vulnerable woman has to sell her body and expose herself to dangers in order to make a living; there is also a positive aspect to this. It may be interesting to know that this woman finds the solution to her problems in the very act of prostitution. Therefore, prostitution became the strategy with which she maintains resilience, materially and emotionally. With the end-product of prostitution (money), she takes care of her material needs. Also, while out there mingling with men, she said that she forgets her problems; thereby alleviating her emotional burden of constant thinking and feelings of despair.

4.5.2 Alcohol. Alcohol is another alternative strategy identified in this research to have fostered resilience. Resp 3 revealed that one thing that keeps her strong is alcohol. She referred to drinking as a way to forget her problems. When things get too tough for her, she just drinks, and that

makes her happy again. She stated: “without alcohol, I probably would have committed suicide. But I don’t get drunk. I just drink and have good feeling and sleep” (Resp 3). While drinking may be bad for some people, for this refugee, it may have served a good purpose and helped her cope with her unfavorable situation.

Although only one respondent identified alcohol consumption as a way of coping; coping motives have been associated with alcohol use (Cooper, 1994); and trauma-exposed individuals demonstrate enhanced motivation to drink alcohol to cope with negative affective situations (Dixon, Leen-Feldner, Ham, Feldner, & Lewis, 2009). Horyniak et al. (2016) found that refugee youth consumed alcohol to forget traumatic experiences and avoid memories associated with losses. The study results showed that marginalized young refugees gathered in public spaces to consume alcohol on a daily or near-daily basis. The key motivations for the heavy alcohol consumption were identified as drinking to cope with trauma, boredom and frustration, and drinking as a social experience.

4.5.3 Avoidance/Numbing of feelings. This refers to the deliberate suppression of feeling by the refugees and IDPs in order to cope with their challenges. Resp 4, an IDP woman, in expressing some of her daily coping methods, said that there is strength from pretending that problems are not there, even though they are still there. She tries to be strong and not cry, even though she is always in pain on account of her situation. She stated:

> I don’t even have tears in my eyes again because I have cried all my life. Coming from a very poor family, my childhood was filled with cries for food, for clothes to wear, for money to go to the university. But cries cannot solve anything. So, numbing my feelings work for me (Resp 4).

Another woman, a refugee also said that she blocks off her bad experiences, although they are still consistently in her subconscious mind. But, she pretends that she is fine, just for life to go on.

However, in her quiet moments, she thinks about bad experiences and the feelings come back. She revealed that she had to train her body not to react to every problem most of the time, but rather suppress them as much as possible (Resp 1).

Although only a few IDPS and refugees did develop the strategy of deliberately numbing their feelings and trying hard to avoid thinking about their problems; it is arguable whether this deliberate avoidance and numbing of one's feelings is a positive or negative coping strategy. But for the purpose of this research, I decided to present this theme just as it was depicted by the respondents.

4.6 Ways to facilitate refugee's Resilience

As part of the research questions, respondents were asked to suggest ways that the government and settlement agencies can help foster the resilience of refugee women. The answers given are captured in the themes below.

4.6.1 Information as key. Information on the host country, its culture and what to expect; as well as information on appropriate services and how to navigate the system were prominent among the answers given by refugees in Canada. In response to the question on how to foster resilience, Resp 1 said that providing a great deal of information on what to expect and the way Canada is, in terms of weather, job market and so on would be helpful in preparing refugees prior to their arrival. She said that she came to Canada with tiny jackets, not knowing that the cold was extreme. She maintained that giving more information to refugees would be very beneficial. She suggested providing refugees with some type of workshop to communicate information when they arrive in Canada. She went further to say that refugees should also ask questions. In her experience, she noted that people in Canada are not friendly in the streets, especially when you are a person of color and speak with an accent. But, when you interact with your community and relate to those who came here before you, you will receive the necessary information for your survival (Resp 1). This refugee made an important observation. For her, the responsibility for adequate information does not just lie

with the government or settlement agencies, but also with the refugees. Thus, she encouraged refugees to always ask questions when in doubt or in need of something.

Furthermore, Resp 2, in stating her opinion, said that settlement workers are not always nice, they are slow, and do not give you all the information you need. She said that her son is emotionally unwell, cries all the time and is always unhappy. The settlement worker was going to arrange for him to see a doctor, but she did not do it. After waiting for a long time, the refugee called, and was told that their worker had left the agency. The refugee and her family were left in darkness; they did not know that the worker had left, and they kept waiting for her to connect them to a psychiatrist. The family did not know how to navigate the health system, and they did not want to ask their community members so as not to be stigmatized or labelled as having mental health issues within their family. So, the refugee suggested that agencies should always update refugees, follow up with them and make the settlement process seamless for them, instead of abandoning them without proper information and direction.

4.6.2 Education and Awareness. Giving enough education and creating awareness was another feature that stood out from the data. Resp 1, in speaking about this, said that some refugees end up in mental health facilities because their problems are not addressed. According to her, refugees from Africa do not go out to seek help, they do not talk about PTSD, they are afraid of the stigma surrounding mental health and they avoid acknowledging mental health problems because of stigma. Hence, regarding awareness and education, the refugee said “we in the African community regard people that have PTSD as people who are completely out of control. So, awareness and education will help remove the stigma in mental health and encourage refugees to talk about it”. This refugee emphasized the need for settlement agencies to educate people and create awareness to debunk the stigma surrounding mental health, especially among African immigrants. If a refugee has mental health issues and her community members look down on her as someone completely out of control,

it rather intensifies mental health problems and jeopardizes the person's mental health. But, the more people become aware that mental health is like any other illness, the better it will help remove the stigma surrounding it. This, in turn, will result in positive outcomes for refugees with mental health issues. Someone with mental health issues needs to be seen as normal, and not be the object of discrimination.

4.7 Relationships among the Themes

So far, I have discussed the themes that featured in the data. In the next few paragraphs, I will discuss how the themes relate to each other. The themes discussed are under three broad categories: premigration, post migration and resilience themes. While it may be fair to say that not all the themes have direct relationships with each other; certainly, some of the themes do have relationships with some other themes. Most of the themes that belong to the same broad category are directly related to each other; whereas the themes in different categories may not necessarily relate to each other. Among the themes from difficult pre-migration experiences, for instance; war and conflict, fear and uncertainty, starvation and food insecurity, loss of homes and properties and rape/trauma are all directly related. In any country at all (not just Africa) where there is war, the above themes are obvious and natural indicators of skirmishes and unrest. War breeds fear and uncertainly, starvation, insecurity and loss of property and lawlessness, including rape, abuse and trauma.

All the more so, some of the themes that are directly related can be said to have casual relationships, so much so that some are direct consequences of others. In post-migration experience, for instance, racism, discrimination and credential recognition issues can be said to causally result in stress. When refugees face racism and discrimination and their educational credentials are not recognized in Canada; they end up becoming frustrated and stressed out. In the resilience themes, education and employment are two themes that have causal relationships. Receiving an education was directly related to obtaining a good job. When one does not have adequate education, she may

not obtain a good job and consequently be unable to take care of her and her family's financial needs. Inability to take care of one's financial needs causally leads to financial stress.

In the third category, alternative resilience, alcoholism, prostitution and avoidance or numbing of feelings are strongly related to each other. Alcoholism is associated with prostitution and risky sexual behaviors (So and Park, 2016). Alcohol has also been said to be a means of escape, numbing and avoiding the feelings brought about by adverse situations. Alcohol consumption impairs cognitive processing, attention and thought, thereby making it difficult to allocate attention to stressful thoughts (Kritsotakis, et al. 2017; Steele & Josephs, 1990). In a study of Karen refugees in the United States, McCleary (2017) identified refugees' use of alcohol to numb feelings of idleness and lack of purpose. While several studies revealed that refugees use alcohol to number their feelings, Fazel, (2005) found that emotional numbing might be a risk factor for substance abuse and suicide. So, both alcohol and numbing of feelings are concomitantly related.

While discussing self-coping methods, Blount, (2018), noted that "refugee populations may turn to deleterious behaviors to manage stress and may face a number of factors influencing their self-worth" (p. 464). In his study, drugs and alcohol were identified as a form of stress management behavior which negatively affects refugees' mental health.

4.8 Relevance of the themes to the research questions

This section serves to briefly discuss the main themes in the research and theoretical literature, and their relevance to the research questions. In other words, I assess whether or not the themes generated from the data answered the research questions on the one hand, and on the other hand, whether or not the themes from the literature reviewed are relevant to the research questions.

The main research questions for this study, as outlined in chapter one includes:

1) How do African female refugees and IDPs with mental health issues stay resilient despite their stressful migration experiences, psychological and mental health challenges? 2) What are some of

the reasons for which African female refugees and IDPs leave their homes to seek refuge elsewhere? 3) What are some of the tough experiences and stressful situations that these refugees and IDPs experienced or are experiencing during their migration and settlement? 4) What are their reactions and feelings about these experiences? 5) How can their resilience strategies be facilitated so as to enhance mental health services and intervention with these women?

The themes from the data were classified under two categories: pre and post migration themes and resilience themes. The research questions that focused on pre and post migration answers are questions two to four, namely: 2) What are some of the reasons for which African female refugees and IDPs leave their homes to seek refuge elsewhere? 3) What are some of the tough experiences and stressful situations that these refugees and IDPs experienced or are experiencing during their migration journey? 4) What are their reactions and feelings about these experiences? Based on my presentation and analysis, the themes generated from the data answered the research questions. To the question: “what are some of the reasons for which African female refugees and IDPs leave their homes to seek refuge elsewhere?”, the relevant themes that answered this question include: uncertainty and fear; starvation and food insecurity; war and conflict; loss of property; trauma and rape experiences. To the question: “what are some of the tough experiences and stressful situations that these refugees and IDPs experienced or are experiencing during their migration and settlement?”, the themes that answered this question are: family stress, credential recognition issues, unemployment, financial stress, racism, and discrimination.

