STATE-SANCTIONED VIOLENCE AND MENTAL HEALTH: IMPLICATIONS FOR LEARNING AND TREATMENT

A Dissertation

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy

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SUMMARY ABSTRACT

State-sanctioned violence and mental health: Implications for learning and treatment

By Athena P. Madan

A Doctor of Philosophy thesis for the Department of Social Justice Education
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2014

This qualitative study examines how Canadian mental health systems may better accommodate people from the Democratic Republic of the Congo (DRC) who are living now in Canada and who may be suffering psychosocial consequences of political violence. Using an anti-racist-feminist lens, analysis of seven interviews highlights the significance of socio-political histories and conceptualisations of trauma in mental health education. Discussions focus on mental health dimensions of war and aspects of resilience in complex life-experiences which are only recently gaining representation (and transformation) in medical discourse. By correlating social and political forces with particular mental health outcomes, I focus on treatment-areas that may be discriminatory for a subset of refugees.

As immigrant and refugee experiences may lack reference within traditional treatment paradigms, it becomes essential to understand specificities within which healing and social change for refugees may be relevant. A first objective looks at processes of resilience where recovery may be more meaningful, countering notions of illness as pathology within systems of
deficit. Similarly, greater considerations of state-sanctioned violence, its nature and intentions, are needed to plan comprehensive mental health supports. A second objective is then to identify social indicators which may more fully articulate, express, or enable change at group and family levels. Finally, as interventions are most effective when informed by group realities, a third objective brings forward cultural, political, and social forces currently underrepresented in what we know about ‘treating war trauma’.

In sum, this study highlights that greater attention to structural violence in mental health education may lead to better treatment outcomes. Treatments may be more effective by offering alternate pathways to care, considering broader conceptualisations of trauma, and encouraging notions of participatory, group-level initiatives. Findings critically suggest that present mental health systems may unintentionally (re)produce victims, more than enable survivors to rebuild lives after fleeing the complexity and brutality of war-affected circumstances.
Those wars are in our genes and in our memories, whether we were there or not. They are part of our collective memory and our collective trauma, our collective and individual unconscious. We remember them from the stories were told and we see them in our lives... Our parents’ experiences mix with our current reality. They could not protect us when we were children and we cannot protect our children. They try but they know as much as we do that this war, like the ones before, comes in wherever it wants to and there are no places too sacred for it.

~Haidar Eid
To my parents
And to those who live now in memory
ACKNOWLEDGMENTS

I must admit that over the course of this program, I’ve found myself frequently keeping habits of owls (sorry, mom!). But good company has kept me awake, buoyant, and engaged. And each deserves heartfelt thanks:

Thanks to my family members. Each of you is a supportive and funny part of life who keeps me smart, on point, and happy. I thank my mother for her belief in my stature, my stepfather (Roy) who believes in the work, and my brothers, Dev & Rich¹, who are the funniest and savviest people I know. I also thank the presence of Harish, Sachid & Bhraji, and the Batras, for caring as my father would have. Each of you has played a role in helping me stand tall (even though I’m only 5’2”).

Thanks to my friends. Davdi and Karen, for your caustic wit, scholarly engagement, and beautiful collegial banter; to Juliet (and by extension Pete and Misty), for our afternoon sessions which sustained me through the writing process; to Wendy and Julene, for being family members to Charm & Battie (and for feedback, especially on those days when I forgot how to engage in public anymore.); and to Winnie, Astrid, and Naana for getting me out to dance! Each of these has been essential in this solitary process.

Of course, as my work here culminates, I extend special thanks to Kwame and George. I have grown tremendously under your mentorship, with your belief, and as a result of your support. Having also been so welcomed and integrated within the SER team at camh was vital, both personally and professionally: so thank you to Denise, Manuela, Nina, Helen, Andrew, Branka, and Sean; also Myanca, Marian, Asante, Angela, Mehek, Maurey, and Anika. You have all been a kind and competent group to learn from and our collaborations have helped my thoughts and energies along the way. Special thanks also to Charmaine, who stepped in very graciously at the end of this journey, with warmth and professionalism to help my work improve.

I’d also like to thank informal role models, who likely have no idea that that’s what they’ve been – so Michelle, Shekhar, Peter, Clare, and Derek, I’ve thought of your approaches often as I navigate next steps of my career. Thanks. And in years past: Roxana and Roger, whose spirits are embodied in this work: your legacies left an impression that is my honour to carry forward.

Last, but not least, before all this work and growth took place, I thank Nteza, Chantal, Marie-Rose, J-C, Justin, and Timothy, for trusting me to share in their experiences as well as the love and memories of those they left behind.

Athena Madan

¹ National Parliamentary Correspondent with CTV National News, Canada’s #1 Rated News Cast. Seen nightly at 11PM, check your local listings.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>CIC</td>
<td>Citizenship and Immigration Canada</td>
</tr>
<tr>
<td>DR Congo</td>
<td>Democratic Republic of the Congo</td>
</tr>
<tr>
<td>GAR</td>
<td>Government Assisted Refugee</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>R2P</td>
<td>Responsibility to Protect</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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</table>
A NOTE TO THE READER

The following notes may assist readers, as this work undertakes a crossing of disciplines: Language specific to mental health treatment as informed by psychiatry appears throughout this work. A brief definition of terms is included in the Conceptualisation of terms section, immediately following. Given also the sociological nature of analysis, I recognise there may be some incongruence of terms (and connotations of terms) across disciplines: for example, the word intervention from some feminist viewpoints may connote a system designed to exercise diffuse social control, however I have chosen to employ it so as to align with psychiatric treatment and mental health education models. Similarly, the word migrant and my self-identification as a ‘woman of colour’ may be reductive namings serving to potentially obfuscate complex lived realities; however as this work pertains largely to the Canadian context, I justify their use as they are employed frequently within Canadian discourse.

Passages quoting participants appear indented from regular margins, and in blue Arial font. Because some of the interviews occurred in French, at times the French statements appear before my English translations of the statements, to more fully capture nuance or where my translations were not a true English equivalent.
CONCEPTUALISATION OF TERMS

Key terms are used throughout this work that have subtle differences and applications. The concept of ‘violence’ in itself has varied characteristics, and given the interdisciplinary nature of this enquiry, different disciplines may take up terms somewhat differently. This section intends to aid the reader with context to the chosen terms. I use terms within this work as they are referenced within the field of genocide studies, and medical sociology:

**Genocide**

See page 27 (section entitled “Considering genocide”) for specific characteristics constituting **genocide**. The United Nations ultimately decides, or declares, which conflicts can be named genocide (United Nations General Assembly, 1948). Within this work, I therefore limit reference to genocides as those declared by the UN and the 1948 Convention. It is important to note that tensions exist and many countries critique how the UN declares genocides. While a critique of the act of naming is not a key focus of my enquiry, the tensions are relevant, manifesting (psychologically and spiritually) in the lives of research participants.

**State-sanctioned violence**

Throughout this dissertation, I refer to **state-sanctioned violence** as civil or national conflict exhibiting protracted, genocidal tendencies, and which has collective and structural roots not corrected by the governing rule (Galtung, 1964; Galtung, 1969; L. Kirmayer, 2010). In other words, **genocide** and **state-sanctioned violence** are used interchangeably in this work to illustrate the nature of political and social forces, structural violence, and social exclusions creating human (and accompanying health) atrocities. **Genocide** is a form of extreme state-sanctioned violence. **State-sanctioned violence** could be considered as structural violence to the extreme.
Structural violence describes social structures constructed in a society – cultural, economic, legal, political, religious – contributing to or perpetuating that society’s inequities. These include disrupted economic activity, governmental restrictions, and social fragmentation, as well as insecurity limiting social mobilities. Embedded in the natures of social relationships and hierarchies, structural violence is normalised by institutional culture, memory, and process of everyday experience (Gilligan, 1997). Structural violence specific to the DRCongo will be addressed in a later section.

Traumatic stress is a non-medical term commonly used to describe reactive anxiety (and/or depression). The condition presents in a manner similar to posttraumatic stress disorder, but without the same intensity (National Institute of Mental Health [NIMH], 2002).

Post-traumatic stress disorder (PTSD) is the medical and psychological name of a diagnosable anxiety disorder that may develop after witnessing or living through an event that caused or threatened serious harm or death. PTSD affects about 7.7 million American adults in a given year, though the disorder can develop at any age, including childhood. Symptoms include strong and unwanted memories of the event, bad dreams, emotional numbness, intense guilt or worry, angry outbursts, feeling “on edge,” and avoiding thoughts and situations that are reminders of the event (National Institute of Mental Health [NIMH], 2002).

A Government-Assisted Refugee (GAR) is a refugee recognised under international protection, based on humanitarian grounds as outlined by the UN Convention of Refugees Abroad. As the name implies, GARs receive government support for their settlement for up to one year from the date of arrival in Canada, or until the refugee is able to support him/herself, whichever happens first. Stipends for a GAR are not strictly
limited to government pensions. Government-funded NGOs and community agencies may also assist with accommodation, clothing, food, employment assistance, and other resettlement expenses. For high-needs GARs, income assistance may be extended up to 24 months. (Citizenship and Immigration Canada, last retrieved 21 April, 2011; Government of Canada / Gouvernement du Canada, 2012; United Nations General Assembly, 16 December 1966).

**Intervention**

The act of interfering with an outcome or course so as to prevent harm, or improve functioning (American Psychiatric Association (APA), 1994).

**PROLOGUE**

**Trajectory of my relationship to this work**

‘*My clinical life is all about having conversations*’². Inevitably shaping this work are my past influences, identities, experiences, opportunities, and limitations in the world, embedded in continuities and evolutions of my “private self” (Ng, Staton, & and Scane, 1995); (Dillard, 2008; Ganga, D. & Scott, S., 2006; Onwuegbuzie, A. J., & Leech, N. L., 2007). While I may have been trained for a certain professional neutrality, analysis would reveal I am articulated in this work (Cohen & Crabtree, 2008; England, 1994). Exploring the meanings of clinical ‘help’ has yielded some intentionalities.

My proximity to the people in this work is part of a larger series of relationships. As a first-generation born in Canada, some of my heritage was not immediately accessible: four citizenships, ten languages, and two faiths framed our five-person family. While culture was an inherent part of my upbringing, I grew up where my parents longed to feel familiar – language,

---

time, place, and events disconnected their childhoods from my world, and the world I inhabited meant that what they knew could not often speak to me.

