Refugee women survivors of war related sexualised violence: a multicultural framework for service provision in resettlement countries

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This paper explores the question of redressing war related sexualised violence, often referred to as war rape, with refugee women in resettlement contexts using a Canadian case example. The first part of the paper uses theory and research to frame sexualised violence as a tool of war whose practice and impact are shaped by gender and cultural factors. This section highlights how, for survivors, the combination of psychological trauma and socio-cultural factors in post migration environments can create barriers for seeking help, social support, as well as vulnerability to further victimisation and mental health difficulties. The second section provides a case example of a community based mental health initiative in Canada for survivors of war related sexualised violence. The case explores the use of a psychosocial framework that integrates cultural competency, gender perspectives, and community advocacy. Challenges and opportunities of service provision in resettlement contexts are discussed, and recommendations are provided for multicultural mental health practice that is collaborative, community oriented, and sensitive to trauma survivors' needs.

Keywords: Canada, refugee women, service provision, sexualised violence, war rape

Sexualised violence as a tool of war: gender and cultural perspectives

In the 1949 Fourth Geneva Convention, rape in the context of war was categorised as a violation of human rights and a crime of war. However, it was not until the late 1990 s at the International Criminal Tribunal for Former Yugoslavia (ICTY) in The Hague that rape was first prosecuted as a crime against humanity (Askin, 1997). In other words, the mass rape of Bosnian women in former Yugoslavia brought this age old issue to the public arena and set the stage for future tribunals, such as Rwanda where rape was designated an instrument of genocide. These testimonies from (around) 1945 to the present provide an increased understanding of how rape is used as a tool of war to demoralise entire communities of people through acts of violence against civilians. Although rape occurs in almost every society, rape occurring within the context of a war has distinct features, and therefore implications, for interventions aimed at preventing, protecting, and supporting the healing of survivors.

Historically, when an area was defeated in war, its wealth, livestock, and women were taken and used to rejuvenate the conquering society. Modern wars are not only targeted at achieving a military victory, they can be seen as an attempt to destroy the opponent's culture as well (Schiessl, 2002). McDougall (1998) defines war rape as *'a deliberate and strategic decision on the part of combatants to intimidate and destroy the enemy as a whole by raping and enslaving women who are identified as members of the opposition group.*' A broader definition of

war rape that captures recorded acts of sexualised violence in war include: sexual harassment, rape, witnessing rape, attempted rape, gang rape, sexual mutilation, sexual humiliation, forced prostitution, forced pregnancy, forced sex among prisoners and relatives, forced sex in public, forcing people to strip naked in public, and injuries to sex organs (Vlachova & Biason, 2005). Currently, these may all qualify as crimes under national and international law. For the purposes of this paper, the terms war rape and sexualised violence are used to encompass a broader definition of rape, and to emphasise the issue as a sexualised form of *violence* (Seifert, cited in Joachim, 2004). While the focus of this paper is on sexualised violence against women, it is understood that during conflict men and young boys can also be victims. This paper focuses on a gender-based act against women where the greater likelihood of being sexually violated, especially during war and conflict, is associated with being female.

The effects of war rape are shaped by the social and cultural context where it occurs. Gender analysis helps us understand that rape has roots in the societal male/female power imbalance (MacKinnon, 2006; Sanday, 2007) whereby rape becomes the expression of domination, oppression, and inequality towards women. Rape during war is not a random act. These acts are conditioned by local historical grievances that can include ethnic, religious, economic, and social conflicts that give rise to violent hatred. Seifert (cited in Joachim, 2004) states that *rape must not be confused as an aggressive expression of sexuality, but rather it is a sexual expression of aggression.* Conquering the enemy with the use of rape becomes an expression of complete abolition of all power, a symbolic revenge, and blatant propaganda where *'the body of a raped women becomes a ceremonial battlefield, a parade ground for the victor's trooping of the colours'* (Brownmiller, 1975).