Furthermore, the primary research question is: 1) How do African female refugees and IDPs with mental health issues stay resilient despite their stressful migration experiences, psychological and mental health challenges? The resilience themes are principally relevant to, and directly answer the primary research question. The ways through which the participants stay resilient are social support, community involvement, religion and faith in God, sense of responsibility towards children,

music, future orientation, education, employment, and volunteerism. Moving on, question five "how can their resilience strategies be facilitated so as to enhance mental health services and intervention with these women?" was answered by the themes under: "Ways to facilitate refugee's Resilience," which include: information as key, education and awareness. Here the refugees and IDPs revealed that providing enough information on available resources and providing more mental health education and awareness will help facilitate their resilience.

Finally, regarding the fourth research question "what are the participants' reactions and feelings about these experiences?", the participants noted that the experiences were traumatic and trigger and/or escalate psychological symptoms. This is in line with some major themes in the theoretical literature. One of the reviewed articles revealed that refugees, (particularly women) were highly exposed to different types of war-related traumatic events that produced high levels of mental illness symptoms, especially PTSD (Ainamani et al., 2020).

Another study by Babatunde-Sowole, et. al. (2020), showed that African refugee women experience hardship. Although they are found to be resilient, their negative experiences affect their mental wellbeing. Fenta, Hyman and Noh, (2004), also found that African refugees reported a series of pre and post migration experiences of trauma that put them at risk of developing mental health problems. Such events include difficult camp internment, being subjected to physical and sexual abuse, seeing other people hurt or killed, discrimination, language barriers, and racism. The data confirmed that the prevalence of depression in the participants was triggered by contingencies surrounding the pre-migration and resettlement experiences (Babatunde-Sowole, et. al. 2020). Perera, et. al., (2013), also found that resettlement stressor exposure generally was associated with higher PTSD symptom levels in African refugees, especially in Ethiopian refugee women.

Basically, from the foregoing, I find that both the themes from this data and the empirical literature reviewed are relevant to and answer the research questions.

Figure 6.

Visual Illustration of the themes

Chapter Five: Discussion Chapter: How Policy, Practice and Research Can Enhance Refugee Resilience

This chapter sets out to achieve the following objectives:

i) To provide a summary of the research findings, including other secondary themes and thoughts that were not captured in the findings chapter.

ii) To provide a discussion of similarities of the findings to, and differences from, the empirical literature reviewed in chapter two.

iii) To outline implications of the findings for theory, policy and practice

iv) To provide a discussion on the limitations of the research and how the limitations may affect the interpretation of the findings.

v) To make suggestions for further research based on the research findings.

5.1 Summary of the Research Findings.

Thus far, chapter four discussed the details of the research findings, based on participants' thoughts and responses. However, for the purpose of clarity and continuity, I will give a quick recap of the findings. The findings chapter consisted of five major themes as follows:

A) Disturbing pre-migration experiences. These were from the respondents' experiences in their home countries and refugee camps prior to their migration. The featured themes include fear and uncertainty, starvation and food insecurity, war and conflict, loss of properties/homes and rape/trauma.

B) Disturbing post-migration experiences. Just as the name implies, the themes under this category emerged from the respondents' experiences after they left their home countries and travelled to their host countries. The themes include family stress, credential recognition issues, unemployment and financial stress, racism, and discrimination.

C) Resilience themes. These emerged from the participants' answers regarding their ability to stay strong and manage their emotional stresses despite their difficult migration experiences. The themes are, religion and faith in God, social support, sense of responsibility towards children, music, future orientation (optimism and hope), education, employment, volunteering and community involvement.

D) Alternative Resilience Strategies. This refers to other unconventional behaviors adopted by refugees and IDPs to cope with their daily challenges and life struggles. They include prostitution, alcohol, avoidance, and/or numbing of feelings.

E) Ways to facilitate refugee's Resilience. This includes the respondents' answers on ways that the government and settlement agencies can help foster the resilience of refugee women. The answers given include information as key and education and awareness.

5.2 Secondary themes from the data

This section discusses a few themes and thoughts emanating from the data which were not captured in the findings chapter as they do not relate directly to the research questions. The first among them is:

5.2.1 Stigma and a Misconstrued idea of Mental Health. Overall, there was a culturally misconstrued understanding of mental health as madness among the respondents. This, in turn, creates significant stigma toward people with mental health issues. Research has identified that the majority of Nigerians have numerous misconceptions, misbeliefs and misinformation regarding mental illness (Okpalauwaekwe, Mela and Oji, 2017). Generally, people believe that some supernatural or evil forces (and sometimes even God) causes mental illness as a form of punishment for one's sins (Abasiubong, Ekott and Bassey, 2007). Thus, Okpalauwaekwe et al. (2017), maintain that understanding mental illness in Nigeria must be approached contextually, culturally and historically.

Among the numerous misconceptions is the derogatory perception of mental illness as 'madness'; as exemplified both in existing literature and in my research. A qualitative study by Adebiyi, Fagbola, Olakehinde and Ogunniyi, (2016) showed the existence of stigma in the Nigerian communities where the pejorative term 'madman' is used to describe people with mental health issues. To buttress this point, Resp 4 said: "I think mental health is for treating people that are mad. It is how to care for all this mad people on the street to ensure they behave well". All the more so, Resp 5 opined "I never want to accept that I have mental health issues. It is not in my lineage. In my culture, madness comes from people's lineage. Someone in your family must have it and pass it on to you". Interestingly enough, Resp 5 did not only use the words mental health and madness interchangeably, she also introduced another misconstrued idea of mental health as being necessarily and completely hereditary. Thus, for her, one can only suffer from mental illness if it was passed on to him or her from a family member.

In order to understand the derogatory nature of the term madness, it is important to understand that a good number of people from Africa understand and describe mental illness as madness (Ventevogel, et al. 2013). For instance, Resp 5, in speaking about her understanding of mental health, opined that some peoples' mental health is worse than others, for instance mad people. She stated that mad people do not even wear clothes. No matter how you try to force a mad person to wear clothes, he or she will always take them off and prefer to wear nothing or at best, dirty, torn clothes, according to this refugee. For her, "madness is the highest form of psychological problem and it has no cure; it is a full-blown psychological problem. They usually live in public marketplaces near the garbage and trash bins" (Resp 5). Again, this respondent introduced the third misconstrued concept of mental as being incurable. She referred to madness as a full-blown psychological problem which means that there are levels of psychological problems and madness is the highest level. For her, because mental illness is hereditary and is the extreme form of madness it is incurable. In her own

opinion, one of the IDPs said that those with mental health issues are people who live in the marketplaces, walk around naked, wear dirty clothes, do not usually shower, and smell (Resp 6). Her idea corresponds to Resp 5's ideas, which portrayed the mentally ill as dirty, unkempt and having no homes of their own, but rather living in marketplaces and garbage areas.

From the forgoing, it is evident that there are large misconceptions, stigma, labelling and stereotyping surrounding the understanding of mental illness among many African communities. According to Ventevogel et al. (2013), the concept of mental illness varies significantly from one cultural context to another. In their study, which included 256 participants from various countries in Africa, almost all the participants described the mentally ill with pejorative phrases like madness, violence, aggressive, rubbish, hopeless, abnormal. Strong and deeply offensive phrases used to describe the mentally ill in my research include mad, dirty and stinking, no shower, torn clothes, living and eating from the garbage, homeless, just to mention a few. This demonstrates conspicuous stigma against people with mental illness in Africa. This aggravated stigma could possibly explain the reasons for the next topic I will be examining, the evasive attitude of refugees and IDPs towards mental health.

5.2.2 Evasive attitude/Objection to Mental illness. The evasive attitude of refugees and IDPs towards mental health may be associated with stigma. Evidence from this research suggests that IDPs tend to reject a mental health label as a way to avoid any chance that they will be the recipients of stigma. This is common in mental health literature, not just for Africans, but for other nations as well (Adebiyi et al, 2016; Bharadwaj, Pai, and Suziedelyte, 2017; Wu, Bathje, Kalibatseva, Sung, Leong, and Collins-Eaglin, 2017).

During the interviews, participants had to identify and agree that they have mental health issues before they could be interviewed. When asked if she has mental health issues, Resp 4 retorted "No, God forbid. I am not mad, and I have not been mad before". However, as the discussion went

along, this IDP not only agreed to having signs consistent with mental health issues; but her screening scores confirmed the presence of metal health issues requiring help. Yet she objected to being identified as one who had mental health issues. She literally was being evasive and was in denial. In the same context, another IDP said that the only reason why we could have the discussion about mental health is because she is now enlightened, having lived through her denials over several years. She revealed that if I had met her four years ago, she would never accept that she had mental health issues (Resp 5). From her comments, she seems to have acquired some knowledge and awareness about mental health and is now able to accept and talk about it. Additionally, one of the refugees, when asked about mental health, said "I decided to come because I have lots of emotional problems. So, when I keep seeing mental health in your recruitment letter, I was like, well, I hope this man does not think that I am mad" (Resp 3). Basically, she is still battling with accepting the term mental health, even though she agreed with having emotional issues. She just did not want to identify with the term mental health.