Over the years and with the privilege of mobility, my parents’ photographs materialised into real, personal attachments, though some conversations were gestured or intuited more than spoken. People as well as places became my teachers. Each place inhabited a home space, with familiar yet distinct traditions, and each actualised me differently: food, kitchen smells, the colours we wore, how we danced, and how we prayed – each felt like home, even though they were not like any other. Back in Canada, I noted the different spaces my parents took up during long-distance phone calls, or when receiving small blue AirMail letters, or when movies like Ghandi came out, or when Miss Siagon cast a Filipina. I saw their mannerisms and excitement in these moments, recognising myself in their longings. I came to understand how I related, negotiated, and expressed my social proximities: ‘home’ intuitively shaped me to bridge different worlds.

But mobility also has its losses. We envy the tangible belonging of heirlooms. Like Salman Akhtar’s work (Akhtar, 1999; Hook & Akhtar, 2007) on dislocatedness, the psychic space of a lost homeland is a palpable but diffuse one. Even though I did not arrive at a difficult time in my parents’ lives – compared to my homes overseas, we lived in relative abundance, and from a young age I was cognisant that any cousin could have held my privilege – there was always an underpinning of yearning, and unspoken adversity. I was not responsible for losses or exiles, yet as research suggests (Barel, Van IJzendoorn, SagiSchwartz, & BakermansKranenburg, 2010; Danieli, 1982; Menzies, November 2010), I believe burdens carry intergenerationally: both of my parents carried a nostalgia not uncommon for immigrants, coupled with the ‘colonial blueprint’ (Shamsuddin, 2009, February 25) endured by their
The 1960s zeitgeist of civil rights / social change acted as backdrop as they moved across states and provinces, carefully and ideologically building their multi-faith, multi-cultural home. Endurance was not a choice, becoming also a belief system, shaping at times circumstances which were not what they would have designed for us. I now recognise the grief of their losses, and their optimism for change that we as children were asked to absorb as a result. This grief and their unsung hopes shaped our engagement with the world.

My older brothers and I chose professions which were thus likely not random or incidental: professions of expression, communication, and reconciliation, respectively. Over the course of this doctoral journey I have been asked to reflect on my subjectivities and location in this work: What motivates this journey, and why? How does my proximity to the subject influence my analysis of it?

It is true that much of my personal life prepared me for clinical work: my parents’ experiences, their professional goals, and my own mobilities have all lent familiarity to dealing with contemporary themes of post-colonial exile, political violence, and traumatic loss. It has also always been difficult for me to rest when situations of concern present a humanitarian need. The most salient reflections are sentimental, and largely because my parents came to Canada ahead of their time. I am their generation, motivated to build a world worthy of their dreams.

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3 My parents’ experiences are complex narratives and histories in themselves. My mother was raised in cycles of colonisation and post-war occupation in the Philippines, waves as perennial and as devastating as flooding season; my father’s youth was indelibly marked by violence and displacement from the 1947 Partition of India, where he walked over 600 km and lost 16 family members. Both then faced an assimilationist model of immigration to North America in the early 1960s where, despite credentials, workplace equality was not yet within reach. When my father died in 1988, cultural contexts had no sympathy for widows. Her strength and his desire for legacy have in no small part influenced my intent and motivation.
Positionality in research: Biases and subjectivities

Like the stories of my childhood/inheritance, some of my characteristics as a researcher are not immediately known. While some aspects to my personhood are identifiably visible, others are tacit, and others are assumed. Table 1 outlines the characteristics embodying my identity as a researcher, both real and perceived, and how this may impact my research goals, and indeed motivation in the research process.

Personal affiliations and identities ground relational aspects in this research, which are especially vital to the subject-matter of this particular project. As Table 1 discloses, I am a woman of colour with theoretical interests invested in social change, however moderately (being Canadian\(^4\), after all), and inclined towards qualitative enquiry. While being born and educated (largely) in the West bestow me with a perceived certain geopolitical legitimacy, being a woman of color ranks me among the subaltern, and being unmarried lacks social capital (Loomba, 2005). Characteristics as I embody them are reflective of macro, geopolitical relationships: in essence, I represent privileged access to centres of power.

\(^4\) Given Canada’s reputation as being a polite and conservative social liberal nation, generally non-confrontational in public policy, and consistently at the forefront of peacekeeping initiatives. In my instance, I have lived outside of Canada more than in; the idea of “being Canadian” to me speaks more of a role in international relations than of personal birthright.

I also read with interest (Reitz, J.G. & Banerjee, R., 2007) about identity among second-generation Canadians (first-generation born in Canada). The study found skin colour to be negatively correlated with self-reported feelings of “Canadian” identity: the darker the skin, the less the individual (as a collective subject) self-identified with a sense of belonging in Canada. Further, darker skin correlated more strongly with feelings of belonging to ethnicities from country/ies of origin, even when the parents reported “feeling Canadian” quite strongly. These findings may reflect (Lopez, 1994) assertions that racial identity is constructed in relation to others, with attachments conceptualised by proximity to ancestry, feelings of citizenship, and cultural/social/spiritual customs. (Baker, 1978) in her seminal considerations on ethnicity, suggests that the constructs of race in turn constructs identity, which in turn shapes intercultural relating. Specific to dynamics of post-colonial loss/injury, John Bowlby’s early work in attachment theory (Bowlby, 1958, Bowlby, 1977) suggested social disruption and power inequality are linked to the distortion, denial, and destruction of group attachment bonds. These suggestions are very relevant to the concepts of reconciliation.
Table 1: Myself as researcher: Visible and invisible characteristics.

<table>
<thead>
<tr>
<th>What's visible</th>
<th>What can be stated &amp; defined</th>
<th>What's invisible (tacit and symbolised)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woman</td>
<td>Qualitative researcher</td>
<td>Access to a particular form of knowledge</td>
</tr>
<tr>
<td>Of colour</td>
<td>In the social sciences</td>
<td>Access to resources</td>
</tr>
<tr>
<td>Fluently bilingual</td>
<td>Canadian (allophone)</td>
<td>Access to privilege</td>
</tr>
<tr>
<td>Educated</td>
<td>Unmarried</td>
<td>Access to independence</td>
</tr>
<tr>
<td>Born in the West</td>
<td>Feminist, anti-racist ideology</td>
<td>Access to politically legitimised power</td>
</tr>
<tr>
<td>Young looking</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Naming subjectivities is essential when undertaking work with ‘other populations’, using both literal and sociological (J. Butler, 1997) interpretations. Geopolitical tensions may manifest when any two cultures and two world-views interact. However these may significantly magnify and compound the clinical relationship, which at its core, still holds an unyielding (and sometimes imposed) amount of power. And because the clinical relationship within mental health treatment is directly related to the innermost workings, constructions, meanings, and understandings of a person’s world, an unchecked point of departure can be more than a strained epistemology – it can be dangerous. As we will see in the next section, to avoid these nuances would blindly reproduce social, political, and historical injury on an interior level. (see (Said, 1978).

The importance of reflexivity: Ethical considerations

Feminist and transformative research agendas may invite criticism from clinicians and researchers accustomed to paradigms of non-disclosure, in the name of traditionally unbiased or objective design (Angus, 2011). The principle of reflexivity (Cohen & Crabtree, 2008; England, 1994), however, suggests that the act of research is imbued with power, and individual researchers themselves see with a particular gaze and hold particular experience which socialise any research enquiry (see (Dei, G., & Kempf, A., 2006; Gagné, 1998; Lubek, 2000). Culture,
values, history, and belief systems (whether dominant / inherited / imposed / internalised / resisted) affect perceptions, ways of constructing the world, and contexts within which research operates.

A reflexive naming of personal and methodological biases is thus necessary in this subject-area to facilitate more equitable representations of bodies and interrelationships, as the search for equity is a co-created and negotiated process (see (Dei, G., & Runneke, J. A., 2010; Dillard, 2008; Ng et al., 1995). Reflexivity, as a “self-conscious analytical scrutiny” (England, 1994: 89), provides (both moral and critical) framework to describe the nature of how I as researcher may intersect and meet participants in the research process. Moral and critical analysis about research relationships become critical when ethnicity and ethnic tensions have acted as backdrop for the human atrocities.

To contextualise Table 1: Anti-racist discourse might suggest that, because I am not Congolese, this research could be perceived as an act of dissection – a spectrum achieving advocacy at best, to misrepresentation and further injury at worst – of a group of Congolese people’s social, political, and historical realities. To not understand what my body represents from the perspective of those whom I seek to engage would obliterate the potential contributions of this work. As per my upbringing and schooling, I also represent a body of knowledge (in itself a political construct) from a particular worldview and within a larger global politic. None of these can be truly neutral, or constrained to a uniquely individual level, especially given the complexities of Congolese history. How this work constructs meaning is part of a broader political and cultural process which may risk echoing colonial judgement (see (Timimi, 2011): *Who and what* I represent carry weight and frame of reference beyond my actual 46.7kg in an interview room.
Clinical equipoise: The case of Nteza

A previous article shared the case study of Nteza, a former client of mine, who was a refugee from the Democratic Republic of the Congo (DRC) (Madan, 2011b). For convenience of reference, Nteza’s narrative may be found in Appendix A. In her case narrative, I relate her diagnosis and treatment of post-traumatic stress disorder (PTSD), and my reflections about how the system sadly lacked socio-political context for her circumstances. The treatment Nteza received was quite pivotal for me in identifying that services needed to improve, as her instance served to compound events in her already very tragic personal history. I reflected:

[The events of Nteza’s treatment] have been ones that I have deconstructed for some time, in efforts to discern what could have been done differently – I’m not convinced that our intervention was successful. In fact, I think our actions were quite disastrous. While extreme, Nteza’s experience illustrates how PTSD intervention lacked relevance to her circumstances, and how the decisions we were trained to make resulted in such inequity ... [for] none of Nteza’s attachments or experiences had reference within the treatment frame, or could be advocated for appropriately. The very framework enlisting ‘help’ predetermined Nteza’s participation as a client, setting her up in fact for further alienation, non-status, and failure. Further, the “task” in explaining the systems and regulations in Canada to Nteza as a newcomer (which in itself assumes a certain lack of historical non-existence), coupled with difference of word and of language (see (Bhugra & McKenzie, 2010; Bouchard & Leis, 2008), seems an ill-timed and unfortunate preoccupation with bureaucracy and disciplinary power. I have since reflected that Nteza fled one autocratic rule in life, only to be replaced by another one – and even though judgement included neither height nor the shape of her nose, we were just as equally unforgiving. (Madan, 2011b), p. 443)

My experience in carrying out Nteza’s treatment comprises in no small part the motivation and driving force behind this project. While extreme, her case exemplifies how treatment focussing on individual symptomology within a system of deficit often translates across incongruently across cultures (see (Jones, 2010; L. J. Kirmayer, Groleau, Guzder, Blake,
& & Jarvis, 2003; L. J. Kirmayer, Lemelson, & Barad, 2007; Summerfield & Hume, 1993). My friends’ own journeys from the DR Congo and Rwanda have added to these reflections; and over the course of my clinical life, I have additionally worked in Bangladesh, the DR Congo, South Africa, and Afghanistan. From each cultural perspective, and within contexts of protracted conflict, biomedical frameworks have not been entirely useful; they have even served to obliterate cultural agency, however unintentionally or symbolic, reverberating dynamics of power that originally sustained genocidal traumas.