In addition to the act of rape, culture also influences the way survivors and communities make meaning and respond to war rape and other traumatic experiences. For example, in societies that highly value sexual purity, a woman who has been sexually assaulted may be at risk of being stigmatised by her community, and sometimes rejected by family members. Experiencing rape in such communities renders a raped woman unsuitable for marriage or motherhood (Fisher, 1996). Interviews with Rwandan women illustrate this when they reported personal humiliation and loss of identity, as well as loss of hope about the future due to not being virgins any more and therefore lacking suitability for marriage (Mukamana & Brysiewicz, 2008).

Likewise, in societies where discussions relating to sexuality are confined to specific individuals and contexts, disclosures regarding sexual violation also mean breaking social taboos. Cultural attitudes, then, can inhibit survivors from disclosing experiences of war rape for fear of losing respect and experiencing further rejection, isolation, or humiliation from their families and communities. Silence in this context is a form of survival, a means of self-protection in the face of potential retraumatisation and further losses. If the silence is broken, such as through disclosure or carrying a child of rape, a woman can be at risk of losing her bond to her current husband or potential suitor, family, community, and society. In this way, rape pulls apart families and communities in psychological, physical, and social ways.

Therefore when understood from a cultural and gender perspective, sexualised violence during war is a means to demoralise whole

communities through acts of violence (mostly against women). It occurs because the distinction between killing and other forms of violence gets easily lost during wartime. At times, rape is not a random sexual act by individual soldiers, but rather a deliberate military tool to tear apart individuals, families, and communities. A gender perspective sheds light on the symbolic violation of female bodies in the context of war, whereas, a cultural perspective highlights the variety of ways in which communities attach meaning to the experience and the consequences of sexual violation. The authors suggest that, in addition to recognising the impact of trauma and real safety concerns, these are important considerations in order to understand the implications for the healing of individuals and communities affected by war rape.

Psychosocial impact on individuals and communities

Despite the current presence of international laws, a legal framework, and international practice guidelines (Inter-Agency Standing Committee, 2005) for protection of civilians during war, sexualised violence continues to occur in areas of conflict, is manifested in numerous forms, and few interventions have prevented sexual violence from taking place. From a psychosocial perspective, protection is built on legal matters and policing to include long-term protection and trauma recovery for those who have survived such atrocities – in post conflict and resettlement contexts.

Individual physical and psychological impact

Rape is identified by mental health professionals as the most intrusive of traumatic events. It can result in a range of physical and psychological effects that are complex and complicated by the psychobiology of trauma reactions combined with the victim's cultural and social context[1]. In discussing their work with survivors of war rape from Cambodia, Mollica & Son (1989) note that women experience not only a loss of control over their body, but also a loss of control in all areas of their lives because the violation results in a shattering of beliefs regarding invulnerability, personal safety, and a fair social world. Physical effects, if women survive, may occur to areas of attack that can include rectal and vaginal tearing, bruising, and bleeding, throat agitation, and broken bones, (Tompkins, 1995). Secondary injuries can include unwanted pregnancy, gynaecological illnesses, psychosomatic disorders, contraction of sexually transmitted diseases (e.g., HIV), and disturbances in hormonal systems, and reproductive health (Joachim, 2004; Vlachova & Biasion, 2005). Any of these changes are traumatic, cause long lasting health problems, and many women die from injuries, unsafe self-induced abortions, maternal mortality, and suicide (United Nations High Commissioner for Refugees, 2003).

Psychological effects of sexualised violence in war are complex and difficult to outline given that few women survivors disclose their experiences (Hagen & Yohani, in press). Information is often obtained from individuals working with survivors in the context of psychosocial and medical treatment. Nevertheless, experts generally agree that psychological effects need to be understood from a well informed understanding of trauma and survivors' personal understanding of their experience. Psychologically, women may experience generalised anxiety, phobias, insomnia, flashbacks, nightmares, grief, and depression (Joachim, 2004). Women may also show a lack of interest in their environment, complete loss of self-esteem, deep helplessness, and despair. Self-loathing and rejection of one's body