To reinforce the idea that this apparent evasion and denial is because of stigma, Resp 5 said "mental health is something bad. Once you mention it, people will run away from you, you will lose your friends and families and relationships will break up. No one wants to hear about it, it is a taboo and people's attitude towards you will make you go completely crazy". One refugee added "we don't talk about PTSD; we are afraid of that connation and we avoid it. We in the African community know people that have PTSD as people who are completely out of hand" (Resp1). This negative conception of metal health as stigmatic is also well documented in the literature. Okpalauwaekwe et al. (2017) noted that negative beliefs influence the attitude of Nigerians towards the mentally ill. Historically, people with mental illnesses were burned, hanged, mutilated, abandoned, and restrained with chains, all in a bid to save their souls, or bring redemption to their families and curb the iniquities causing mental illness within the families.

5.2.3 Little knowledge of Mental Health. Another observation that emerged from the data is that the majority of IDPs and refugees have little knowledge of metal health. During the interview, I asked one of the participants (Resp 4) what she knows about mental health and if she has sought help for her mental health issues, and she said: "Well, people have come to the camp to tell us about psychological problems. They told us they are mental health workers or public mental health, something like that. That is all" (Resp 4). For her, the only time she has been talked to about mental health was when a public health worker visited the camp, and she did not really know much about the term mental health.

When asked a similar question, another IDP said "mental health as a term is not something that is a household word for me. Not a lot of people know about it" (Resp 5). This represents the reality for many people, especially those living in the remote parts of Africa. Yet they are the ones who suffer the lack of access to metal health services the most. In line with this, Resp 6 said "Honestly, I didn't know anything about mental health, but coming here, I was diagnosed with mental health issues. I didn't know what it meant to have mental health issues. No one talks about it. It is a taboo". From the above citations, one can understand that because of the stigma associated with mental health, people do not really talk about it. If mental health is not talked about, how then can people know about it? This is one reason people in Africa have little to no knowledge about mental health, beside the dominant labels, stereotypes and misconceptions surrounding the understanding of mental illness among many African communities.

5.2.4 Preference of food over mental health treatment. The idea of choosing food over mental health treatment was another important thought that emerged from the data. The interesting thing is that this is peculiar to only IDPs. When I spoke to Resp 4 about seeking help for her mental health issues she said, *"*you should have asked me if I have eaten before you talk about seeing a doctor for my problems". She revealed that there is a doctor who comes to the camp to talk to people

who have emotional problems, but she has not seen him. She believes that you have to take care of the most important problems, like lack of food, before you talk about other problems. It is interesting to know that although a psychologist comes to the refugee camp to counsel people, this IDP has never sought counseling or any other type of treatment. Her preference is to first save herself from starvation before she can seek treatment.

Resp 5 thinks in a similar manner. She said, “a person who is hungry does not sing alleluia in the church”. I have to eat first and foremost before I talk about mental health. Physical health is first, if I don’t eat, everything else shuts down”. The very first sentence about singing alleluia is a cultural adage which implies that food is a basic human need which must be satisfied before any other need. When you eat well, you will have the strength to carry out other daily tasks, but a person who is starving is unable physically and mentally to do anything else. As straightforward as this may be, it portrays the ideological and cultural understanding and belief of a people struggling to satisfy basic human needs. Another IDP also opined that she does not consider herself needy when it comes to mental health. As long as her children eat and she has a job and can be independent, then she has no problems. She agreed that her feelings of severe emotional disturbance occur at times when there is no food or resources to meet other basic needs. Other than that, she is in control of her psychological wellbeing. So, she thinks that she does not really need any mental health services for now; rather what she needs for survival is good food, good accommodation and a job. This IDP thinks that there is a causal connection between her emotional problems and the lack of resources to meet basic needs, like food, shelter, and finances. Once those basic needs are fulfilled, she believes her mental health issues will be gone.

Overall, IDPS preferred the satisfaction of other basic needs before one can talk to them about help seeking for mental health problems. I will discuss this help seeking attitude more in the implications for practice section. Nevertheless, this desire for gratification of basic needs can also be

better understood with consideration of Maslow's hierarchy of needs as discussed earlier in chapter four. Human needs lower down the hierarchy must be satisfied before people can attend to needs higher up. From the bottom of the hierarchy categories of need are: 1. Physiological (air, water, food, shelter, sleep, clothing and reproduction); and 2. Safety (personal security, employment, resources, property) needs. These must be met before other higher needs can be pursued (Simply Psychology, 2020). As I said earlier, IDPs can be said to be existing at the first stage of human need; therefore, they prioritize food and shelter over seeking metal health help.

5.2.5 Biological notion of resilience. Furthermore, data from Resp 5's response features the notion of biological resilience. While revealing how she stays resilient, she said that the will to stay strong sometimes is natural. It is genetic for her female family members to be strong women. She noted that her mother lost her father at a very young age and she still worked hard to raise all her siblings. She believes that she carried her mother's genes and people say that she looks like her mother in everything. She maintains that it was her natural resilience that helped her survive the traumatic experience she has been through. In her opinion, that natural will to stay strong is innate; this is why two people will face the same situation, one survives and the other will not. This refugee believes that being strong is hereditary; something with which we are born. When I asked her to explain further what she meant, she provided an analogy of the natural habitat where plants compete for survival as a result of lack of nutrients. Plants need light for photosynthesis. But, when a plant like cassava is planted beside a mango tree and the mango tree blocks it from getting enough sun, the cassava will naturally grow as tall as the mango tree in search of light. But normally cassavas do not grow tall. There may be grasses below the mango tree, as well, and they will all be yellow and eventually wither for lack of sun. So, the cassava grew tall because it has a natural tendency to compete for survival, whereas the grasses were yellow because they do not have the gene to compete

and grow tall. So, she believes that if you have the tendency for survival you will survive and stay strong no matter the situation.

Although this biological notion of resilience seems to be novel, resilience however has also been found to be a product of genetic factors (Cameron et al., 2007; Charles & Almeida, 2007; Stawski, Sliwinski, Almeida, & Smyth, 2008). Resilience has featured in neurobiological research literature into human and animal resilience where certain neurons and molecules in the body affect resilience or the lack of resilience. Animal models and emerging technologies, such as optogenetics (Friedman et al., 2014, 2016), electrophysiological recording (Christoffel et al., 2015; Friedman et al., 2016) and animal imaging systems (Delgado y Palacios et al., 2011; Anacker et al., 2016), are generating a great deal of interest in the clarification of the neural circuits and molecules involved in resilience. Resilient individuals have been shown to have drastically different behavioral performances and neural substrates compared with, more susceptible individuals (Feder et al., 2009). Some recent studies shows that a K^+ channel in the ventral tegmental area (VTA) and dopamine (DA) neurons differentially mediate neuronal activity in resilient, normal and susceptible mice (Friedman et al., 2016; Han and Nestler, 2017; Barrese et al., 2018). Also, mPFC interactions determine the different behavioral responses to stress, and, in particular, resilience to stress (Wang et al., 2014). Inhibiting neuronal activity in the mPFC by DBS is effective at alleviating symptoms in depressed humans or rodent depression models (Covington et al., 2010; Warden et al., 2012), while enhanced mPFC excitation results in depression-like behavior (Wang et al., 2014). These neurobiological differences are thought to be genetic in origin and have implications for resilience.

This neurobiological notion of resilience suggests that while people with dominant resilience genes stay strong in the face adversities; those without resilience genes may not. This somewhat differs from behavioral therapy (BT), which suggests that all behaviors are learned, and unhealthy behaviors can be changed; thus, behavior modification can help non-resilient individuals to develop

resilience. BT has been used to improve resilience, reduce the symptoms of mental disorders and increase mental flexibility (Wolmer et al., 2011; Horn et al., 2016; Creswell, 2017). Thus, the biological notion of resilience featured in my research as well as in existing literature.

5.2.6 Other Subordinate thoughts. The thoughts I would like to mention here are classified as subordinate because they may have come out as part of the main themes or subthemes but contain some features which I personally think are significant and need to be echoed. They are some thoughts and observations that I believe deserve to be mentioned. In this research, it suffices to mention that education and employment were large factors and sources of strength, both for refugees and for IDPs. Obtaining a good education was expressed as very important by the respondents as it opens the door to opportunities for employment. Employment, on the other hand, guarantees financial stability and independence. Being stable and independent is something for which refugees and IDPs yearned. Those among them who are educated and/or employed have a more positive attitude and outlook towards life. Resp 1 said “Going back to schools opens a whole new door for me as a refugee and hope for a better future. Going back to school gives me hope and assurance for a better future”. In the same vein Resp 2 said that going to school would make her feel better. She wants to become a teacher and there is no other way to do it than to go back to school. She opined that if she starts school, she will not have time to think about other negative things. And, finally, Resp 4 also thinks that having an education is the only means to self-sustenance. She and some of her friends at the refugee camp plan to seek education soon and she wants to go back to school to study computer technology so that she can work. It is a popular belief among refugees and IDPs that without education or some training, you cannot survive.

Furthermore, from the themes presented in chapter four, food and poor housing were issues for IDPs but not for refugees. Only the IDPs complained about starvation, poor nutrition and housing. For me as the researcher, this was not surprising because I represent part of the two worlds of IDPS

in Nigeria and refugees in Canada, given that I am originally from Africa, but also have lived in Canada for a long time. The contextual explanation to this observation is simply that IDPs who complained of the paucity of food and poor housing are in Africa where the majority of people grapple with food insecurity and housing issues (Battersby, 2011; Dunga, 2017). The refugees, on the other hand, are in Canada where food insecurity and housing are not a major concern. Settlement agencies in Canada and the government ensure that food and shelter are provided for the refugees. So, the majority of the refugees in my sample have access to food and shelter unlike IDPs in Africa.