Within the context of political violence, stakes in the act of intervening are heightened: psychological injury compounds professional intention. In the clinical relationship, intent to help may be interpreted as a dissimulative act or service. Where systems have stripped agency, safety, and mobility, healing has more than individual, physiological dimensions. The South African Truth and Reconciliation Committee’s final report states:

[Our work] seeks to repair the injustice and to effect corrective changes in the record, in relationships, and future behaviour. [New] South Africa … is concerned not so much with punishment as with correcting imbalances, restoring broken relationships – with healing, harmony, and reconciliation … to empower individuals to take control of their own lives. (as cited in Short, 2005, p. 269)

My closing reflections in the article about Nteza / Appendix A were opening motivations for this project. With time, my advocacy has perhaps become more moderately expressed, but I do not believe the urgency is undiminished:

The call often heard in the West, to “[afford] indigenous peoples equal recognition and respect . . . [and extend] universal fundamental political rights” (Short, 2005), p. 275), while theoretically genuine, is disenfranchising: It seems to locate the African (the Aboriginal, the subaltern brown woman) in a position that is “lower”, with the act of “transfer” as one that is bestowed, a generous act and not a fundamentally restorative one. Further, the discourse of “rights” is also seen to be a Western notion; in indigenous or Eastern or African discourse I
have noticed more discussion of “responsibilities”. The constructs of “empowerment” and “[taking] control” are also very reflective of a particularly located thought – I would posit it’s not grounded in indigeneity…

The issue at stake for Congolais(e) and Rwandais(e) war survivors is not simply a “moving on” from the past affected by war. It is a political affirmation of selfhood, a change in collective responsibility, and a global acknowledgment of legislated murder, legislated poverty, and legislated racism. In short, it is a call to witness to cultural, political, and symbolic change. Unless PTSD expands its current ideology of trauma, limited and potentially harmful treatment is a probable outcome. Current treatment simply lacks cultural relevance, contaminating instead the spirit of the self and its community. This lack of a Rwandan voice in treating a particular Rwandan injury perpetuates the era of a Rwandan with no social capital (K. Mckenzie & Harpham, 2006; Whitley & McKenzie, 2005). While I wish to acknowledge that PTSD treatment is largely governed by people who work with genuine intent to alleviate mental distress not only from “horrible imaginings”, but actual and lived “present fears” (Bagilishya, 2000), my main suggestion here is that even – or especially – so, there is need for pause in navigating future directions. There is need for a more considered (if not equitable) point of departure in trauma treatment. As (Watters, 2010) suggests, “perhaps it’s time that we rethink our generosity” (p. 255).

My points of departure for this work are thus very much grounded in personal political and social sensibilities, which coupled with the experience of Nteza, have had varying emotional impacts. While I may not share like visible identity as Nteza identifies, I believe I do understand her feelings of marginalisation and desire for social change. Within the boundaries of my professional designation, this work therefore is a taking up of Nteza’s narrative to contribute a perspective, which may in turn inform or improve mental health services.
Overview of chapters

Four sections comprise this paper. **Part One** of this dissertation will address work that led up to and informed to this study, and give a brief overview of dynamics of genocide specific to the DR Congo. I will also identify where this work has potential to contribute to the larger body of literature, to inform social change, and where I hope to influence future areas of research. **Part Two** lays out the present study’s objectives, with point of departure, conceptual frameworks, with methods and theories undertaken in analysis. **Part Three** comprises research findings and thematic analysis, with some analysis linking themes to individual-, group/family-, and macro-level treatment levels. **Part Four** recommends treatment-areas where change may be considered / where change is possible, pointing to specific learning modules which systems may undertake to improve their services.
Social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence social responses to social problems. Included under the category of social suffering are conditions that are usually divided among separate fields, conditions that simultaneously involve health, welfare, legal, moral, and religious issues …

[T]he trauma, pain, and disorders to which atrocity give rise are health conditions; yet they are also political and cultural matters … health is a social indicator, and indeed a social process. (Kleinman, Das, & Lock, 1997: ix)

INTRODUCTION

Precedents to this study

A growing body of literature attends to limitations in applying post-traumatic stress disorder (PTSD) (American Psychiatric Association (APA), 1994) to instances of war trauma. Researchers and clinicians across low-income and multicultural contexts agree that a PTSD diagnosis lacks sufficient attention to sustained political and social precursors, assuming generalised occurrences of war, and conceptualisations of ‘trauma’ which may not be culturally appropriate (see (Blackwell, 2005; L. J. Kirmayer et al., 2007; Moncrieff, 2010; Summerfield, 2001a; Summerfield, 2001b; Summerfield, 2004). As ‘immigrant and refugee’ experiences have lacked context and specificity in treatment literature, a review of interventions and what immigrants and refugees want from and find effective in treatments are essential to determine the best ways within which ‘healing’ and ‘social change’ are relevant.

Points where traditional therapeutic treatment models have been critiqued for exacerbating postcolonial injury include: their genesis in western European enlightenment and
patriarchal thought; a focus on the individual as the root of pathology; and a process of assessment that lacks multicultural norms. Of their work in Peru and survivors of political violence, Snider, Cabrejos, Marquina, Trujillos, Avery & Aguilar (Snider et al., 2004) write:

Some of the dangers of indiscriminate application of Western schema, such as ‘PTSD’ to indigenous societies include: (1) pathologizing normal responses to stress, (2) lack of attention to cultural bereavement and socioeconomic context, (3) bias towards individualist treatment approaches stigmatizing to local persons, (4) ‘category fallacy’, or the false idea that symptoms described in different contexts share the same meaning, and (5) reductionism of the meaning of traumatic experience into clinical descriptors. The meaning people ascribe to traumatic events, to their losses and to their survival of those events, has powerful implications for recovery. (p. 390)

To consider geopolitical nuances as independent from treatment paradigms limits the ‘success’ of any eventual outcome (Summerfield, 1995); (Bhui, McKenzie, & Gill, 2004; Blackwell, 2005). Describing his work at the Medical Foundation for the Care of Victims of Torture in London, the psychiatrist Derek Summerfield questions:

The impact of violence and other shocking types of suffering are now measured through the (morally neutral) sciences of memory and psychology ... Western health professionals and the public have a misguided image of war and its aftermath that is often far removed from the actual experience of non-Westernised societies. It might be timely for mental health professionals to review our definition of [PTSD] as a disease and decide whether it has sufficient robustness and explanatory power to apply to the diverse uses it is now being put (Summerfield, 2004):1; 2001: 322, respectively, emphasis added).

Research questions

Nteza’s narrative acted as impetus to understand how mental health interventions could better support survivors’ lived experiences within the Canadian context. Questions have further been refined by studies looking at links of racism on mental health (see (K. McKenzie, 2002; K.
McKenzie & Bhui, 2007b) and perspectives questioning unchecked political epistemologies in a ‘post-colonial’ era (see (Dei, G., & Runneke, J. A., 2010; Dillard, 2008; Ng et al., 1995). My point of departure focussed on the following questions:

1. How can mental health interventions better assist people affected by state-sanctioned violence?

2. How can narratives of people affected by state-sanctioned violence inform and improve traditional mental health treatment paradigms, specifically underpinning: (a) conceptualisations of trauma in mental health education, and (b) discourses of resilience in the face of traumatic stress?

3. What approaches to treatment or alternate pathways to care in the Canadian context may avert traumatic stress (for people affected by state-sanctioned violence) more effectively?

The desire to find out how traumatic stress treatment could be more culturally relevant for clients like Nteza, as well as the belief that socio-political forces affect health outcomes, comprised the basis for this work. Mental health education is assumed to be the mechanism whereby treatment services could broaden or structure more comprehensive supports.

**Study objectives**

Within this study, a total of seven people shared their thoughts and feelings during interviews discussing their lived experience of state-sanctioned violence. Literature has underlined how effects from violence do not necessarily develop psychopathology, and traumatic experience is not inherently pathological (see (Subramane, 2006; Summerfield, 2004). Current diagnostic approaches, with their ‘narrow’ and ‘imprecise’ (Vasilevska, B. & Simich, L., 2010) 38; (Summerfield, 2001c) : 197) paradigms, focus on individual, physiological symptoms, according to Anglo-Eurocentric and androcentric cultural norms. A **first** objective to this study
will look to shift discourse from dominant notions of injury, pathology, and systems of deficit, to processes of resilience and areas where ‘recovery’ may be more meaningful (see (Dei, G., & Kempf, A., 2006), dedication page).

If ‘intervening’ is to be meaningful or beneficial, it must be designed with the impacted communities, according to expressed desires for change, and cognisant of collective resources: these include social, political, and spiritual attachments, networks, perceptions, resiliencies, and the ability to contribute and share dreams collectively. A second objective is then to identify social indicators which may more fully articulate, express, or enable change at group and family levels, and how these help understand components for resilience and recovery. While decrease in symptomology or behaviour may be one salient way to measure ‘recovery’ for an individual, more comprehensive understanding of impacts – not only ‘what happened’, but also psychosocial-spiritual dimensions, collective injury, and what communities need to get better – are needed to plan effective mental health supports. Speaking to the involvement of medical teams in the Balkans conflict, The Medical Network for Social Reconstruction in Yugoslavia (Gutlove, P. for the Medical Network for Social Reconstruction in the Former Yugoslavia, 1998) writes:

In order for a community to nourish hope that they might be able to have a future together that will be better than their recent past, they need to be able to envision their common future. Sharing positive visions of the future can mark an important turning point, away from the trauma of the past towards a shared optimism for the future (Appendix F4).

At present, pathways in which Congolese people are referred for treatment, interviewed, or given options may not actually be helpful. This study will apply a largely explanatory method, supplemented with a questionnaire ranking service friendliness, about treatment models to elicit perspectives from Congolese participants for greater cultural specificity. An anti-racist-feminist analysis will then contextualise the significance of socio-political histories, identifying areas
where treatment-areas may be unknowingly discriminatory. A **third** and final overarching objective to this study thus seeks to improve care literacy by illuminating cultural, political, social, and spiritual conceptualisations about trauma in mental health education, currently underrepresented in what we know about ‘treating war trauma’.

**Epistemological contributions**

This work has potential to contribute three distinct points of knowledge specific to mental health education and medical sociology. The strict biomedical paradigm informing trauma treatment has significant limitations to capturing whole dimensions of injury. Treatment outcomes would likely be improved if frameworks considered broader subjective experiences such as perceptions, conceptualisations, social causal factors, and feelings constituting trauma. Traumatology as a field, and thus mental health as a discipline, could serve populations and intended individual beneficiaries better from point of departure.