often results in self-injurious behaviour and suicidal tendencies. A survivor may consider herself dirty or a morally inferior person, further contributing to her self hatred (Diken & Lausten, 2005). Symptoms characteristic of posttraumatic stress disorder (PTSD) may also occur as a result of war rape, although practitioners need to recognise that the criteria for this diagnosis does not fully capture experiences of individuals from nonwestern cultures (Summerfield, 1999). Common psychological defences in traumatic rape include: denial, suppression, depersonalisation, distancing, and dissociation (Vlachova & Biason, 2005). As Pappas (2003) explains, wartime rape can turn its victims into '*dissociative containers*' who disconnect from humanity and the external world. Yet, once again, the connection between women's psychological health and rape often remains hidden. If women seek interventions, they are more likely to report physical rather than psychological symptoms, while others suffer in silence and risk serious health consequences (Joachim, 2004). It should be noted that survivors' psychological coping strategies, such as distancing, silence, and denial, must be understood in relation to their life contexts. In environments with continuous threats to safety, such coping mechanisms are adaptive survival strategies rather than psychological disorders (Silove, 2006).

Community impact A woman's physical and psychological trauma can be exacerbated by her relationship with her community. The shame, dishonour, and humiliation she feels, can be reinforced by a society that rejects her, thereby increasing psychological harm and bringing about a multitude of individual losses such as loss of identity, sexual virtue, dignity, and self-esteem (Mukamana & Brysiewicz, 2009; Vlachova & Biason, 2005). Herman (1997), who has worked with survivors of sexualised and political violence, aptly captures the complexity of these violations by noting that trauma causes a disconnection within the individual and in relation to others, a sense of disempowerment, and feeling of lack of control over one's life.

It should be considered that trauma and loss as a result of war rape occurs in the context of larger complex emergencies that include the destruction of political, economic, sociocultural, and healthcare infrastructures (Toole & Waldman, 1997). Women and their families often experience the breakup of community as a result of forced migration and displacement into refugee camps, or in countries where education, work, and recovery opportunities are limited. In post conflict environments, women's distrust can be reinforced by experiencing continued violence in refugee camps and domestic settings (Raj & Silverman, 2002; Vlachova & Biason, 2005). The inability of traumatised populations to be economically self-sufficient also has a major impact on psychological wellbeing (Steel et al., 2002). For women, the burden of bearing the trauma of war rape can be embedded and lost in the resulting poverty due to the collective losses experienced by community. Entering into a life of extreme poverty and dependency, women are at risk of further victimisation and are often forced into other forms of sexual exploitation, including participation in the sex trade (Rojnik et al., 1995). As Olweean (2003) explains, '*the cycle of violence contributes to the cycle of trauma*', which in turn, contributes to further cycles of poverty. In other words, women's entire lives are disrupted by chronic insecurity and continued victimisation causing a '*sense of no longer feeling at home in this world, no longer belonging to it*' (Joachim, 2004).

In the first author's clinical community practice, women with histories of war related,

sexualised violence, experience significant difficulty managing language training, employment, and parenting as a result of trauma related symptoms such as sleep difficulties, anxiety, sadness, and social withdrawal. These prevent successful integration that makes the women vulnerable to poverty. Aware of the above, these women's difficulties further contribute to feelings of hopelessness and powerlessness in resettlement countries. Thus, the individual and collective consequences of war rape often become entwined with the broad consequences of war that include cycles of poverty. In this context, the specific sociocultural issues that give rise to rape as a tool of war become lost in post conflict recovery and resettlement activities.

Post migration contexts: barriers for accessing and providing services

The cumulative effects of war rape in the context of other displacement experiences can follow a community of refugees into the country of resettlement, further complicating the resettlement process for survivors. That is, victimised refugees suffer severe distress from their trauma histories, multiple losses, and forced relocation, and these traumas and losses are carried into, and disrupt functioning within, a new culture (Steel et al., 2002). In fact, studies of refugees living in Western resettlement countries suggest they experience higher rates of trauma related psychological disorders than individuals from host countries (Fazel et al., 2005). Survivors of war related sexualised violence are one subgroup who are at high risk of developing mental health complications due to their pre migration experiences and limited psychosocial supports within resettlement contexts.