On the other hand, discrimination was an issue for refugees and not IDPs. Most refugees in Canada complained of being treated differently because of their color and social situations, but the IDPs did not complain of discrimination. All the more so, there were sexual abuses in IDP camps, but none were described in organizations serving refugees. Again, this difference may be explained, perhaps, in the same context of location. In Canada rape is taken seriously and offenders can be apprehended by law enforcement agents and be punished for the offence of rape. But, in Africa, particularly in Nigeria, even though rape is punishable by law, most people who are raped do not report it to the authorities because of stigma, victimization or other reasons (Amucheazi, 2019). Another reason is that the justice system and law enforcement agents are either incompetent or complacent in identifying and punishing offenders (Amucheazi, 2019).

Finally, based on the data, refugees are more stable than IDPs in terms of having jobs, family reunification (almost all of them live with their husbands and children) and a positive outlook on life. This is expected because IDPs are still under the protection of their home country; the same country going through conflicts and instabilities. So, it may be hard for them to achieve considerable stability or a better future in the context of instability.

5.3 Similarities of the findings to, and differences from the literature

Earlier in this discussion chapter, I did relate most of the themes to available literature. In this section, I will attempt to expose how the resilience themes may relate to or differ from existing literature. To do this, I will also follow the sequence of the themes presented in the findings chapter: Family support, religion and faith in God, social support, sense of responsibility towards children, music, future orientation (sense of optimism/hope), education and employment, volunteerism, community involvement.

5.3.1 Family support. Family support was a strong resilience factor that featured commonly among IDPs and refugees. Family members watch out for one another; they support one another emotionally, physically and financially. This is very akin to existing literature, not just on refugee and IDP, but, as well, related to immigrants in general.

In a study conducted by Nam, et. al., (2016), family adaptability and cohesion were resilience factors that would protect refugees from developing depressive symptoms. Family cohesion was significantly associated with less depression among North Korean refugees. The study revealed that resilience significantly mediated the relationship between family cohesion and depression. Furthermore, refugees without family support may be at particularly high risk for depression. Family support and resilience could therefore be protective factors among refugees.

Carranza (2012), in recognition of the prime place of families in the resilience and success of immigrant and refugee women in Canada, presented an innovative approach to working with Latina refugee women in therapy termed Cross Border Family Therapy. In the journal article, family therapists working with refugee and immigrant women were provided with the space to be innovative and adopt alternative family centered therapy models contrary to Eurocentric models. The case presented in this article portrayed how the therapist during therapy sessions connected a Salvadoran refugee woman in Canada with her family and community members who lived in her country of

origin and in the United States via teleconference. The woman's sources of resilience were the emotional and spiritual connections with her family and community members. During the therapy sessions, her family members offered helpful tips and emotional supports that not only resulted in successful therapy but also quick recovery.

Pejic, et. al., (2016) describe a model that targets immigrant interventions through a family systems perspective. Emphasis was placed on the need for a family support model that builds on the strengths of refugee families while recognizing their specific needs and challenges. The basis for a family systems approach is to demonstrate the importance of family support programs for refugee families' mental wellbeing.

5.3.2 Religion and faith in God. Religion and faith in God or a supreme being were important factors that helped refugees and IDPs to stay resilient. Overall, when it comes to Africans on the macrocosm, the place of faith in God and religion is paramount in dealing with difficult situations (Igwe, 2010). Literature abounds on African refugees coping by using religion, prayer and faith in God, while dealing with mental health and other life issues (Babatunde-Sowole et. al. 2016; Sherwood and Liebling-Kalifani, 2013). In a photovoice study conducted by King et. al., (2017), on the psychosocial well-being of African refugees in Winnipeg, participants reported inter alia that they often relied on their religion, prayer, praise songs and reading the bible to cope with their stress. Another study (Renner et. al., 2020) conducted among Syrian refugees on mental health and coping revealed that faith and prayer were among the major coping strategies adopted by the refugees to stay resilient.

Furthermore, another study (Hodge and Roby, 2010), used a mixed method approach to explore how a group of sub-Saharan African women living with AIDS cope with their circumstances. Results show that approximately 85 percent of the women reported that spirituality played some role in their ability to cope. Among these, 43 percent indicated that spirituality was the most important

factor that kept them going. The most prominent spiritual coping strategies consisted of faith, prayer to God, singing worship, among other things (Hodge and Roby, 2010). An Australian study, (Shakespeare-Finch and Wickham, 2010) also found that African refugees' belief in God through prayer and faith helped them to stay strong and endure trauma and resettlement stressors in Australia.

Although literature is replete with studies that identify religion and faith in God as strong resilience tools; some researchers have suggested a possible difference in the way that religion and faith impact migrants. In their quantitative study of 59 Somali refugee Muslims from East Africa, Bentley, Ahmad, and Thoburn, (2014) found that participants' religious practices did not protect them against post-traumatic stress disorders resulting from experiencing war and torture prior to migrating to the United States. Babatunde-Sowole et. al. (2016) revealed that the relationship between trauma and religiosity was important in the Somali study; however, the quantitative study design limited the possibility of collecting contextual information that may have explained the reasons why religion was helpful.

5.3.3 Support from non-family members. Social support was another theme that emerged from this data. Refugees and IDPS resilience is increased through social support from friends, acquaintances, and church and community members. Social support has been found in several studies to promote better psychosocial adjustment (Adelowo, 2012; Koelmel, et al., 2017; Schweitzer et al., 2007; Shakespeare-Finch & Wickham, 2010; Watson et al., 2016). In their study, Koelmel, et al., (2017) investigated the longitudinal relationships between social support and subsequent mental health outcomes. The results showed that at any given time, social support from significant others, family members, and friends was significantly associated with subsequent positive mental health outcomes (Koelmel, et al., 2017).

According to the Public Health Agency of Canada (PHAC), adults with strong social support are more likely to report being happy, have high psychological well-being, report high life

satisfaction, report a strong sense of belonging to their local communities, and to report their mental health as very good or excellent (PHAC, 2016).

5.3.4 Sense of responsibility towards children. As I discussed in chapter four, both IDPs and refugees reported that their strong desire to take care of their children has kept them strong. They chose to be strong so as not to fail in their parental obligation to take care of their children and provide for them. However, in my literature search, I was unable to relate this interesting discovery to any existing study. My literature search could not yield similar outcome in any of the resilience studies I reviewed.

In scanning for literature on sense of responsibility towards children, I tried to search different data bases and online libraries like the Cochrane library, Wiley online library, Social Science Research Network, Google scholar, and University of Manitoba library data bases. I searched for various words and phrases related to sense of responsibility towards children as a resilience factor. I searched for articles and studies written from 1990 – 2020 (30 years) and I found 532 articles and studies. When I went through a couple, I discovered that they were not relevant. Then I decided to restrict the scope of the search. I searched from 2010 to 2020 (10 years) and tried various key words; then I obtained = 45 articles, books, book chapters, and reports. Out of the 45 elements of literature, Cochrane library generated none, Wiley online library generated 9 articles, Social Science Research Network had only 3, and Google scholar had just 5 peer reviewed articles, while the University of Manitoba library data bases had 28 articles of the total search result. However, upon going through these 45 articles, none of them, unfortunately, was specifically on sense of responsibility towards children as a source of resilience. They were rather largely focused on various aspects of resilience in children. So, this is an area where more research is needed.

5.3.5 Music. Based on available literature, music is found to be central to the coping and wellbeing of various Africans and non-Africans dealing with both mental health issues and other life

situations. There is theoretical and empirical evidence to suggest that music therapy has been employed as a therapeutic intervention to facilitate healing and resilience across a variety of clinical populations (Landis-Shack, Heinz and Bonn-Miller, 2017). A study by Renner et. al., (2020) revealed that dancing and singing were very important in coping and the well-being of Syrian refugees with mental health issues. In Hodge's and Roby's, (2010) study, listening to music, singing and other expressions of spirituality enabled a group of sub-Saharan African women attending an AIDS clinic to cope with their circumstances.

Gerber, et. al. (2014) conducted a study among children living in Kosovo, a post conflict Eastern European country. The study was designed to evaluate a novel approach to promoting resiliency and diminishing distress through music. Children were enrolled in a music programs for 12 months and the results showed that children who attended the musical school program for a longer period evidenced fewer signs of cognitive disruption than children who had just entered the music programming. The study concluded that music was a sustainable way to foster resiliency and recovery in war-affected children.

5.3.6 Future orientation (optimism and hope). Hope is a positive feeling and motivational state, which arises from the belief that one has the energy and pathways (behavioral means) required to attain one's goals. Optimism, on the other hand, is the extent to which individuals expect desired outcomes to occur in the future and expect undesired outcomes not to happen (Bailis and Chipperfield, 2012). Future orientation for the purpose of this research is almost synonymous with hope and a sense of optimism.

In this research, future orientation was a strong resilience factor for refugees and IDPs. As I mentioned in the findings chapter, there is research evidence linking future orientation with improved health and educational outcomes (Johnson et al., 2014). Future orientation has been identified as an important predictor of adolescents' ability to overcome adverse situations (Ostaszewski &

Zimmerman, 2006). A greater future orientation indicates that an adolescent has clearer goals, better planning ability and a stronger ability to overcome obstacles to their future plans. The power of future orientation to influence adolescent behavior is based on expectancy-value theory, which suggests that individuals modify current behavior based on their judgment of future outcomes (Johnson et al., 2014).