An explanatory model of traumatic stress has not yet been documented according to a Congolese perspective. So as a first point, this study elicits knowledge from voices that have not had representation in the literature. Psychotherapy for a Congolese refugee would likely be more culturally relevant if meanings were sought from their perspective, with explanatory models to fit their realities: that is, if treatment were formally cognisant of the complex life circumstances they have experienced, including forces sustaining the original ‘traumas’, and lived narratives beyond individual symptoms.

Second, a 2010 Canadian study with medical residents (Munshi, Woods, & Hodges, 2010) reported that although most had encountered a patient who had been traumatised by political violence, none reported feeling completely prepared, with 90% desiring to learn more in this area. Thus, for residents and professionals who may encounter people from the DRCongo
seeking new lives in Canada, such information may make a difference in providing better, more comprehensive and effective mental health supports. While traumas may differ according to the contexts or war and subsequent journeys sustained, the Congolese experience may provide a particular lens in understanding some social and political forces relevant for optimal mental health.

Last, for Congolese people seeking care, this work may be helpful in providing advocacy representative of their hopes and lived realities, with improved rationale for more comprehensive treatment options. I have tried to frame narratives within a reflexive analysis, and attention to socio-political histories and relationships of power, to demonstrate how current care systems may be reinforcing additional but tacit layers of discriminatory power. It is my hope that this research may speak to broader issues of equity in society, in addition to mental health implications from a particular war.

**REVIEWING STATE-SANCTIONED VIOLENCE**

**Considering Genocide**

Genocide is considered ‘one of the worst moral crimes of a government’ (Canadian Centre for Victims of Torture, 2009, Winter): 10), and has resulted in the deaths of approximately 174 million people since the 20th century (ibid). The United Nations’ *Convention on the Prevention and Punishment of the Crime of Genocide* defines genocide thus:

[A]ny of the following acts committed with intent to destroy, in whole or in part, a national, ethnic, racial or religious group, as such:

a. Killing members of the group;

b. Causing serious bodily or mental harm to members of the group;
c. Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;

d. Imposing measures intended to prevent births within the group;

e. Forcibly transferring children of the group to another group.

(United Nations General Assembly, 1948: article II)

The most extreme documented forms of genocide have occurred in the USSR (resulting in 62 million deaths), China (45 million), and Germany (21 million); key to note here is the act of documentation. Many conflicts have not had resources or political will to document bodies, which has in itself been the subject of international contentions. During the 20th century, documented genocides also occurred in Cambodia, the Dominican Republic, Guatemala, Japan, Namibia, North Korea, Mexico, Partition of India (India, Pakistan and present-day Bangladesh), Poland, Russia, Turkey, Vietnam, and Zanzibar; the last quarter century has borne witness to genocidal conflicts in Burundi, the Congo, Darfur, Rwanda, Sudan, and the former Yugoslavia; not all of these conflicts have been declared as genocide, for reasons where only lack of documentation is a partial factor, reflecting larger geopolitical tensions. Also considered but not officially recognised as genocides in the last 25 years include conflicts in the following seven regions: Afghanistan, East Timor, Israel, Lebanon, the Occupied Palestinian Territories, the northern Philippines, and Sri Lanka. The Rwandan 1994 genocide not only decimated Rwanda, but sparked tensions in Burundi, the Congo (formerly Zaire), Tanzania, and Uganda – from UNHCR estimates, not including voluntary repatriation, these total 688 000 refugees (United Nations, 2009), my own extrapolations).

I reference these facts to illustrate that genocide-affected migrants are not an isolated minority; indeed, the World Health Organization and the World Bank predict that war will be the eighth leading cause of death and disability by 2020 (Murray & and Lopez, 1996). It is thus likely that increasing numbers of patients will present with lived experiences of protracted,
politically motivated conflict as part and parcel of their medical and psychological histories. However, particularities of genocide and mass violence are complex, and each carry particular contexts and consequences that we are still coming to understand. Further, the above naming of conflict is not definitive: Advocates, lawyers, and political scientists all suggest that declaring or discerning the Convention’s ‘intent to destroy’ clause is precarious, outside the scope of Autonomy’s rule (see (Kupchan & Mount, 2009), and fraught with both political and politicised interpretations.

It is important to note that genocide is a distinct form of mass violence in two ways. First, when the UN declares genocide – a process that some argue has in itself become also political (see (Moses, 2006) for review) – the international community is required to intervene, as mandated by the 1951 Convention’s “Responsibility to Protect” clause. However, as the UN has yet to agree on exact parameters of intervention, political and humanitarian intervention efforts often present with conflicting agendas of interest, and are in direct competition for resources to deploy aid. Second, also according to the 1951 Convention, acts of genocide (since 1951) are punishable by international law. This may affect whatever stability of immigration protection and intervention a host society may be able to provide. Analysis of decisions concerning the Convention’s implementation, and the UN’s governing enactment of it, are outside the scope of this work, but it is important to note these decisions reflect geopolitical realities, and are not without psychological impact (see section entitled, *The act of witnessing as co-constructed experience*).

**Refugee trends in Canada**

Canada accepts an estimated 14,500 claimants and contributes 30 million dollars to the UNHCR Government-Assisted Refugee (GAR) programme (Citizenship and Immigration
Canada, last retrieved 21 April, 2011) each year. Receiving roughly 6% of all documented refugee claims (United Nations High Commissioner for Refugees, 2011), Canada ranks fifth as the world’s target destination for settlement and ninth as financial contributor for international refugee assistance (United Nations, 2009). Government-Assisted Refugees are refugees qualifying for UN Convention Refugee status and whose cases must be supported on humanitarian grounds, as outlined by the UN Convention Refugees Abroad), and whose initial resettlement in Canada is entirely supported by the Government of Canada or Quebec. Support is delivered by government-supported non-governmental agencies, for up to one year from the date of arrival in Canada, or until the refugee is able to support him/herself, whichever happens first, and may include accommodation, clothing, food, employment assistance, and other resettlement expenses. For high-needs GARs, income assistance may be extended up to 24 months.

Refugee trends and state-sanctioned violence in the global health context

The World Health Organization and the World Bank predict that war conflict will be the eighth leading cause of death and disability by 2020 (Murray & and Lopez, 1996). Indeed, Afghan, Congolese, and Iraqi refugees presently account for over 50% of refugees worldwide (United Nations High Commissioner for Refugees, 2011); (World Bank, last updated March 2, 2011). It is thus likely that increasing numbers of medical and psychological patients will present with direct or indirect experiences of political and mass organised violence. But particularities of state-sanctioned violence are complex, carrying contexts and consequences that are not yet fully documented or understood.

5 The Government of Canada has committed to increasing the number of GARs, and the financial commitment of Canadians to the program, by 20% by the year 2016(Government of Canada / Gouvernement du Canada, 2012)

6 The UNHCR estimates that it registers approximately 800,000 refugees each year.
Dynamics of genocide may act as a lens to understand political violence to the extreme: it is violence with specific, systematic intent to destroy a particular group – in other words, where extinction and even murder becomes the ultimate end. Political violence may or may not share the same end goal, although its characteristics may in fact be genocidal. State-sanctioned violence is referenced in the literature (and indeed, in this work) as a lens to understanding effects of extreme violence on the group/population level. Table 2 lists the instances and casualties due to genocide (as defined and declared by the United Nations; see (United Nations General Assembly, 1948) within the past 20 years.

Table 2: Declared instances of genocide in the past 20 years.

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Casualties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rwanda</td>
<td>1994</td>
<td>800,000 and 2 million displaced</td>
</tr>
<tr>
<td>Former Yugoslavia</td>
<td>1992–1995</td>
<td>8000 and 30,000 displaced</td>
</tr>
<tr>
<td>Darfur / Sudan</td>
<td>2003–present</td>
<td>300,000 and 2.7 million displaced</td>
</tr>
</tbody>
</table>

Table 3 lists instances of and total populations affected by state-sanctioned violence which are at risk or characteristic of genocide (United Nations High Commissioner for Refugees, 2010), but which are as of yet contested or undeclared. Data in Table 3 may not be definitive. In many instances, casualties are unconfirmed; further, advocates, lawyers, and political scientists all agree that declaring or discerning the Convention’s “intent to destroy” clause is precarious, outside the scope of Autonomy’s rule (see (Kupchan & Mount, 2009), and fraught with both political and politicised interpretations.

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This table is composed of extrapolated data from HRW and UNHCR statistical tables (Human Rights Watch, last retrieved 21 April, 2011, United Nations, 2009, United Nations High Commissioner for Refugees, 2010), according to the positions and decisions as reported by the United Nations (Office of the Special Advisor on the Prevention of Genocide, (last retrieved April 2011)). Only conflicts where casualties have exceeded 100 documented civilians have been included in this list. Contested genocides are outside the scope of this work.
As noted in the Conceptualisation of Terms section, political processes in declaring genocide, and how the declaration process has specific implications on mental health, are beyond the scope of this work. While the nuances of lived experience must also acknowledge racialisation as a socio-political process (Dei, G., & Runneke, J. A., 2010; Pham, Vinck, & Weinstein, 2010), my primary focus is to look at some consequences of state-sanctioned violence, and provide understanding to improve treatment models where “critical mental health care is needed” (Médecins sans frontières (MSF), 2011).

**Migrants affected by state-sanctioned violence in Canada**

Refugee trends in Canada reflect international ones. Figure 1 shows data from the Canadian Immigration and Refugee Board (IRB) (McKie, D., for CBC News, 2010) indicating that, from January to June 2010, the highest numbers of accepted refugee claimants were of Somali, Afghan, Congolese (DRC), or Rwandan nationality. While source countries fluctuate

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8 See (Office of the Special Advisor on the Prevention of Genocide, (last retrieved April 2011)).
according to patterns and crises of world situations (Citizenship & Immigration Canada, 2010), Somalia and the DRCongo have consistently represented among the highest numbers of claims accepted to Canada in the past ten years (Citizenship and Immigration Canada, last retrieved 21 April, 2011). As we have seen in Table 2, all of these countries are areas of UNHCR concern.

Since 2008, trends show increased trends of GARs arriving to Canada from Africa and the Middle East (Social Research and Demonstration Corporation, for Citizenship and Immigration Canada, 2002):7). There are equal numbers of male to female claimants accepted to
Canada, and the average claimant represents at least one additional family member. **Figure 1** does not include compassionate or humanitarian claims.