Despite being a resource rich country, most Canadian cities lack the services to address the specific needs of survivors of war related violence and torture. This includes a limited multilingual, culturally appropriate mental health service, and few service providers with an understanding of refugee mental health and trauma. Further, social support in a post migration context is identified as an important determinant of the severity of PTSD and depression in refugees (Lie, 2002). Without appropriate social supports and interventions, women refugees who have experienced sexualised violation may continue to cope with traumatic memories through defences such as repression, dissociation, and somatisation (Pappas, 2003; Weine et al., 1998). That is, adaptive coping strategies may develop into maladaptive behaviours in the aftermath of real danger.

Research on sexual violence and refugees and immigrants in resettlement countries is sparse, and often embedded in literature on intimate partner violence (IPV) (Yohani, 2008). While there is a need for more research to understand the particular experiences of refugee survivors of war related violence, a review of barriers faced by immigrant women in domestic violence situations (Raj & Silverman, 2002) shows a number of areas that overlap with the authors' observations in clinical and community practice. These barriers include: fear of jeopardising immigration status, language barriers, lack of awareness of services and legal rights, distrust of mainstream social institutions, and cultural meanings, roles and beliefs. These factors are discussed in further detail below.

Immigration and settlement Individuals who have not disclosed experiences of pre migration sexual violation may lack adequate information regarding the immigration system. They fear that disclosing or reporting experiences of sexual violation may jeopardise, or bring attention to, their

immigration status if they are illegal immigrants, or are in the process of applying for citizenship. In the context of family violence, threats of deportation are often used to intimidate and control victims (Bui & Morash, 1999). Survivors of war rape who are also in situations of domestic violence may already be under pressure to protect themselves from ongoing violence or perceived deportation. In both situations, survivors are willing to live without seeking supports, as they are terrified of increased threats to safety, such as being sent back to their countries of origin.

Language barriers Barriers relating to language include lack of definitions or variations of what constitutes sexual violence in different countries, and limited language specific services. For survivors who come from countries where sexual assault is defined very narrowly and not considered a crime, accessing services may not be a consideration. The experience of victimisation is highly emotional, and silencing for most individuals. Lack of language specific services makes it difficult for survivors to: (a) explain what happened to them in a second or third language (b) trust revealing their story in front of an interpreter from the same cultural background, and (c) understand minor differences in dialect between interpreting services. This is particularly challenging when therapeutic healing with survivors involves a reconstruction of trauma narratives (Neuner et al., 2004; van Dijk, Schoutrop & Spinhoven, 2003). While most mental health workers use interpreters, a survivor's discomfort could impede therapeutic progress. Also, using an interpreter unfamiliar with war rape has the potential to weaken the therapeutic relationship.

Lack of awareness of services and legal rights Refugee women often lack information regarding the reporting process for crimes that occur within and outside of Canada. They may also come from countries where laws regarding gender based violence differ, or do not exist (Tran & Des Jardins, 2001). Survivors may feel that the opportunity to receive justice is limited, or fear the ramifications of breaking their silence. They may inadvertently fear the risk of being deported, or involvement with the justice system may impact immigration processes. Additionally, a lack of general information regarding sexual assault, its impact, and how to heal will be compromised in some communities where the issue is hidden. While survivors are often aware of their symptoms, they may not understand that their experience is typical for individuals who have undergone similar traumas. As such, they can miss an opportunity to have their experience validated and normalised, which can help to reduce the sense of isolation.

Distrust of mainstream social and legal institutions Survivors may have had negative experiences with legal institutions in their countries of origin and resettlement and are often afraid of being retraumatised in the process of reporting and seeking services. For example, the first author has worked with women who disclosed their experiences to officials in counties of origin, but no justice was obtained. Similarly, those who have experiences of racism in settlement countries may fear being stereotyped if they disclose their experiences. Fears of being misunderstood, combined with mistrust, also prevent individuals from disclosing experiences of personal violation to service providers such as medical personnel (Berman, Girón & Marroquín, 2006). Cultural differences within justice systems, including the role of police, judges, community and family, need to be considered for survivors. For example, families are often confused by the

individualised attention given to a survivor of assault, rather than the whole family, or at least the eldest family member. Often sexual violation is a matter of family honour and therefore justice needs to address these culturally relevant issues.