Hope and optimism are hallmarks of psychological health (Bailis and Chipperfield, 2012). Solberg, Nes and Segerstrom (2006) completed a meta-analytic review of 50 studies on optimism and coping. The findings revealed that optimism related positively to problem and emotion focused coping strategies that had an approach orientation; and negatively to both problem and emotion-focused strategies that had an avoidance orientation. So, hope, optimism and positive future outlook help individuals dealing with life situations to stay resilient by adopting approach-oriented coping strategies.

5.3.7 Education. Education featured in my research and in the literature as a major resilience strategy. Various studies acknowledge that education was a very important factor that contributed to resilience among refugees. Sleijpen, Mooren, and Kleber, (2017) conducted a qualitative study to identify factors and processes that promote resilience among young refugees in the Netherlands. The results showed that school was very important for the adaptive process of the participants as it signified the key to a better future. Again, this is related to my previous discussion on positive future orientation. The hope for a better future facilitates the resilience of refugees. Sleijpen et al., further showed that being in school provided distraction from negative thoughts about refugees' traumatic history and it gave them some sense of power, pride and feeling of control over aspects of their lives.

In my research, being in school also provided social contacts and helped refugees integrate into the new society. As discussed in the previous chapter, most Africa refugees in my study perceived going to school as a chance to move up in the world. They see it as a sure means to secure

a good job and, therefore, have a guarantee for future security for them and their families. On the contrary, Sleijpen et. al., (2017) showed that participants who had no access to school because they were too old to go back to school, felt lost and this negatively impacted their resilience.

5.3.8 Employment. There is evidence from the literature supporting employment as a resilience strategy among African refugees. King, et. al. (2017) in their study on African refugees' psychosocial well-being and coping strategies maintained that stable employment was related to successful coping for African refugees. Their ability to earn income to meet their needs and those of their families helped them to stay strong. The study further revealed that not being employed for an extended period could lead to loss of motivation and disillusionment about ever building a career in the new country (King, et. al., 2017).

Furthermore, Dubus, (2018) in her qualitative study on integration and resilience among refugees noted that sustainable employment for refugees is a prime goal. Employment is seen as a way to establish economic independence for the family, develop social roles as productive members of the community, and lay a foundation for opportunities for the children of refugees (Al-Qdah & Lacroix, 2011; Asgary, Charpentier, & Burnett, 2013).

5.3.9 Volunteerism and Community involvement. Studies have shown that refugees involved in culture-specific refugee communities have more positive health outcomes than individual refugees who are not part of an engaged community (Goodkind,2005; Needham & Quintiliani, 2007). Developing relationships within local communities was also necessary for resilience and successful integration among refugees (Dubus, 2018). In a recent qualitative study, Curry, Smedley, and Lenette (2018) explored how people from refugee backgrounds experienced regional resettlement in New South Wales, Australia. Results showed that social connections in the refugees' communities were very pertinent to their success. Most participants felt that their local community was very supportive, and they developed connections and friendships through their involvement in their various

communities (Curry et. al., 2018). Many participants stated that they preferred their local community in comparison to major cities, especially when they speak the same language and share same culture (Curry et. al., 2018).

From the preceding discussion, connections to local comminutes are very much identified in the literature as well as in my research. Evidence from my research as well as from the literature shows that refugees connect to their local communities for information and social support, easier system and services navigation and self-motivated volunteerism. They leverage community and human resources to support themselves, increase their knowledge of services and navigate the system in their entirely new world. Connections to local communities work best when the refugees are connected to people of the same culture, language and tradition (Curry et. al., 2018).

5.4 Implications of the research findings for theory

Based on my conceptual framework and the empirical findings, this research has several implications for theory, which I discuss within the context of the theoretical frameworks set out for this research.

5.4.1 Anti-Oppressive Theory. This research is guided by anti-oppressive and feminist perspectives. Anti-oppressive practice (AOP) as discussed in chapter three is a framework which addresses social divisions and inequalities in service provision to clients. It is a person-centered framework that aims to provide more appropriate and sensitive services by responding to people's needs regardless of their social status (Dominelli, 2002). AOP is all about embracing diversity and difference in working with disadvantaged clients (Mullaly, 2010). Participants in this type of research are seen as experts on their own lives who are capable of self-determination (Strier, 2007).

Based on my research outcomes, AOP theory may be beneficial in understanding and improving the lives of refugees and IDPs. It opens the door of equal opportunities for refugees and IDPs to participate in society by removing barriers and providing enabling environments. Therefore,

AOP theorists should be more expansive in their development and application of AOP theories. They need to recognize and lay emphasis on the need to improve the lives of African refugee women by harnessing their potential throughout the entire settlement process. African refugee women face a multitude of issues of oppression, marginalization, disadvantage and jeopardy during their immigration and settlement process (Hampton, LaTaillade, Dacey, & Marghi, 2008; Guruge, Collins & Bender; 2010). Thus, adoption and expansion of an anti-oppressive theoretical approach that is emphatically inclusive of the experiences of this group of women will promote values of equality and social justice by challenging the power of oppression of vulnerable refugee women (Dominelli, 2003, Rogers, 2012). By expanding AOP theories to include the unique experiences of refugees and IDPs, mental health interventions with African female populations can be undertaken in a more egalitarian and inclusive way (Dominelli, 2003). It will also open doors for AOP interventions, which will provide more culturally appropriate and equitable services to new immigrant and refugee women (Sethi, 2013); while taking into consideration race, class and gender (Bernard, White, & Moore, 1993).

Application of AOP theoretical frameworks in working with refugees and IDPs will ensure that, since participants are experts in their problems, they are better able to utilize their resilience in dealing with their mental health issues. Mental health workers are also able to respect and promote the resilience skills of African refugee women while adopting AOP theory in their practice. Again, AOP emphasizes that the social work role is an intensely political one in which practitioners occupy a privileged status in contrast to clients (Korsnes and Noem, 2015; Healy, 2005; Heron, 2005). Hence, practitioners, by using AOP theory, will be able to adopt an ongoing critical and reflective stance on examining their position within social structures. By so doing they might minimize the disempowering effects of social divisions and avoid reinforcing oppressive social relations in practice. They must adopt person-centered frameworks that aim to provide more appropriate and

sensitive services by responding to people's needs regardless of their social status. Refugee and IDP women are experts in their own lives, are capable of self-determination and should be seen as such when practitioners adopt AOP theory.

5.4.2 Feminist Theory. This research was also guided by feminist perspectives and I hope that my research may contribute to the development of feminist theory. The main focus of feminist theory is to recognize and center the importance of women's lived experiences in order to unveil neglected or hidden knowledge (Aldred & Gillies, 2012; Olesen, 2011; Stacey, 1988; Westmarland, 2001). Feminist theory may help in successful resettlement and emancipation of African refugee and IDP women. My research from a feminist theoretical viewpoint created opportunities for marginalized refugee women to share their experiences and their hidden voices.

According to Becker and Aiello, (2013), social knowledge should not be based solely on the experiences of men or other privileged groups. So, by applying feminist theory, I was able to discover knowledge of resilience as it is understood and experienced by refugee women. These women's voices, for the most part, have been unheard, and they were happy to give their opinions on the realities through which they are going. They felt recognized, validated and appreciated.

Another implication of my research is that it will help in the expansion and development of feminist theories that will reflect particularly the unique experiences of African refugee women. Scholarship in the field of feminism has neglected the development of feminist frameworks to trace the power relations that shape the gender and other politics of forced migration (Hyndman, 2010). Feminist theory can make important theoretical and practical contributions to refugee studies, and conversely, refugee studies provide a rich, largely unexplored, empirical domain for feminist inquiry (Indra, 1989). By doing feminist research, this study contributes to scholarship in the field of feminism that aims at projecting the hidden realities of forced displacement and female refugees. Women may have fewer cross-cultural and cross-class brokerage resources, such as education or the

ability to speak the language of bureaucrats (Indra, 1989). This is because, bureaucratically, our political and social institutions have suppressed women in general and refugee women in particular. Yet, refugee women continue to be resilient because they possess qualities that foster resilience and improve their lives. So, my research contributes to both scholarship and the development of feminist theories by providing information and knowledge solely from a refugee women's perspective.

Practitioners are encouraged to practice feminism in their practice. The practice and application of feminist theory will also help practitioners to engage in constant self-awareness, which, in turn, helps to minimize the disempowering effects and consequences of power and privilege over refugee women. It will help to legitimize refugee women's experiences. Feminist theory helped me to examine and interpret the data within the context of race, class, culture, and gender (Meleis, Sawyer, Im, Messias, & Schumacher, 2000).