The Mental Health Commission of Canada (MHCC) recommended a national strategy in 2010 “responding to the diverse needs of all people living in Canada … for the development of knowledge about the diversity of communit[ies], to help service providers consider the most appropriate service developments and plans, and … ensure that diverse communities are being served” (Hansson, Lurie, & McKenzie, K., for the Task Group of the Services Systems Advisory Committee, Mental Health Commission of Canada, 2010: 31). Of specific urgency in the MHCC recommendations were service provisions for refugee mental health: “Without a clear plan and without data, ad hoc services are being developed across Canada. Excellent services have been produced in this way. However, it is not clear that services in any area formed a coherent response.” (ibid.: 34).

**State-sanctioned violence and mental health**

Previous writing (Madan, 2010: 262) has discussed the “systemic and ingrained long-term implications” of violence from genocide: psychological effects are complex. The targeting of a collective identity often involves systematic subjugation to “being less than human” (Madibbo, 2005, June3), with mass killing, open rape, and psychological and physical torture. Also very relevant is a heightened sense of collective loss, with deliberate annihilation of community, dignity, personality, and health; and destruction of family and property, often in front of entire communities to witness (Summerfield, 2000). For women, rape is a common and symbolic “act of aggressive potency … calculated … with intent to destroy” (MacKinnon, 2011). For children, violence becomes an accepted, acceptable, and expected schema, where murder is legislated power (Beah, 2007; Mossallanajed, 2005).
Migration from violence lends additional complexities. These may include guilt for having escaped and / or survived; preoccupations with family and property (inheritance) remaining behind; acute grief for improper burial of the dead; and distress from both limbo and loss of status in the new host country (Bagilishya, 2000; Blackwell, 2003; Blackwell, 2005; Mossallanajed, 2005; Mossallanajed, 2005), respectively. In some cultures, improper burial and inability to attend to ancestral passage are significant causes of distresss (Bagilishya, 2000)).

Daily circumstances as a GAR often include inadequate housing, poor diet, financial instability, and change of role or potential to contribute to the family. In his work with Iraqi asylum seekers in the UK who had a history of torture, Summerfield (see page 24) found that well-being “had rather more to do with the coherence of their local circumstances, whether they had been able to start a new lives for themselves, than with a history of torture per se” (Summerfield, 2014). This is congruent with the idea of needs as being hierarchal / influencing uptake in service use (see Maslow, 1943), as well findings that attendance levels for torture survivors are higher in settlement programmes than mental health ones (Access Alliance, 2014; Mossallanejad, 2011, March).

State-sanctioned violence also extends to the ecological and symbolic. A host country’s threat of deportation, coupled with lack of access to citizenship and a shift to individualistic world-views, may foster isolation and create adversarial relationships with communities (including government) that the refugee is still trying to trust. Specific to relocating children, Revell (Revell, 2001) and the (National Institute of Mental Health [NIMH]., 2002) note that there can be worry due to the unavailability, disappearance, or death of family members; interruptions to schooling or other life trajectories; responsibility to act as mediators for parents who have less familiarity for the new language; and a general, sustained sense of uncertainty. Dimensions of diaspora may include a legacy of feeling perpetually second-rate under the
‘colonial blueprint’ (The Canadian Broadcasting Corporation [CBC], 2009, March 20; Shamsuddin, 2009, February 25), and a heightened responsibility to act in the commemoration of loss (or, as is said in the case of the Rwandan genocide, ‘le devoir de mémoire’ / duty to remember) (Bagilishya, 2000). Writes the South African social psychologist Norman Duncan (2004: 132) on the legacies of apartheid: “[V]iolence … gradually permeates the social order to affect everyday living. In time, [it] takes on different guises and becomes less blatant and more integral to institutional as well as interpersonal reality” (132). In instances of state-sanctioned violence, collective lack of access to education, healthcare, and participation in political processes keep entire communities and their mobilities under control. People remain isolated, mistrustful, polarised, and poor, unable to gain confidence in themselves or each other.

Further, an indirect but perhaps equally symbolically violent (Grenfell, 2008) outcome presents in the international community’s intervention efforts: Political and humanitarian bodies are often in direct competition or tied to conflicting agendas of interest for resources deploying aid. Such dynamics foment hypersensitivity to rejection, persecution, and perceptions of “institutionalised lying” (Summerfield, 2000):2) wherein authorities of governance (including service providers) are not inherently trustworthy or impartial. Thus, entire generations may grow where there may be too much fear to hope, insufficient will to dream, and where life may be an unexceptional currency.

Canada has noted a “marked increase in the complexity of medical conditions of GARs” (Government of Canada / Gouvernement du Canada., 2011) since 2006. However specificity on these conditions are not publically available.
The DR Congo in context

Approximately the same size as Western Europe, the DR Congo is the most resource rich country in the world. It contains two thirds of the world’s remaining rainforests, 80% of the world’s reserve of coltan (used in cell phones and other smart technologies), and ranks fourth in the world's diamond production (American University, 2014). Copper, cadmium, gold, petroleum, and other minerals are abundant in its soils which extend north and south of the equator. Figure 2 is a quick snapshot of the DR Congo at a glance.

DEMOCRATIC REPUBLIC OF THE CONGO

At a glance:

- Population: 72 million
- Life expectancy: 55 years
- Average education level: Grade 3
- In conflict since: >1994


Figure 2. Presentation slide providing a brief overview of the DR Congo. (lifted from my own conference presentations)

The resources within the DR Congo have often been called the Congolese curse, “as history tells the story of a series of foreign powers invading to exploit the country’s wealth, each time to the detriment of the Congolese people” (Heal Africa, 2014). Diamond mining in the DRC is perceived to be an economic extension of colonialism, as extracted diamonds are handled, exported, and sold by international third parties with little to no known profit returning to the
country. As a population, 80% of the DRC lives on less than 50 cents a day, with 42% able to eat at least once daily, and 70% have no access to health care or education. The average person is able to attend school for 3.8 years. (Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, 2012; Global Alliance for Clean Cookstoves (United Nations Foundations), 2014; UNICEF, 2009; United States Government Central Intelligence Agency, 2012). These statistics are staggering, placing the DRC as the second lowest ranking country on the Human Development Index (United Nations Development Programme (UNDP), 2013).

Both development and democracy have been slow to take hold in the DR Congo since independence from Belgium in 1960, with corruption and conflict escalating to and taking on genocidal tendencies. While poverty and underdevelopment were significant legacies of the colonial regime, described as “brutal” even under moderate historical accounts (American University, 2014; Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, 2012; LaCapra, 1997; Stearns, 2011), these have since been exacerbated by ethnic hatred, cross-border tensions, and civil war. Political and economic instability, corrupt governance, and guerrilla tensions create cycles where progress is slow, subject to inconsistent bureaucracy, and improbable.
As noted earlier (see Table 3), naming the DR Congo’s conflict as a genocide has also been controversial: a 2010 United Nations mapping cited characteristics of genocide (Office of the High Commissioner for Human Rights (OHCHR), United Nations, 1996-2012), but reversed the decision to officially declare genocide shortly after. Human rights advocates have criticised the UN decision / lack of action in the DR Congo, citing an unfulfilled Responsibility To Protect / R2P (United Nations General Assembly, 1948) on the part of the international community. These tensions compound psychological legacies from colonialism where the colonised feel relegated to lower-class rungs of citizenship, except this time on the global stage (Shamsuddin, 2009, February 25; Short, 2005).

Most relief efforts in the DRC (both international and national) remain invested in microfinance and economic development, though much attention has also been given to reconciliation and population health initiatives. Significant problems exist due to conflict losses and mechanisms used in tools of war: while children consist of 19% of the country’s population, they account for 47% of war casualties, and with one rape every 30 seconds, the DR Congo ranks as the rape capital of the world (BBC News, 28 April 2010). Reconciliation cells, the primary location for community health and psychosocial support initiatives, have seen moderate success in family reunification efforts – a 2011 poll showed that 43% of males believed that if a woman is raped, she should be rejected (down from 67% in 2004); however the general societal norm is still such that if a male were to be raped, he would not report or admit it, else expect to be killed (Slegh, Barker, Ruratotoye, & and Shand, 2012).

The number of people in the DRC who have died from the ongoing genocide is estimated at 5.8 million, or 1 person out of every 59. These 5.8 million comprise what’s been called

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9 Given that the average family in the DRC consists of six people and that the average household consists of at least two families (Global Alliance for Clean Cookstoves (United Nations Foundations),
Africa’s World War, the world’s deadliest war since WWII. Not all deaths have been documented, and the war is ongoing. Yet few areas in the world actually speak of it, and even its survivors call it “The Silent War” (Human Rights Watch, last retrieved 21 April, 2011; Office of the High Commissioner for Human Rights (OHCHR), United Nations, 1996-2012). Recent trends are likely to lead to an increase in these stats. From my field notes (Madan, 2011a) Kinshasa, November 1):

*Arrive*é\(^{10}\) in Kinshasa. My assignments here are threefold: Working in peace cells with women and children who have been affected by political violence and genocide, helping tutor children who have had interruptions in schooling, and observing the national (Nov. 28, 2011) election. Accommodations are modest, but they are still quite luxurious compared to Kivu. We have a water pump on-site, the toilet operates on flush, and our kitchen stove has cover so it may still be operational when it rains. There is a local market within walking distance, but the produce cannot be brought in fresh. It is a local custom to divide tomatoes into quarters, as whole ones are too expensive to buy.

Legacies of colonial governance, political volatility, and conflict have ravaged this country’s landscapes. You see it exploited in every infrastructure, and tested the most faithful of souls. There are many obstacles: a sourced-out, impoverished earth; education which is neither public nor free; a government built on privilege, run largely on corruption and fear; and generations of war, instability, and extinguished dreams … The value of life in Bumbu [our borough; known for its overcrowding, low resources, and chronic unemployment] can carry an unexceptional and inadequate currency. That questions any health intervention.

Even so, we’ve seen more instances of hardship than we’ve heard.

---

\(^{10}\) “Arrived” (trans.)
State actions which have perpetuated Congolese injury
(What makes violence in the DR Congo state-sanctioned?)

Mass exodus from Rwanda during the course of the Rwandan genocide placed a spotlight on the eastern DR Congo, where cross-border skirmishes, manifestations of ethnic hatred, and over twenty armed groups\textsuperscript{11} fought for control of resources and regional leadership. Consequences have been alarming: while children account for 19% of the DR Congo’s population, they comprise 47% of casualties, and a further additional 3.3 million people died from preventable communicable disease (malaria, diarrhoea and pneumonia) and malnutrition (Heal Africa, 2014; MSF, 2014; UNICEF, 2009). These numbers make the entire death toll from the DRC’s genocide to an alarming total of 9.1 million, more than any other country or single national group since WW2. Political will has exacerbated pre-existing conditions of poverty and low resource availability by refusing or excluding access of some tribes to water, food, medication, health care, stable education programs, and opportunities to lead.