Cultural meanings, roles and beliefs It is important to understand cultural definitions and interpretations of assault. Traditional roles may serve to normalise certain practices that are harmful (Bui & Morash, 1999). For example, women assuming positions of subservience in relationships may not question sexual assault. In this context, survivors can be blamed for speaking up, or turn the blame on themselves, for not acting appropriately. Cultural and religious values of sexual purity and fidelity of women can make it hard for survivors to accept what has happened and disclose their experience to others. The way in which some individuals interpret the effects of their assault can be further isolating. For example, the first author of this paper worked with a Middle Eastern woman who viewed her trauma symptoms not as a result of rape but as evidence of spirit possession. She withdrew from her community due to her perception that she may be a danger to others.

Building gender and culture into mental health services: a Canadian case study

Given the role of gender and cultural factors in the occurrence and aftermath of war related, sexualised violence, effective mental health services could include the integration of these factors in treatment. The following section explores the usefulness of using a multicultural framework that is sensitive to both cultural and gender dimensions in the lives of refugee women. The main component of this approach is a recognition that culture influences help-seeking behaviour and how distress is expressed in mental health services (Sue & Sue, 2008). Building principles of multicultural competence into mental health services should be collaborative and responsive in order to empower individuals who have experienced massive human rights violations and deeply humiliating experiences. This does not preclude attending to the effects of trauma and threats to safety experienced by survivors. Instead, it involves an additional recognition that the structures and processes of mainstream or western mental health service may be antagonistic to the values held by some culturally diverse clients and can, unintentionally, be viewed as unsafe and humiliating for some.

The following section presents a case example of an organisation's experience with developing a programme for survivors of war-related sexualised violence. This programme was based on the previously discussed principles of multicultural service provision. The case describes successes and challenges over a four-year period, while also highlighting how multicultural principles are integrated to take a more responsive and active helping approach. This includes adapting traditional approaches to service provision through outreach in homes, and in the community. As well as orienting programme activities towards prevention of further victimisation rather than just remediation through public education, and collaboration with other agencies engaged in similar work.

Project background and description The War Rape Initiative was developed by a nonprofit agency offering education, advocacy and services for survivors of sexual assault in a mid-western Canadian city. The programme was initiated after a number of ethno cultural community members and agencies began contacting the organisation with concerns over how to address war related rape

issues due to an increasing number of refugees coming forward with disclosures of sexualised violence, torture, and complex trauma. A working group was formed by the agency to address these community concerns. The working group provided a forum for organisations and individuals to learn about sexualised violence in the context of war, and raise awareness about this form of violence and its potential impact on survivors. It was composed of individuals from 10 refugee and immigrant serving agencies.

The War Rape Initiative was subsequently developed to provide a multifaceted programme with two different components: a counselling programme and an outreach/public education programme. The counselling programme provides services to adults and adolescent survivors and their families, as well as consultations to service providers in order to facilitate support systems. The outreach and public education component provides resources and information to communities, family members, and front line professionals such as settlement, healthcare, and social workers. The working group acted as an advisory committee for the project activities and a liaison between member agencies and the programme staff.

Project goals and activities A lack of safety is a significant barrier for war rape survivors. Survivors, especially in communities that value sexual purity, are not often willing to disclose their experiences due to fear of being shunned, ostracised, or driven out of their communities. Survivors require an environment that feels safe and contains adequate social support systems. Therefore, a key component to successful programme development was to foster relationships with ethno cultural community members, agencies serving refugee populations, cultural brokers, and other community workers. Through partnerships, an increased awareness of war rape issues was aimed at empowering front line workers and other community members to become more involved in identifying and responding to emerging community challenges. Most importantly, it was hoped that over time, this level of community engagement could foster an environment where survivors felt safe to access supports as needed. The following section offers a list of successes and then provides a more detailed discussion of the challenges and lessons learned from this programme.