5.4.3 Resilience and Coping Theories. Another theoretical implication of my research is that it may contribute to the development and formulation of theories of risk and resilience. Such theories will help in subsequent planning of resettlement services that can benefit refugee women of African origin with mental health concerns. My research findings will contribute to the understanding of cultural perspectives on resilience theory by illuminating the role of culture as a contributing factor to resilience, rather than as a risk factor. As stated in chapter two, the host country might expect refugees to adopt its own cultural ideals and values; thereby undermining the refugees' own culture. Research has found that although the cultural values of ethnic minorities have been ignored in prevalent resilience theories; culture plays a very important role in understanding and maintaining resilience (Southwick, 2014). Rather than viewing refugees' cultural values as risk factors, resilience theories need to expand to include refugees' cultural practices. My research exposed the cultural aspect of resilience from refugees' perspectives that may contribute to the ongoing study and development of resilience theory. One example is the role that religion and families played in

fostering the resilience of refugees. Another is refugees' expansive definition of family, which includes extended families and distant relatives, as opposed to the Canadian definition of family as the nuclear family. So, in order to make resilience theories inclusive, refugees' culture and values need to be studied and understood. The more we learn about refugee's resilience, the more possibility there is for integrating relevant concepts of resilience, like culture, into relevant fields of medicine, mental health and science (Southwick, 2014). So, integrating the cultural, religious and other aspects of refugee resilience into theoretical knowledge and practice will foster progressive and expansive resilience and coping research.

According to Davydov, et. al., (2010), Hoge et al., (2007) and Patel & Goodman, (2007); resilience theory in mental health research is presently inhibited by poor concept definition. Hence, some other broader conceptual models, such as culture, might also help in the understanding of resilience in refugee mental health. Resilience is a mechanism involving numerous factors, including families, culture and communities (Charney, 2004; Davydov, et. al., 2010). This is in line with my research where participants demonstrated resilience through systems like families, culture and communities. Hence, it is necessary to incorporate into resilience theories how African female refugees maintain resilience amid their mental health issues.

5.5 Implications of the research findings for policy

First, in some countries in Africa, like Nigeria, poor mental health facilities, poor health outcomes, health inequalities and disparities abound (Okpalauwaekwe et al, 2017). So, there is a need for mental health literacy, and workable health policies that will help ameliorate the above problems. My research also discovered that stigma and labeling are a large barrier to mental treatment help seeking. People do not talk about mental health issues lest they be labelled negatively. Policies that will significantly reduce stigma and increase the help seeking behavior of the mentally ill are necessary (Okpalauwaekwe et al, 2017). People do not talk about mental health; this makes it hard

for the common man or woman to have a basic understanding of the concept of mental illness, even when she or he is living with it. There need to be policies that seek to increase mental health knowledge in the African continent where evidence has shown a paucity of basic knowledge about mental illness (Okpalauwaekwe et al, 2017).

Furthermore, from the outcome of this research, family plays a very important role in facilitating recovery from mental illness. Therefore, Canada and other host countries of refugees, should endeavor to enact policies that will expedite family reunification of refugees. Refugees in Canada complained that delays in reuniting with their families back home escalate their mental health issues. There are certain factors that delay or completely obstruct refugee family reunification. One example is that refugees are required first to establish effective settlement and financial independence before they can bring their families. For someone struggling with mental health issues, it may take a long time before she or he establishes herself or himself financially. Having a family member in Canada would facilitate the refugee's recovery, and such family members could also contribute financially when they arrive in Canada and start work. Another factor is the burden of proof on refugees to demonstrate their relationship with their family members. Most times refugees lose their documents and are unable to prove familial relationships by documentation, especially when they come from countries at war. So, the government should make family reunification policies and legislation geared towards expediting the process of family reunification. Government should make family reunification a right for refugees, and, as well, relax some laws to enable a more flexible reunification process.

All the more so, the African definition of family, unlike the western nuclear family concept, expansively includes extended family members. This expansive and inclusive idea of family in Africa is very important because family represents the strongest support system; anyone who supports you is considered a family member. Canada and other host countries are, therefore,

encouraged to be flexible and find ways to recognize this concept of extended family. That way, refugees who do not have direct families can sponsor some of those they consider family by emotional and social ties.

Moving further, when it comes to the mental health of refugees and racialized groups, there is little Canadian research on initiatives at a policy level that would improve pathways to mental health care and positive outcomes (Hansson et al., 2010). On the policy level, I hope that my research findings will help to advocate for policies that promote culturally appropriate mental health rehabilitation services in community mental health programs. I hope that the findings will assist social services agencies and policy makers to create policies that will enhance the efficient and successful rehabilitation of refugees and IDPs living with mental health issues. The Winnipeg Regional Health Authority (WRHA) community mental health program, for instance, had only one cross-cultural specialist for all immigrants; one of its kind in the entire province. Yet many immigrants from varied cultural backgrounds have found Winnipeg as their home. One would expect that there would be a few to many cross-cultural specialists in a province that in recent times, welcomed about 15,000 immigrants yearly (Statista, 2020). More surprisingly, I reached out to the cross-cultural specialist and was informed that the position was scrapped by the government as of July 2016.

Finally, given that community connections are a great resilience factor among refugees, it would be beneficial to have policies that value and fund community programs that promote diversity, cultural acceptance, and understanding in host communities. This could help address some refugee issues, particularly in localities where refugee resettlement is relatively recent (Curry, Smedley**,** and Lenette, 2018).

5.6 Implications of the research findings for practice

People with mental health problems try as much as possible to avoid being identified as mentally ill because of the stigma associated with mental health in Africa. They tend to reject the label to avoid any chance that they will be the recipient of stigma. This affects their help seeking behavior (Adebiyi et al., 2016) and has implications for how mental health workers offer help. In this research, I discovered that most refugees do not go out to seek help. During my interviews, participants were likely to be aversive and dissociate themselves from the word mental illness; but they felt more relaxed and able to talk when I used alternate words like stress, emotional issues, and so on. The implication then is for mental health practitioners to be sensitive and respectful in their use of the word mental illness while dealing with refugees of African origin. Awareness and education will also help remove the stigma in mental health and encourage refugees to talk about it.

Additionally, when it comes to mental health intervention and treatment, it is important for service providers, settlement workers and practitioners to take into considerations the perspectives of refugees on the mode of treatment. Based on this research, most African refuges do not believe in western therapeutic models like cognitive behavioral therapy (CBT) counseling. One of the refugees said: “we don’t believe in therapy; therapy is your family” (Resp 1). She went on and said that as an African refugee, no matter how long she goes for therapy, if she does not have family support, chances are her recovery will take a long time or may not even happen. This is why some refugees end up in mental health institutions because their family problems are not addressed. So, helping refugees stay connected with their families and leveraging their families’ support to aid in therapy sessions may be helpful for both the refugees and the mental health practitioners.

All the more so, given that the majority of refugees in this research had recourse to spirituality and religion as strategies for resilience, it is important for settlement workers and practitioners to explore the religiosity of their refugee clients from Africa in order to adapt their practice and provide

help in a way that is more meaningful and relevant to the recipients. For instance, those refugees who indicate that religion is important to them could be given free bus passes to go to church or mosques. The practitioners could generate a complete list of all the churches and mosques in the city and make copies available to refugees who may be interested.

Furthermore, another implication of my research for social work practice is that the findings will help to improve community mental health service delivery to African refugee women. Resilience research is important as it aids in developing interventions to prevent and/or treat common mental disorders (notably anxiety, depression, and stress reactions) with risk factors that have high individual and cultural variability in impact (Connor & Zhang, 2006). The study provides evidence to bolster, strengthen and sustain a more holistic understanding of help-giving and provision of appropriate mental health rehabilitation services to African female refugees in Canada. For example, my research found that family support could lead to a more positive recovery form psychological issues, more than psychotherapy. Therefore, facilitating family support and unification may improve social work practice. More so, the better service providers understand the resilience strategies that work well for African female refugees, the more capable they will be to provide more appropriate training to social workers and rehabilitation workers who deliver services to this target group. As Lacroix, & Sabbah (2011) rightly pointed out, social work practitioners are increasingly confronted with refugee families who have come from war-torn countries, experiencing various forms of ordeals. Hence, there is a pressing need to be attentive to refugees' experiences and their impact. When service providers are equipped with the appropriate training to promote resilience among African refugee women, we can expect improved services for this group. According to Davydov, Stewart, Ritchie, and Chaudieu, (2010), improving resilience may be an important target for treatment and prevention in mental health rehabilitation. Therefore, my research hoped to improve mental health services for refugee women of African origin. For instance, family support came up as

a prominent theme among refugees and IDPs. Social work practitioners could find ways to incorporate IDPs' and refugees' family members in the therapeutic process. Carranza, (2012) portrayed an example of how a therapist connected her Canadian client's extended family members living overseas, to the therapy session via teleconference.

Moving on, the research findings overall call for appropriate and tailored mental health and resettlement interventions that consider the specific needs of refugees. This is where cultural competence and sensitivity come into play. Cultural competence is an essential values-based component of optimal social work practice (Horevitz, Lawson, and Chow, 2013). Hence, healthcare practitioners should be able to develop and implement culturally competent health interventions at both provider and institutional levels. They need to be responsive to the cultural needs of clients and their families. They must have the ability to understand and effectively communicate with refugees across cultures, while being aware of their own worldview. developing positive attitudes towards cultural differences and gaining knowledge of different cultural practices and worldviews. By doing so, they can ensure that each client has access to the best available evidence-based treatment that represents the perspective and culture of the client. Thus, cultural competence in the context of the health care encounter can be viewed as a negotiation. Sometimes the patient's perspective should prevail, sometimes the provider's, and sometimes collaboration or compromise will result in the optimal outcome (Dreachslin et al., 2012).

Taking from my research, one example of how a practitioner can be culturally competent may be drawn from the discovery of refugees' preferences for food over mental health treatment. Most of the participants revealed that they prefer frequent meals more than receiving treatment for mental health issues. A practitioner who is not competent in African refugees' culture might consider this bizarre. But, as an African myself, I understand that these refugees came from a place where basic amenities like food and water are scarce. So, their quest for food is understandable because it

is a quest to satisfy the most important basic need of every human being. We all need food to survive. So, while working with refugees, it may be beneficial to ensure that they have access to resources to meet their basic needs like food and shelter, before starting mental health therapy. The success of therapy might be delayed or thwarted by unmet pressing basic needs.