\textsuperscript{11} including rebels, guerrilla, and government-funded factions, as well as nine independent African nations.
Various bodies of analysis have pointed the DR Congo’s societal inequities as stemming from Belgian colonisation, where various groups were deemed more worthy of privilege by proximity to the noble colonial birthright. While the Rwandan genocide (and residual French colonial tensions) have diluted purely post-colonial regime dynamics, some suggest governance in the DR Congo is still a closed hierarchal set which has been internalised and reproduced as a form of social oppression and political control (Arnold, 2006; Miller & Miller, 2004; Stearns, 2011; Strozier, 1995). These constraints on group mobility and life opportunity, while unlegislated, are ingrained in present systems of governance to the point where people perceive no future vision for the country’s leadership independent of exploitation of power (Arnold, 2006; BBC News, 28 April 2010; Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, 2012; Heal Africa, 2014; Stearns, 2011).

Further, aid deliveries and remittances face delays, re-routings, and outright losses due to an inflexible governmental hierarchy that limits rapid or wide-scale response. In each instance, both national and provincial leadership have citing variable perceptions of need, in addition to mistrust of foreign assistance as being a form of third-wave colonialism where favouritism for particular tribes will continue (American University, 2014; Heal Africa, 2014; Hogg, 2002;
Miller & Miller, 2004). Further, relief operations are generally limited to clearance for uniquely urban centres, where access to care is prohibitively expensive, and far from the acute majority of affected populations (MSF, 2014; UNICEF, 2009).

**Further complexities from humanitarian aid**

Not only does humanitarian aid in general bring up philosophical questions of agency, sustainability, and dependency, but in the instance of the DR Congo, aid evolved to bring more harm than good. Two arguments were used as case examples: First, people in the DR Congo watched as their communités suffered more losses, for a longer duration, and took more children than the war in Rwanda, and they watched similarly as their youth were recruited in greater numbers to become soldiers than in Uganda; both neighbouring countries, and not without their own difficulties, yet the DR Congo received none of their international attention, funding, or publicity. Second, humanitarian aid delivery evolved to inadvertently sustain and politically align brutalities (Terry, 2002; UN Department of Peacekeeping Operations, 1996). *Médecins sans frontières / Doctors Without Borders* have acknowledged with regret their lessons learnt from efforts on the eastern borders of the DR Congo: Groups arriving to relief camps with social orders and hierarchies intact were at first considered a humanitarian worker’s dream, where supplies could be distributed according to natural social avenues, and taken up directly by displaced families; however, workers later discovered with horror that those receiving and gatekeeping supplies were Tutsi-affiliated, hoarding distribution kits and at times making rounds to rob or rape kits from non-Tutsi villages and displaced Hutus. These actions in fact strengthened beneficiaries of aid with means to continue their intent of sustaining genocidal tendencies (see (Anderson, 1999; Magone, Neuman, & Weissman, 2011; Orbinski, 2008; UN Department of Peacekeeping Operations, 1996), far from what had been originally intended.
Such realities add layers of complexity under which services / implementation of aid now must navigate, and in some instances obfuscate international service providers from holding any neutral impartiality.

**REVIEWING MENTAL HEALTH APPROACHES TO TREATMENT**

As discussed, however “imprecise” (Summerfield, 2001c: 97) PTSD is as diagnosis, it is still the current, standard diagnosis for distress and injury due to war. Theoretical and empirical support determining treatment effectiveness for PTSD is still emerging. While some alternative and group-oriented modalities have been seen to yield potential to alleviate symptoms, (documented) modalities of focus rest with individual pharmaceutical, psychological, and psychosocial approaches.

Increasing numbers of migrants affected by state-sanctioned violence are being referred to institutions for PTSD treatment but effectiveness of services is largely undocumented (Beiser, 2005; Canadian Centre for Victims of Torture, 2009, Winter; Immigration and Refugee Board of Canada, 2004). In most treatment settings, the drop-out rate / loss of participation in follow-up is high, and distress presented at referral is still just as high upon termination (Diallo & Lafrenière, 2006). The *Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees* writes:

Thirty per cent of the people seen at mental health clinics drop out after the first interview; the corresponding figure for ethnic minorities is 50 per cent. The most common complaint is that mental health therapists do not provide culturally and linguistically appropriate treatment. Victims of persecution and torture are suspicious and hypersensitive to rejection … shattering as the statistics gathered [for victims of genocide in Canada] are, they likely are substantial underestimates. The Task Force recommends research to delineate the psychological consequences of torture and to develop effective treatment modalities for

Retrieving the literature

A first step to understanding how Canadian services could be improved for survivors of political violence was to find out the state of current treatment models in Canada. A literature review was thus conducted, focussing on current interventions for migrants affected by genocide / areas of UNHCR concern, asking the following questions: Who’s being treated?; What’s being done in treatment?; What’s working well?; Where are the gaps?; and, What could be done better?.

For the reader’s convenience (as individual steps of the review process were fairly technical and not related to the overall body of this work), Appendix B lists the consulted search engines, which extended to research, policy, and treatment-oriented sources, as well as subsequent key words and ranking methods. This section will focus on the summary of treatment commonalities and implications of best practises, rather than detail the empirical search process. In sum, ten sources comprised the literature review: two intervention manuals, two research summaries of intervention approaches, and six agencies providing source information about their interventions through personal correspondence. Of these, three were facilitated at community agencies, two were child-specific, two were verbal interview summaries, two were intervention training manuals, and one was a randomised controlled study.
Findings in current approaches to treatment

A summary of characteristics found across all the treatment sources is more clearly delineated in Table 4. Salient points include:

- Intervention effectiveness can be difficult to determine. What works for one population’s experience may not extend to another’s. Similarly, a study ranking high methodologically (according to the QAT) did not necessarily yield effective or predictable outcome.

- Group intervention where ethnic identity, national identity, or country of origin was criteria for membership did not necessarily yield decrease of symptomologies such as depression (Persson & Rousseau, 2009).

- While elementary school-based interventions are sound in methodological design (see (The AGREE Collaboration, 2001): guidelines are thought to predict intended outcome) there is “paucity” (Persson & Rousseau, 2009 : 88, 98) of evidence to suggest such interventions are effective. In some instances, school-based interventions were found to exacerbate symptoms, create new ones, or foster additional intergroup conflict.

- Few national programmes have been developed to highlight the mental health needs following state-sponsored violence; further, those that exist have been almost exclusively developed in high-income countries (Persson & Rousseau, 2009).

- Reconceptualising notions of trauma to include more culture-specific contexts is especially needed in instances of state-sponsored violence. Three of the four community agencies (Docherty, 2011, 28 April; Mossallanejad, 2011, March; Mossallanejad, 2011, March; Thomas, 2011, March) noted institutional philosophies that traditional psychotherapy can exacerbate feelings or perceptions rooted in socio-political tension.

- All four community agencies considered the group level as primary focus of intervention. As such, programming included support for community networking, employment
assistance, English-language learning, family education, recreational activities, and settlement. The Canadian Centre for Victims of Torture (CCVT) also incorporates programs in legal outreach and education.

- The CCVT advocates programming fostering community links, partnership through peer relationships, and restructuring of the traditional psychotherapy frame. Interventions based at the group and community level, with links to education, settlement, and church or mosque networks were reported to be the most well-attended and meaningful for clients (Mossallanejad, 2011).

Spirituality is a very important consideration of healing for people affected by protracted conflict and state-sponsored violence, especially in instances of African genocide where (a) rituals of burial are interrupted; (b) faith in church, community, and identity are often intertwined. (Diallo & Lafrenière, 2006)

- Interventions consisting of family activities had the lowest rates of attrition (Docherty, 2011; Mossallanejad, 2011).

- Low attrition rates were also found for intervention programmes where the clinical framework was modified to include community support (for example, providing food, assisting with transport, meeting at a building established in and for community) (Doherty, 2011; Diallo & Lafrenière, 2006).

- Narrative Exposure Therapy (NET) (Schauer, Neuner, & Elbert, 2005) was found promising for PTSD and depression (Schaal, Elbert, & Neuner, 2009). Symptom improvements of up to 46% were sustained at nine months after NET treatment in comparison to control groups who received interpersonal therapy.
<table>
<thead>
<tr>
<th>QAT rank</th>
<th>Authors</th>
<th>Description of intervention</th>
<th>Study design</th>
<th>Sample</th>
<th>Age</th>
<th>Setting</th>
<th>Country of origin</th>
<th>Average time since conflict</th>
<th>Modalities</th>
<th>% Attrition</th>
<th>Outcome</th>
<th>% Recidivism</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ruf et al. 2010 (Germany)</td>
<td>Program: 8 sessions</td>
<td>Randomised controlled</td>
<td>26</td>
<td>6-18</td>
<td>Outpatient clinic (Public)</td>
<td>Rwanda</td>
<td>NS</td>
<td>NET</td>
<td>4</td>
<td>sx 60%</td>
<td>N=1</td>
</tr>
<tr>
<td>2</td>
<td>CCVT 2010 (Toronto)</td>
<td>Direct service</td>
<td>Cohort</td>
<td>2418</td>
<td>All</td>
<td>Community agency</td>
<td>Various</td>
<td>&lt;3 months and after</td>
<td>Advocacy Education Pharmaceutical Psychological Social Spiritual</td>
<td>10</td>
<td>Variable sx</td>
<td>5%</td>
</tr>
<tr>
<td>3</td>
<td>RIVO 2009 (Montréal)</td>
<td>Service network</td>
<td>Cohort</td>
<td>612</td>
<td>All</td>
<td>Community agency</td>
<td>Various</td>
<td>&lt;3 months and after</td>
<td>Pharmaceutical Psychological Social Spiritual</td>
<td>14</td>
<td>Variable sx</td>
<td>NS</td>
</tr>
<tr>
<td>4</td>
<td>VAST 2010 (Vancouver)</td>
<td>Service network</td>
<td>Cohort</td>
<td>209</td>
<td>All</td>
<td>Community agency</td>
<td>Various</td>
<td>&lt;3 months and after</td>
<td>Educational Psychological Social</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>5</td>
<td>Diallo &amp; Lafrenière 2005 (Franco-Ontario)</td>
<td>Review of programs</td>
<td>Purposive sampling</td>
<td>12</td>
<td>NS</td>
<td>Community agencies: Francophone</td>
<td>W. Africa</td>
<td>&lt;3 months and after</td>
<td>Pharmaceutical Social</td>
<td>NA</td>
<td>NA</td>
<td>NR</td>
</tr>
<tr>
<td>6</td>
<td>Diallo &amp; Lafrenière 2005 (Franco-Ontario)</td>
<td>Interviews</td>
<td>Purposive sampling</td>
<td>60</td>
<td>All</td>
<td>Community agencies: Francophone</td>
<td>W. Africa Lebanon</td>
<td>&lt;3 months and after</td>
<td>Pharmaceutical Social</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>7</td>
<td>Revell 2001 (Canada-wide)</td>
<td>Program: 12 sessions</td>
<td>Cluster</td>
<td>6</td>
<td>4-7</td>
<td>Community agency</td>
<td>NS</td>
<td>≤1 year</td>
<td>Arts-based Educational Psychological</td>
<td>NS</td>
<td>NS</td>
<td>NR</td>
</tr>
<tr>
<td>8</td>
<td>Persson &amp; Rousseau 2009 (Montréal)</td>
<td>Review of programs</td>
<td>Cluster</td>
<td>7</td>
<td>6-18</td>
<td>Schools</td>
<td>Kosovo; Sierra Leone; Gaza Strip</td>
<td>Various</td>
<td>Arts-based Educational Psychological Social</td>
<td>Various</td>
<td>Various</td>
<td>Various</td>
</tr>
<tr>
<td>9</td>
<td>Traumatology Institute 2010 (Toronto)</td>
<td>Program: 12 sessions / Various</td>
<td>Case study</td>
<td>NS</td>
<td>&gt;18</td>
<td>Outpatient clinic (Private)</td>
<td>Various</td>
<td>≥1 year</td>
<td>Psychological (TF-CBT)</td>
<td>NS</td>
<td>sx 80%</td>
<td>NS</td>
</tr>
</tbody>
</table>

NA = not applicable; NR = not reported; NS = not specified
• EMDR\textsuperscript{12} and TF-CBT\textsuperscript{13} may be helpful in managing flashbacks (Trauma Institute), according to one source. However other sources (and indeed, the psychiatric literature) did not have proof of any efficacy for these treatment methods.