Successes and opportunities

- Reaching women through women's groups, home visits, and neutral locations
- Growing support from ethno cultural communities
- Referrals from medical doctors, settlement workers, mental health workers, religious leaders, and English language teachers
- Collaboration with other frontline professionals
- Collaboration with other organisations responding to related issues such as human trafficking, reproductive health, and primary health care

Challenges and lessons learned

- Open dialogue regarding sexualised violence
- Cultural tensions and growth for a mainstream agency
- Adapting evidence based mental health approaches
- Balancing discreet work with survivors and the need for public education

Open dialogue regarding sexualised violence In the initial stages of the programme, focus groups were conducted with frontline workers from different agencies consisting

of social workers, public health nurses, and settlement workers. During these discussions, it became clear that the links between sexual violation, mental health, and impact on daily living needed to be identified. However, while immigrant serving agencies acknowledged the topic, there was much hesitation about initiating an open dialogue regarding this sensitive issue. Responses ranged from '*this is not a major issue in our agency/community*' to '*this will upset our clients and staff who are refugees*.' Agencies preferred brief presentations in the context of other topics, or presentations at conferences/workshops rather than provide in house training. This is understandable as discussions around sexual violence often touch on cultural taboos regarding issues related to sexuality (i.e. whom, when and under what circumstances sexuality is discussed).

The programme attempted to address these concerns by presenting the issue in the context of human rights, rather than with a strict focus on mental health. Interestingly, this approach was well received by community groups and agencies. It was perceived to be less invasive and yet of universal concern, resulting in more openness to learning about the issue. Programme staff was contacted frequently to train on general mental health, trauma, parenting, and cultural competence. Rather than maintain a specialty area of presentation, staff responded by integrating concerns relating to sexual violence with other mental health issues. By being responsive to the needs of communities, a relationship was built and mental health staff became more approachable to individuals who were accessing support.

Cultural tensions and growth for a mainstream agency The majority of the groundwork in building the programme was to initiate contacts with individuals, communities, and agencies regarding the issue of war rape, and assess the availability of services within the city. Being viewed as a trustworthy organisation was especially important for refugee communities that have undergone traumatic experiences and can be wary of any initiative. In some Canadian cities, refugees and immigrants who are most comfortable receiving services from known immigrant serving organisations that have established histories with ethno cultural communities regard mainstream agencies with some suspicion. Similarly, clients were wary of the new initiative and did not always feel comfortable going to the programme's office. Consequently, staff met clients in their homes, or at an immigrant serving agency where space was obtained to work. While home visits proved to be an effective means of reaching out to survivors who were isolated, or who were concerned about discretion, professional liability concerns resulted in the discontinuation of this form of outreach.

The names, 'War Rape Initiative' and 'Sexual Assault', also proved to be problematic. One cannot underestimate the power of language and cross-cultural implications. Some people admitted that they thought that the agencies' focus on '*sexual assault*' meant it was a place where people '*go for assault*'. While this interpretation may seem unusual for Canadian-born individuals, this may not be implausible for some refugees coming from countries where such atrocities take place. In attempts to address these concerns, the War Rape Initiative's name was changed to the *War Violence Initiative* in order to reach out to those whom the word '*rape*' may have created cultural discomfort. Forms of public education regarding gender based violence also needed to be shifted towards a more culturally sensitive dialogue. For example, Western dialogue around sexual violence typically involves forms that

promote '*speaking up*' and '*naming*' the issue. Consultations with community workers, however, suggested that this approach would not be well received in some ethno cultural communities. Staff learned from survivors and communities that the initiative required as much cultural brokering and negotiating within the organisation, as it did outside of the agency. Developing individual and organisational cultural competence is an ongoing process of reflection, negotiation, and responsiveness. This issue is especially prominent in the case of providing collaborative and responsive services to refugee survivors of sexualised violence.