5.7 Limitations of the research

Just like most other research studies, there are limitations to my research, and those limitations may affect how the findings should be interpreted. First, all refugees in this research are government assisted refugees (GARS) as opposed to privately sponsored refugees (PSRS). GARs are refugees who are chosen by institutions, such as the UN Refugee Agency, then referred to the Government of Canada for resettlement, and are supported by the government for up to one year. After one year they must start paying the government back for the money spent on their travel and settlement. PSRs are refugees sponsored by a private group that promises to financially and emotionally support a refugee for the first year that they live in Canada (El-Chidiac, 2018). Interviewing only GARS could possibly limit the experiences and opinions represented in this research. This is because GARS may have different shades of experiences from privately sponsored refugees. Their varied experiences may well influence their perception of life and mental health, and subsequently their overall responses to the research questions.

Research has found that PSRs have more success rates than GARS (El-Chidiac, 2018). Immigration, Refugees and Citizenship Canada (IRCC), (2016) conducted a rapid Impact Evaluation (RIE) to assess the early outcomes of Syrian refugees accepted between 2015 and 2016. The evaluation focused on resettlement and early settlement outcomes for GAR, PSR, and Blended Visa Office-Referred (BVOR) refugees. Comparisons were also made to previous resettled refugees who arrived in Canada between 2010 and 2014. The results of the study demonstrate that PSRs have significantly higher chances of finding a job, getting help settling in Canada, and improving their

outcomes in general, than GARs. Therefore, a mixture of GARS, PSRS and BVOR would have presented a wider picture of refugees' experiences in Winnipeg.

Furthermore, all the refugees were displaced because of war, whereas, all the IDPs were displaced because of terrorist attacks, which are very similar to war. The data would have been more interesting and wide-ranging to have included refugees with experience of various other displacement factors other than war. This would have brought variety and diversity to the data. Another limitation is that all IDP respondents interviewed were from the same camp. It would have been more wide ranging to interview women from other IDP camps in order to compare the quality of lives and experiences of the respondents from different IDP camps. Therefore, the opinions expressed in this data may not represent the reality of all IDP camps in the same manner and degree.

Finally, some participants did not speak good English. Only one of them spoke and understood perfect English because she was a teacher. Some were mixing real English with broken English. I had to interpret the rest of the interviews from the local broken English to real English. Like the saying goes: translators are traitors. Although I understand both languages perfectly well, there may still be the possibility that my translation may affect the quality of the data.

5.8 Further research suggestion based on the research findings

My research focused on resilience of African refugee and IDP women living with mental health issues. The result of my research has raised a few other issues that might be explored by researchers in ongoing research on ethnic minority women who are refugees and IDPs.

Rape and violence against refugee and IDP women came up during my interviews. Further research could also investigate the extent to which rape and violence occur in IDP and refugee camps and the subsequent impact they have on refugee and IDP women. All the more so, stigma was a factor that prohibited refugees and IDPs from speaking about mental illness and seeking help. Further research could explore the help-seeking behavior of mentally ill refugee and IDP women and the

extent to which it is affected by the overarching issue of stigma. More research efforts are needed to unravel the burden of stigma within the communities of refugees and best practices on stigma-reducing interventions.

5.9 Conclusion

Refugees and IDP women obviously show a great deal of resilience and have various strategies for staying strong despite their migration and mental health struggles. Resilience was shown to be derived from religion and faith, going back to school, upskilling, support from families, friends, acquaintances, and communities, music, hope and optimism and a host of other alternate strategies. As Udah, et al. (2019) stated, instead of pathologizing refugees and focusing on their victim's stories, society should focus on their strengths and resilience. Therefore, government agencies, mental health and immigration practitioners working with refugee women in Canada and IDP women overseas; are encouraged to foster the resilience of refugees in ways that are familiar, preferable and deeply appreciated by the refugees. This will help the practioners to implement culturally safe interventions to meet the mental health needs of Black African newcomer refugees (Baiden & Evans, 2020).

In retrospect, while it is great to emphasize and foster the resilience of refugees and IDPs, we should not forget that these women, especially refugees, could also experience vulnerability and disadvantage emanating from being visibly different in white dominated country, coupled with other indicators like cultural difference, skin color, physical features, accent, dress or religion et cetera, (Udah, et al. (2019). People working with refugees should therefore be conscious of these points noted above and endeavor to mitigate between fostering resilience and meliorating oppression, disadvantage and discrimination.

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Appendices

Appendix A: Individual Interview guide

Appendix A: REB approval

Appendix C: Letter of Recruitment

Appendix D: Consent Form

Appendix E: Permission emails

Appendix A.

Individual Interview guide

Introduction

Welcome … (Participant's name). My name is Declan Amadi, and I am a graduate student of the University of Manitoba's Faculty of Social work. The purpose of this interview discussion is to complete a thesis in fulfillment of a graduate degree in social work. My thesis advisor will have access to anonymized data, that is data without any information that can identify you. I will use pseudonyms (that is false names) instead, to disguise anything that might make you identifiable. The foreign study supervisor and her research assistant will also have access to both raw and anonymized data. I might also use part or all of this interview and the findings to write an article which will not contain any identifying information.

The presence and purpose of this recording equipment is to ensure that I capture everything you will say so as not to misinterpret your valued ideas and information you will provide me. In this interview, I promise to keep the information you share very confidential, and your name will not be shared with anyone.

This interview will last for approximately one and a half hours. We may take a break anytime you wish. You have the right to pass on any question I ask you if you wish not to answer. You equally have the right to walk out of the interview anytime. It is entirely voluntary.

The purpose of the interview discussion is to hear your perspectives on the approaches and ways with which you stay strong and manage your mental health issues despite your tough migration experiences. This will enable me to understand in detail what you think and feel about living with mental health challenges as a refugee and possible ways to foster timely rehabilitation. I have chosen to interview you because you are a refugee/internally displaced woman and I think you are the best person to talk to on issues of migration stress.

Some Key points:

I would like you to take note of some key points. The World Health Organization (WHO) regards mental wellbeing as a basic necessity for everyone. Hence it has included mental well-being in the definition of health as: … "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2018, p.1). It further defined mental health as: … "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2018, p.1).

From the above definitions there are three basic factors pertinent to the improvement of health: 1) mental health is an integral part of health, 2) mental health is more than the absence of mental illness, and 3) mental health is intimately connected with physical health and behavior. Therefore, mental health is the primary foundation for well-being and effective functioning for an individual and for a community. It is more than the absence of mental illness (WHO (2005).

Key Questions

Below are the sample questions that will be on this interview guide:

1) Could you please tell me about the reasons why you left your home to seek refuge here?
2) Are you married or living common law?
3) Do you have kids, if yes how many?
4) How old are your kids?
5) Are you here with other members of your family here?
6) Tell me about some of the tough experiences that you went through during your journey from your home to this refugee camp?
7) What are some of the stressful situations that you experience since you arrived here at the refugee camp/settlement house?

8) How do you feel about these experiences?
9) How have you been affected emotionally by these experiences?
10) Please tell me about how you are able to keep strong and manage your emotional stresses despite your tough migration experiences?
11) Are there other approaches, strategies or factors that help you to stay strong and keep up with life?
12) You have told me a lot of things that keep you strong despite the challenges you are currently facing. In your opinion, what can the government and the refugee agencies do to enhance the mental health services that are offered to you so as to help you to stay stronger?
13) Is there anything else you want to tell me regarding your ability to stay strong in this time of difficulty?

Conclusion

We have covered a lot of ground today. Is there anything else you want to add? Before we finish, I would like to tell you that I will (transcribe) write down all the information that you have given me today word for word. I will also give you a copy of the transcript to go over and then I will like to meet with you for the second time to go over the overall themes to make sure we got everything right. At that time, if there is anything else that you would like to add or change you could do so. Can I contact you if I have further questions?

Thank you for answering my questions today.

Appendix B.

REB approval

UNIVERSITY OF MANITOBA | Research Ethics and Compliance
Office of the Vice-President (Research and International)

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone +204-474-7122
Fax +204-269-7173

APPROVAL CERTIFICATE

July 4, 2016

TO: **Declan Amadi** **(Supervisor: Sid Frankel)**
Principal Investigator

FROM: **Kelley Main, Chair**
Psychology/Sociology Research Ethics Board (PSREB)

Re: **Protocol #P2016:076 (HS19885)**
"Resilience in African Female Refugees/IDPs living with Mental Health issues"

Please be advised that your above-referenced protocol has received human ethics approval by the **Psychology/Sociology Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). It is the researcher's responsibility to comply with any copyright requirements. **This approval is valid for one year only and will expire on July 4, 2017**.

Any changes to the protocol and/or informed consent form should be reported to the Human Ethics Coordinator in advance of implementation of such changes.

Please note:

- **If you have funds pending human ethics approval, please mail/e-mail/fax (261-0325) a copy of this Approval (identifying the related UM Project Number) to the Research Grants Officer in ORS in order to initiate fund setup. (How to find your UM Project Number: http://umanitoba.ca/research/ors/mrt-faq.html#pr0)**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The University of Manitoba may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

Appendix C.