• TF-CBT has limited applications with children (see (Persson & & Rousseau, 2009; Schaal et al., 2009).

Findings from the literature acknowledged the difficulty to generalise gold standard treatment practises for people affected by state-sanctioned violence. Looking at the methodologies of individual studies, controlled trial studies in Canada simply did not exist to draw robust references from, and it is likely that populations will not reach sufficient sample sizes for a randomised study to be conducted in the future. Cohort studies may be the next best acceptable method in moving forward to evaluate effectiveness, because they offer active intervention to all, but do not lend strong evidence of efficacy (Higgins & and Green, 2011 (March)).

How the literature informs the present work: Salient themes.

Four salient themes informing trauma treatment recommendations emerged from review. In general, traumatic stress treatment was most effective when designed with social, spiritual, and participatory community supports. While sources did not speak

\textsuperscript{12} Eye Movement and Desensitization and Reprocessing. See (Shapiro, 1989). This intervention however is highly contested as having therapeutic value within the psychiatric literature.

\textsuperscript{13} Trauma-Focused Cognitive Behavioural Therapy. See (Cohen, Mannarino, & and Deblinger, 2006).
specifically to the improvement of services for Congolese migrants, as an overview of recommendations for refugee health, the following lessons summarise key lessons from researchers and clinicians in the field:

1 - **Prioritising what’s most helpful is a social endeavour.**

Sources in review all agreed that defining measures of response can help direct (or operationalise) available resources, but the act holds social and political tensions (see (Lubek, 2000; Moncrieff, 2010; Summerfield, 2008b; Timimi, 2011) congruent with Summerfield’s (2002: 1107) questioning, “Whose interpretations of the world will count at this critical moment?” – In other words, who decides what constitutes traumatic response, and conversely, who decides what constitutes trauma? Which systems and populations are consulted and which are excluded during service delivery? What (economic, political, social, spiritual) affiliations are represented in each allocated resource or response? Who decides which response is most legitimate?

Describing and defining effective outcomes for war trauma is difficult to determine. While socio-political nuances are starting to be more fully documented and understood, neither contexts nor populations are homogenous. What ‘recovery’ might ideally look like will depend on context and culture, and even the definition of success as an outcome is perceived and valued differently. All service providers in this review advocated asking the person seeking services: What interventions are desired? What does participation in an intervention mean? Is retention at a service even a desired outcome? The success of an intervention was found to be questioned on both clinical sides, serving to centre open-ended questions so that services could be better oriented for delivery in
client-centred ways. Especially considering the limited knowledge / generalised assumptions about populations affected by war (see (Munshi et al., 2010)) more explanatory questions were advocated to help design effective treatment planning.

2 – Considerations of context are key. They construct the trauma.

Treatment plans varied across sources. What was found to be effective with one war-affected group of people, in one city, at one clinic, did not translate to other treatment settings. The literature confirmed previous writings advocating that as psychological assessments were not designed to assess political violence, mass torture, or collective loss in childhood, it cannot ‘[make] sense’ (Summerfield, 2005):6) to use these tools without adaptation. Sources further indicated that greater consideration should be taken during assessments to permit political or social factors to be (empirically or otherwise, or which have acted as precursors) associated with lived experience as the norm.

Considering context a bit further, particularities coinciding with other events cannot assume shared implications. For example, rape as an act occurs almost universally in contexts of war, but the implications (and consequences) of rape in war are not universal (refer to section ‘State-sanctioned violence and mental health ’). Traditional therapies have only recently differentiated or recognised a revised psychology of the rape perpetrator in genocidal contexts (MacKinnon, 2011). This may both reflect or be reflective of psychotherapy’s origins from within individualistic and medicalised paradigms (see (Persson & Rousseau, 2009))
3 – There is a difference between mental health and mental illness.

Serious traumatic events do not necessarily develop psychopathology. While survivors of state-sponsored violence are referred to treat depression more than other victims of trauma (Immigration and Refugee Board of Canada, 2004; Immigration and Refugee Board of Canada, 2006), there could be other relevant indicators or precursors of distress which are not being adequately considered. Equally relevant but unknown which would help alleviate distress are pathways of community and / or personal support not available or integrated into models of treatment.

Mental health (whether a person languishes or finds flourish) is not the same as mental illness (the absence or presence of a diagnosis). In instances of political violence, mental health difficulties, including traumatic stress, may not in fact signal maladaptation or a generalised state of decline. Traumatology and symptomatic checklists posit an unduly individualistic and psychologically deficient response to a socially mediated experience, and that the person ‘infected’ should get better as if one would over the course of any other kind of illness. There are tensions in classifying aftereffects of political violence absent of, or disassociated from, ecological contexts and social states of being. Writes (Summerfield, 2002a:1106):

Ultimately, it is the economic, educational and socio-cultural rebuilding of worlds, allied to basic questions of equity and justice, which above all will determine the long-term well-being of [survivors of war] ... For those for whom this does not happen, war may indeed turn out to have been a life sentence, but this is not 'trauma'.

Thus, while the diagnostic framework and reasons for referral in the case of war trauma may focus on a set of particular behaviours in a particular individual, there are a
myriad of very relevant external, social factors. To ignore the impact of these has potential to perpetuate trauma, instead of alleviate it.

4 - Community links build social and political capital, and are the gateway to ‘feeling better’.

For refugee communities, communal wounds often orient a communal response. Similarly, wounds suffered in the collective were perceived to be best mitigated at the group level. One particularly successful group program in this review was found at the Canadian Centre for Victims of Torture (CCVT), called Befriending, focussing on peer relationships and community integration. The program sought and sustained community connections for participants, increased social capital by enlisting participants to help others at the Centre, and subverted traditionally top-down power dynamics in clinical relationship by co-creating the groups and supports which were perceived to be most helpful.

Because ‘helping’ relationships outside of family or community are often foreign to a client’s social order (Diallo & Lafrenière, 2006; Mossallanajed, 2005), traditional clinical relationships may shame individuals already feeling helpless in a new country and without status to provide (Bagilishya, 2000). Within refugee communities, those identified as ‘helpers’ in the community are often perceived to hold higher status. For someone where the social order would dictate ‘help’ to be sought from an elder, the act of ‘therapeutic support’ from a medical professional may not be considered culturally appropriate or even desirable. Clients should be “given a chance to become psychosocially, economically and legally independent” (Aryee for Kidd, 2010: 23), while
still being able to feel connected and contribute to community. Especially for those whom may have been or feel exiled from former states of ‘home’, and where world views are communal, such reciprocity is ‘crucial’ (Bagilishya, 2000): 342).

Summary of points of contribution from the literature

Trauma services in the literature reflected an underrepresentation considering geopolitical and social influences on mental health and overall psychosocial well-being. However, ‘[t]his field of practice has clear political dimensions’ (Bowles, 2001); and especially for people who have survived state-sanctioned violence, or for refugees who in many instances have been actively politically engaged in their countries, resolving socio-political tensions are significant concerns. Collaboration between academic and community resources have the potential to foster ways to increase knowledge leading to advocacy for this area, both for robust or accurate application to treatment models and for maximum effectiveness in service delivery. Establishing greater community-based partnerships may also provide training opportunities in mental health education and frontline workers (teachers, settlement and social workers, police and law enforcement officials) who may be the first people dealing with symptomologies reflective of trauma. Effective intervention is possible, and there is need; but these will require greater opportunity for clients to contribute, participate, and rebuild as active citizens, with reciprocal attention given to them by their newly chosen host communities. Access to participatory citizenship and community links (at least philosophically) were determined be most effective in mitigating psychological distress from state-sanctioned injury.
Point of departure for present enquiry.

Greater contextual analysis is supported within the literature to improve treatment outcomes. While the “narrow” or “imprecise” (Vasilevska & Simich, 2010: 38; Summerfield, 2001c: 197) nature of PTSD as diagnostic category may not be contested, the constructs of social and political realities, indeed war, differs between countries and across time. From a clinical perspective, decrease in symptomology for conditions such as depression may be one salient way in measuring effective treatment outcome; however, from a client’s perspective, ‘healing’ may not extend to a feeling like sadness at all. What ‘healing’ looks like (or feels like, or what is required to achieve it) is not clearly defined within or across sources, and so became the most relevant and central starting point to my study.

Similarly, all study sources in the literature review suggested that changes must be discerned at family and group (collective) levels, and ideally in contexts of prevention and not after treatment or referral. Thus, considerations extending to group- and family-level treatment orientation comprised the second major element needing elucidation within my enquiry. This notion also reinforced and seemed to support the theoretical components of Befriending (CCVT) and ideologies at play within an anti-racism model.