Adapting evidence based mental health services Cultural responsiveness involved working with women to integrate other forms of informal support deemed important by clients, such as referral to religious leaders for spiritual guidance or help with identifying trustworthy community members. In addition, one experience with a group taught us the importance of following women's lead to identify appropriate intervention approaches. As part of the initiative, the first author was invited to facilitate a mixed cultural psychosocial group for refugee women living in subsidised and supported housing. During the first year, the group followed a cultural adaptation of more traditional formats for psychotherapy in order to address depression reported by the women. However, in the second year, the first author decided to ask the women to direct the goals and activities of the group. The group of women (who were from countries ranging from Iraq, Somalia and Columbia) unanimously wanted to '*just relax*' and not '*talk*', and stated they wanted to engage in a variety of activities that helped them to relax. As such, the first author facilitated a variety of activities focusing on teaching and practicing emotional and behavioural self-regulation (e.g., relaxation exercises such as progressive muscle relaxation) and expressive arts based activities such as photography. After a few months, the women in the group began to spontaneously bring in music from their various cultural backgrounds for sharing. Music, as a means of connection, was incorporated into the group whereby women would talk about the personal and cultural meaning of music and dance to (and with) the group members. The group became an opportunity for women to be witnessed and witness each other in a manner that was self-directed and culturally meaningful. Over time, the women began talking about their personal experiences of trauma in an atmosphere that was safe and supportive. For example, in April, a woman from Rwanda asked the group to perform a remembrance ceremony for women in her family and country who had died in the 1994 genocide. This experience highlights the importance of facilitating safety both at a psychobiological and social level. By encouraging women to direct the group, they were able to show that expressive arts and body based approaches can be used to build connections and safety within women's trauma groups.

Balancing discretion with survivors with the need for public education As discussed earlier, survivors of sexualised violence do not often disclose their experiences due to fear of being retraumatised, ostracised, or driven out of their communities. Disclosing information in resettlement countries puts them further at risk of losing the little support system they may have. For this reason, therapeutic work requires enormous discretion. Often survivors preferred to be consulted in their homes or at a refugee serving agency where the purpose of their appointment was not obvious. For example, one Sudanese woman asked

to be seen at home after she saw a male Sudanese settlement counsellor at the refugee serving agency. This need for discretion is juxtaposed against the need for education and awareness incorporated into the programme. For instance, staff of the initiative was asked to provide media interviews regarding the activities of the programme and the working group. Ironically, by educating the public, staff could unintentionally unhinge the safety that is required to offer therapeutic services. Ongoing reflection and consultation with the working group members was of value in balancing cultural sensitivity, discretion for survivors and communities, and advocacy through awareness rising.

Toward a model of collaborative practice

Our observations from working with survivors of sexual violence suggest that an approach to mental health practice that is collaborative and responsive to women's multiple and emerging needs shows potential within the Canadian context. Working within a multicultural framework with women who are from various ethno cultural backgrounds, yet with similar experiences of personal violation, requires a stance that allows women to begin to rebuild hope, regain control of their lives, and reconnect to themselves and others (Herman, 1997). From a multicultural mental health perspective, this means working in a collaborative manner that allows women to have a voice in the direction of their own therapeutic work, while at the same time actively providing safety, structure, and facilitating access to other support and services. Focus also needs to be expanded from individual survivors towards addressing the issue of sexualised violence at a community level. Based on the emerging experiences of working with survivors of sexualised violence in Canada, the authors suggest a multicultural framework that is sensitive to issues in trauma treatment and includes particular attention to cultural competence, working with communities, while giving attention to service providers.

Cultural competence In providing mental health services to survivors of war related sexualised violence; the authors have worked alongside cultural brokers who provide linguistic and cultural interpretations in the context of therapeutic services (Jezewski, 1993). Cultural brokers offer more than translation services by providing insight into cultural issues that may influence a client's healing. For example, when the first author asked a client about her cultural understanding of her frequent nightmares relating to a dead brother, the client discerned that the brother (who was killed trying to protect her from rapists) wanted a proper burial. With the assistance of the broker, the author was able to work with the client to plan a symbolic burial for her brother in Canada. Collaboration with a cultural broker was often successful because individuals who they knew personally, and at times were already acting as cultural brokers either in health or settlement services referred women. A collaborative approach means the client, cultural broker, and mental health practitioner form a working alliance whereby they are addressing the concerns raised by the client. This may be related directly to the experiences of sexual violation such as management of symptoms of PTSD, or indirectly by addressing concerns with parenting or school difficulties. At times staff and cultural brokers worked with clients to access community support for families whose children were engaged in gang activities, safe housing to ensure protection from further violation, or referral to a community elder for support. Ongoing consultation with

clients regarding their comfort with the direction of service and the flexibility to respond to the client's suggestions is paramount, and at times this may mean changing the cultural broker, the location of meetings, or approach to treatment.