Letter of Recruitment

UNIVERSITY OF MANITOBA

May 30th, 2016

Hello,

I am a student at the University of Nigeria, Faculty of Social Work. I am assisting the principal research (Declan Amadi - a student at the University of Manitoba, Faculty of Social Work) to conducting a study on "Resilience in African Female Refugees/IDPs living with Mental Health issues". He is interested in knowing your resilience strategies and mechanisms that you use to cope with your mental health and psychological issues. Your answers will enable him to understand in detail what you think and feel about living with mental health issues as a refugee and possible ways to foster recovery based on your unique resilience mechanism. As he will be recruiting refugees/internally displaced persons, which you are one of them; I thought you are the best person to talk on issues of resilience among African female refugees.

I have here with me copies of his recruitment letter and consent form which contain the details of the study. These forms also contain the principal researcher's detailed information and contact. I will leave these forms with you today and after going through them you can contact the researcher if you so wish to participate in the study.

Thank you.

Name of the mediator, Name of agency or University

Signature:

Email: Phone number:

Appendix D.

Consent Form

UNIVERSITY OF MANITOBA

May 30th, 2016

Research Project Title: Resilience in African Female Refugees and internally displaced persons living with Mental Health issues.

Researcher: Declan Amadi, Student, Faculty of Social Work (amadid@myumanitoba.ca).

Other Contacts: Thesis Advisor: (Dr. Sid Frankel: (204) 474-9706; Sid.Frankel@umanitoba.ca) and host supervisor Dr. Uzoma Okoye.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the interview is about and what your participation will involve. If you would like more details about something mentioned here or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the research:

The purpose of this research is to understand how female refugees and IDPs of African origin cope with their mental health conditions and are able to stay strong despite their tough migration experiences. My main focus is to explore those strategies which strengthen their perseverance and facilitate their rehabilitation in the midst of their mental health issues and difficult migration experiences. You have been chosen to participate in this study because you are a refugee/internally

displaced person and you meet the eligibility criteria. I am conducting this study to complete my master's thesis and I might also use some or entire data to write an article.

Research Procedures and Recording:

This will be a one on one interview that will last for about one hour and it is taking place in a mutually convenient location. The interview will be recorded with an audio digital device and will later be transcribed verbatim by myself and the research assistant. I am the principal researcher and I have a PhD student who is assisting me to collect data. After the interview, I will send you the transcripts for your review either by email or hand delivery. You will have one week to go over it, at which time you may change, amend or recant anything you have said if you so wish. This should take you at least forty-five minutes.

Risks and Benefits:

So far, I anticipate no risk to only minimal risk that the interview questions might pose to participants. But should there be any psychological/emotional break-down of participant during the interview resulting from recounting a sad experience, I will make available to you, the contact telephone number for the agency's psychiatrist for free counselling should you have any need to do so. I will also give you the contact number for the refugee workers who offer free provisional counseling, some of who you may already know. You can also contact any of your preferred counselors (such as your pastor, priest or Imam) should you have the need to talk to someone as a result of this interview. There are lots of discussions about mental health and psychological issues among refugee/IDP women. This interview will be an opportunity for refugees/IDPs like you to talk about your experiences on the issue.

Anonymity or Confidentiality:

Qualitative data will be collected from participants via oral face-to-face interview. The interview (raw data) will be recorded with a digital audio device. I will store raw data in a password enabled digital device and lock it inside the Host professor's school office drawer at Nsukka, Enugu State Nigeria. Raw data will be transcribed verbatim after interview and transcribed data will be stored on "one drive" - a cloud-based storage system that is password protected. I will also do back-up storage on my password protected personal laptop and the transcript will be encrypted with encryption software on my computer. The host supervisor, the research assistant and I are the only people who will have access to the raw data. Transcribed data will be anonymous and contain no personal identifiers that might pose risk of identification to participants. All identifying characteristics will be replaced with pseudonyms. The thesis advisor and thesis committee will have access to anonymized data. All data will be erased approximately Dec. 2017.

Compensation: No compensation will be given to participants; however, food items will be bought for the agency to be cooked for all the refugees/IDPs. The participants will not know that I bought food items for them.

Interview Feedback/Debriefing:

Feedback and debriefing will occur at the end of the interview and clarifications will be made. This will ensure that you are still willingly to give out the information and should you wish to change anything you said; I will delete such at your request. I will also send you the transcripts by your choice of email or hand delivery to have you confirm your answers/comments. I will give you two weeks to review and send it back to me through email or hand delivery/pick up**.** Upon completion of the study, you will receive a summary of the results and you can indicate at the bottom of the form your preference for receiving the summary.

Dissemination:

Some portions of the initial findings may be discussed with the thesis advisor and thesis committee. The thesis advisor and thesis committee will have access to anonymized data. Host supervisor and her research assistant will have access to both raw and anonymized data. I will use some or entire data for my master's thesis; and some or entire transcript may be used to write an article. Summaries of research result will be provided to you at the end of the research if you will like a copy.

Destruction of the Data

All data (both transcribed and raw) will be erased approximately December 2017. Electronic data will be deleted from the computer and cloud-based storage system. Hard copies will be carefully shredded.

Your signature on this form indicates that you have understood to your satisfaction the information regarding this interview and you agree to willingly participate. In no way does this waive your legal rights nor release the researcher or involved institution from their legal and professional responsibilities. Your participation is voluntary, and you are free to withdraw from the study at any time, and/or refrain from answering any interview question you wish to omit, without prejudice or consequence. You may leave the interview session or withdraw from the study completely at any time. Should you decide to do so; simply get in touch with me at the contact information provided below and all information you provided will be completely erased without prejudice. Your continued participation should be as informed as your initial consent; so feel free to ask for clarifications to any question.

Declan Amadi, amadid@myumanitoba.ca.

This interview has been approved by Psychology and Sociology Research Ethics Board (PSREB). If you have any questions or concerns about this interview, you may contact the above-named person or Pinar Eskicioglu, Coordinator - Human Ethics Phone: (204) 474-7122; e-mail

Pinar.Eskicioglu@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference. The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

Participant's Signature ……... Date …….

Researcher's Signature ……. Date …….

- I wish to receive this summary by regular mail. My address is:
- I wish to receive this summary by e-mail. My address is:
- I do not wish to receive a summary.

Appendix E.

Permission emails

RE: Copyright permission

Declan Amadi <amadid@myumanitoba.ca>
Mon 10/19/2020 8:37 AM
To: Caressa Kok <caressa.kok@idmc.ch>
Thank you so much. I sure will acknowledge IDMC.

Sent from my Samsung Galaxy smartphone.

-------- Original message --------
From: Caressa Kok <caressa.kok@idmc.ch>
Date: 2020-10-19 3:16 a.m. (GMT-06:00)
To: Declan Amadi <amadid@myumanitoba.ca>
Subject: RE: Copyright permission

Dear Declan,

Thank you for your email. I hereby confirm you can use our figures.
Find more information in our terms of use document. Please make sure the content is accompanied by an acknowledgement that IDMC is the source.

Warm regards,
Caressa

From: Declan Amadi <amadid@myumanitoba.ca>
Sent: Monday, October 19, 2020 5:02 AM
To: CH IDMC Info <info@idmc.ch>
Subject: Copyright permission

Hello,

I am a master's student at the university of Manitoba Canada, and I would like to ask for the permission to use some of your IDP demographic figures and tables gotten form your website. The university requires that I seek copyright permission from you. I am wondering if you can grant the permission to use those figures in my thesis.

The link to the figures is:
https://www.internal-displacement.org/sites/default/files/publications/documents/201912-Africa-report.pdf

Thanks, in anticipation.
Declan Amadi

AFRICA REPORT ON INTERNAL DISPLACEMENT

7 FOREWORD Although forced displacement is a global phenom-enon, it is more pronounced in Africa. Africa hosts over one-third of the global forced displacement population.

www.internal-displacement.org

RE: Copyright permission

From: Declan Amadi <amadid@myumanitoba.ca>
Sent: September 14, 2020 10:47 PM
To: Gisele Nyembwe <nyembwe@unhcr.org>
Subject: Re: Copyright permission

Hi Gisele,

Thanks for your email. I will certainly give credit to the UNHCR for the use.

Sincerely
Declan.

From: Gisele Nyembwe <nyembwe@unhcr.org>
Sent: Monday, September 14, 2020 8:08 AM
To: Ottawa Canada <canot@unhcr.org>; Declan Amadi <amadid@myumanitoba.ca>
Subject: RE: Copyright permission

Dear Declan,
Unfortunately, this is not something UNHCR will usually provide for resources that have been posted on our public website. I suggest you use the link to the resource as your source, and give proper credit to UNHCR for its use.
Thank you,

Gisele

Gisèle Nyembwe
Public Information/Service de l'information du public
Tel/Tél: 613-232-0909 ext./poste 225 - Mobile: 613-986-4300
Email/Courriel: nyembwe@unhcr.org
Suite 401, 280 rue Albert Street, Ottawa ON K1P 5G8
United Nations High Commissioner for Refugees (UNHCR)
www.unhcr.ca
www.unhcr.ca/fr

From: Declan Amadi <amadid@myumanitoba.ca>
Sent: September 10, 2020 2:45 PM
To: Ottawa Canada <canot@unhcr.org>
Subject: Copyright permission

Hello,

I am writing a thesis and I cited some figures of refugee movement from your website. However, the university wants me to get copyright permission from UNHCR.

I am wondering if you can direct me on who to contact for the permission to use the information on your website.

Thanks,
Declan
2047971000

Sent from my Samsung Galaxy smartphone