Working with communities Traumatised populations often find it difficult to become economically self-sufficient (Steel et al., 2002). This difficulty is often a component of the refugee experience in receiving countries such as Canada. War related sexualised violence is aimed at entire communities and, ideally, healing should also be a collective process. While psychosocial and mental health issues are often addressed at the individual and family level, the programme identified a need for interventions at the community level. There is also a need for advocacy and justice work to raise awareness regarding sexualised violence and its consequences in order to prevent further victimisation and increase access to health care. As noted in the case study, this is a slow process that requires much reflection and tact in order to avoid creating further disconnection within communities, or stigmatise a community within the larger population. Models that integrate mental health supports within a context that is less intrusive, collaborative, and responsive to community needs show promise for awareness rising.

Attention to service providers According to the American Psychological Association (Sue & Sue, 2008), multicultural competency in mental health requires practitioners to have knowledge of their own cultural background and biases, an awareness of the cultural context of their client, and skills to address the issues presented by clients in a culturally sensitive manner. This practice requires deep, honest and ongoing reflection. Given the challenging nature of work with survivors of sexualised violence, and the high risk of vicarious traumatisation (Pearlman & Saakvitne, 1995) staff of the initiative engaged in reflexive praxis to identify their experiences and beliefs that were being triggered by working with survivors. The working group also acted at times as a support by providing the space to reflect on programme practice issues, particularly as they relate to cultural differences. Through the working group, awareness regarding war related sexual violence in various regions of the world was developed by members, research and presentations on cases. Likewise, the working group was privileged and humbled to have a survivor come to speak about her personal experience, thus providing insight into the issue from a phenomenological perspective. Finally, working with survivors of war related sexualised violence requires skills stemming from a number of areas including war related trauma, sexual abuse trauma, multicultural counselling, race and gender issues, global mental health, and skills in advocacy and collaborative practice. In addition to close attention to self-care, service providers require training and ongoing professional development in the aforementioned areas.

Concluding remarks

Despite increased attention to war related sexualised violence, there remains a limited understanding about the long term psychosocial impacts of this type of trauma. As examined in this paper, our experiences show that premigration trauma experiences and impacts of war related sexualised violence follow refugee women into resettlement contexts, and present as a myriad of trauma related mental health difficulties over time. These difficulties include sadness, anxiety, social withdrawal and somatic

complaints. Furthermore, these difficulties often get lost in the challenges of resettlement and can be overlooked by unaware service providers. The main barriers for service provision include language, lack of awareness regarding services and legal rights, distrust of social institutions, and limited expertise to address this issue. Cultural perceptions of sexualised violence and impact are also factors that influence help seeking and preference of service. Finally, women may not seek help due to ongoing threats to safety in resettlement countries. Until safety can be established, both psychologically and contextually, silence remains an important means of survival.

Lessons learned from the Canadian case model include the need for services that integrate multicultural sensitivity with a deep understanding of trauma, and sexualised violence in particular. This includes a framework that is flexible and able to adjust to the particular needs of the individuals and communities being served. As seen in the case study, avoiding intrusive approaches helps to ensure safety and general cultural sensitivity. This was done by paying attention to choice of, and changing, language (such as the name of the programme), framing mental health, trauma and support within human rights discourse, and providing services in neutral locations (such as immigrant serving agencies) to avoid stigmatisation. Outreach methods, such as home visits and participating in existing women's groups, increases access to services. Investing in building relationships and collaborating with other organisations and community groups facilitates the necessary awareness raising needed to build community capacity to address and prevent ongoing victimisation. Finally, our experience emphasises the importance of the cultural competence of service providers. By giving attention to gender and cultural factors, service providers need to assess what meaning women and communities give to sexualised violence and what women require in order to foster a healing process. Indeed, there is a need for research with a focus on appropriate methodologies to better understand mental health needs and suitable programming for individuals and communities that have experienced this form of human rights violation. Our case highlights a number of these factors that show potential for redressing sexualised violence with female survivors.

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[1] For background on psychobiology and psychosocial aspects of trauma see B. van der Kolk, A. McFarlane, and L. Weisaeth (1997) (Eds.). *Traumatic Stress: The effects of overwhelming experiences on the mind, body and society.* New York: Guilford Press.