Third, community-oriented treatment models looked at issues related to spiritual and ecological well-being and relatedness, in addition to feeling relief from psychological symptoms. While each of the nine reviewed sources indicated moderate success employing non-verbal modalities, such as metaphor, storytelling, and art, there is an insufficient evidence base to demonstrate these modalities’ effectiveness, if any. The same is largely true for psychological interventions such as TF-CBT and EMDR, the
latter of which is highly controversial but still largely employed in private settings (REF; Summerfied REF). Providing evidence on the comparative effectiveness, format of treatment, and specific applications would benefit from future research. This was determined to be outside of the scope of my enquiry.
PART TWO: THE PRESENT STUDY

THEORETICAL FRAMEWORK

Anti-racist theory

Extracted themes within the literature and within my own clinical practise in the chapter just described highlighted an underrepresentation of minoritised voice in traditional mental health paradigms. As a minoritised body myself, in starting this doctoral journey I felt drawn to authors whose names or experiences resonated with mine (and there were but a few: see (Haroon, 20 July, 2013; Loomba, 2005; Spivak, 1988), in addition to those whose narratives could speak for Nteza’s (Dillard, 2008; hooks, 2000; C. C. Williams & Chau, 2007). The politics of racial identity, feelings about a colonised body’s inheritance, and perspectives of race / culture in therapy have been key points of address in anti-racist philosophies (Cesaire, A. (J. Pinkham, trans.), 1972/2000; Dei, G., & Kempf, A., 2006; Fanon, 1952; Fanon, 1961; Fanon, 1967; Roger, 2000; C. C. Williams & Chau, 2007). In these writings, whiteness is decentralised so that diverse or divergent perspectives are not ‘marginal’.

Decentralising whiteness permits multidimensionality in the consideration of ‘other’ ethnicities. Anti-racism rejects the multicultural approach which overwhelmingly focuses on the celebration of “difference” without challenging white privilege and power (Access Alliance, 2014; Agoro, 2003; Ng et al., 1995; Reitz, J.G. & Banerjee, R., 2007; C. C. Williams, 2010). In this way, anti-racist thought provides framework for space and analysis elucidating feelings encountering (and counter to) ideological hegemony. The
legacies of black/white power inequities, complicated by the whiteness of psychotherapy, compelled me to feel the following reflections were quite applicable:

Therapy is a social process. It therefore constitutes a location in which the larger society’s dynamics are inevitably present within the attitudes, concerns, beliefs and behaviours of both participants in the interaction … ‘Whiteness’ operates through counsellors and their theories and practices in a manner that has potential[ly] significant impact upon therapeutic outcomes – yet which is often outside of awareness and beyond conscious control. Whiteness is neither neutral (an idea frequently postulated) nor an absence of ‘something’. It has strong, all-pervading, determining and frequently harmful effects … Substantial change will not occur until such time as the White majority group members in society fully recognize and appreciate the conditions and circumstances created for others by their present way of being. Without attention to these ethnic inter and intra group phenomena in society and within self, therapists are in danger of repeating these discriminatory patterns. (Agoro, 2003; Lago & Haugh, 2006) (29, and 200-202, respectively).

Considerations of socio-political context, ancestral inheritance, racial identity, and conceptualisations of trauma seemed of primary importance within which to ground this enquiry. Five themes were considered as foundational ones to undertake / learn more about: (a) the life-fields of the individuals engaged; (b) transversal connections between theoretical paradigms and narrated lived experience; (c) power relationships (in particular how race, citizenship, and illness are constructed within geopolitical dimensions); (d) states and (dis)locations of life-experience, and how these are expressed within the body, mind, and spirit; and, (e) what participants express are their hopes and feelings.
Anti-racist feminism

As a woman of colour whose own voice will be integrated throughout, my theoretical framework would make sense to include feminist and subaltern philosophies (Crenshaw, 1995; Loomba, 2005). As point of departure, anti-racist feminist theory holds three key assumptions: (a) That race and gender are articulated constructions, and therefore have accumulated tangible institutional and social consequences; (b) These consequences can be considered oppressive, or at the very least, unequal to spaces allocated to and legitimising patriarchal voices; and, (c) While experience is not generalisable between minoritised groups, spaces of alliance are both possible and necessary to subvert the dominant power paradigms of the oppression (G. Dei & Johal, 2005; Dillard, 2008; Ng et al., 1995; Razack, 2000; C. C. Williams & Chau, 2007). As I seek to extrapolate voices which include black, racialised, African women (and women who have likely lived through brutal experiences of war which include systematic rape) (BBC News, 28 April 2010; Wolfe, L. for Women Under Seige, 2013 (Oct. 18)), all of the assumptions upon which anti-racist feminist theories build are relevant. Writes Ingrid Waldron (Waldron, 2010), an occupational therapist at Dalhousie University:

African participants [in treatment] conceptualize mental illness using alternative labels and evaluations of how mental illness should be resolved. [But] the epistemological terrain upon which both indigenous and Western health professionals traverse is not level, resulting in a hierarchy of knowledge, as well as superficial dichotomies between the indigenous and Western health approaches that obscure opportunities for alliances at the epistemological crossroads … [O]ppORTunities for syncretism between both health systems need to continue to develop and evolve … [away from] the established power, hegemony and status of Western medicine which reproduce[es] and sustain[s] hierarchies of knowledge that position indigenous health
knowledges (and in particular African health knowledge) on the lowest rung. (pp. 52, 53, 57, respectively)

Anti-racist feminist theory describes intersections between gender, race, and poverty, with special attention to social capital and social difference (Calliste & Dei, 2000; G. Dei & Johal, 2005). Such analysis permits reflections for allied connectedness (Razack, 2000) for both myself and the women who might share their stories in this work. Allied perspectives and collaborations are necessary to take up discussions of systems transformation wherein racialised bodies have felt psychological injury (Dillard, 2008; Mathews, Ng, Patton, Waschuk, & Wong, 2008; K. McKenzie & Bhui, 2007b; Ng et al., 1995; C. C. Williams, 2001b). (C. C. Williams & Chau, 2007) reflect upon the need for unified feminist voices, despite racial differences, from an anti-racist perspective:

Anne Anlin Cheng (2001) asserts that racial separation has resulted in a melancholia that is threaded through the individual and collective psyches of those on both sides of the racial divide. Feminism may seem to be the ground upon which we can all heal the wounds that racial domination has created. Therefore, for both political and personal reasons, we reach out to each other for sisterhood … feminism transformed by anti-racism needs to centre the heterogeneous experiences and consciousness of racism as it is experienced and perpetuated by all women. (286)

**Links to literature about the Aboriginal context in Canada**

Discourse of indigenous and First Nations’ experience in Canada resonate with psychic and spiritual injury referenced in (Afrocentric) anti-racist literature. Literature within the First Nations context advocates various ill health effects caused by social
structures and processes controlled by various forms of governance – these include access to healthcare, education, stripped economic opportunity, and the legacy of residential schooling. Further, an Aboriginal population in everyday Canadian consciousness is often synonymous with social endemics, or social stigma\textsuperscript{14}. Information on mental illness among Aboriginal populations vary, but depression, complex PTSD, and alcoholism present as prevalent (REF).

Aboriginal discourse further supports anti-racist notions of coloniality. The National Aboriginal Health Organization (2001) draws a critical link between health conditions of First Nations communities, current legislation and political discourse, and the legacy of settler-colonialism:

Racism is one of the characteristics of colonization and as such it has a negative influence on how Indigenous peoples are positioned in Canadian society. ‘Because they have endured rather invisible and long-term oppression and discrimination, they have fared worse in economic, political, cultural and social terms’ (p. 13). Racism fuelled the disenfranchising, assimilationist and genocidal tactics; as well as the amnesia of this detailed history and how it has produced intergenerational impacts, compels us to question if racism as a motivator has ever dissipated. Thus, it is through the mentalities that perpetuate and reproduce these incidents and the continuation of certain policies that we see how settlers have gained illusionary freedom assuming colonialism is a finished project …

\textsuperscript{14}The incarceration rate of Aboriginals is 5 times higher than the national average; 39\% of Aboriginal adults report domestic and family violence problems; 15\% of females under 18 have reported being a victim of rape, more than three times the national average; Aboriginal women are four times more likely to be murdered than non-Aboriginal women; and about 4\% of Aboriginal children are in custody of the Child and Family Service agencies (see the \textit{Health Inequalities and Social Determinants of Aboriginal Peoples’ Health} [National Collaboration Centre for Aboriginal Health, 2009]).
Indeed, borrowing from Anne McClintock’s The Angel of Progress (1990), this "premature celebration of the pastness of colonialism, runs the risk of obscuring the continuities and discontinuities of colonial and imperial power" (p. 88). The term ‘post-colonial’ also encourages a settler description of time and interpretation of history. This perception prioritizes European historiography and a perhaps hasty desire to put uncomfortable stories behind us (Sch.“N”; St. Denis, 2009). This dichotomy of colonial and post-colonial ‘[then] may be in danger of neutralizing historical inequalities’ (Miyawaki, 2004) and emphasizes a sometimes inappropriate vocalization of relations that does not necessarily reflect the lived realities of contemporary Indigenous peoples and the state.

Being aware of health conditions and the perception of social realities for the Aboriginal (in comparison with the Black [my study participants] and subaltern [myself]) may help locate the construction of “difference” identified by anti-racist and anti-racist-feminist discourse.

**Ethnography: Situating myself and my assumptions within the work**

Anti-racist and anti-racist-feminist theories posit relevant points of analysis for my enquiry, not only simply it speaks closest to the lived experiences (or what I project are lived experiences) of participants in my study, but also because within such framework, my ethnographic reflections have place in relation to the people this work impacts. Discussions will thus also be supplemented by ethnography (reflexivity). At times as I undertook this work, describing encounter and relationships with study-subjects have been essential to contextualise historical and socio-political analyses. Ethnography legitimises my point of entry, providing further ground of analysis to include relational perspectives. My experience with Nteza and in the DR Congo have
refined how I project and perceive my positionalities with Congolese clients. I reiterate those reflections here, as they informed preparation for undertaking this enquiry with all the research participants:

Nteza came regularly to therapy throughout the pregnancy. I reflected that perhaps I was not the most ideal source of support: I was a stranger in a strange land; my privilege cast me unable to identify, really, with her struggles on a day-to-day basis; and however likeable our rapport, my [youth and unmarried] status cast me more like a sister than an elder helper. The constructs of my office, with all its care about ‘confidentiality’ and ‘professionalism’, offered no pride to her. But I recognised that I was, despite all of these things, a woman; that was enough to give me privileged access.

With emphasis on interaction, engagement, and ways in which people create their social worlds (Kleinman & Benson, 2006), an ethnographic approach inherently permits reflexivity to discuss relationship dynamics, including social differences and constructs of power (Baker, 1978; Calliste & Dei, 2000; Onwuegbuzie, A. J., & Leech, N. L., 2007). As traditional research has not historically served to benefit members of oppressed and marginalised groups, but in fact perpetuate and reinforce dominant paradigms (and sometimes to the detriment and harm of minority populations) (Dei, G., & Runneke, J. A., 2010; Department of Health, Education, & Welfare, 1979; Ng et al., 1995; Rossman & Rallis, 2003), it has been essential for me to be conscious of my actions and writings as they (re)present (Levinas, 1979) participants throughout the research process. Further, legacies of exploit and colonialism within the DRCongo’s history (see The DRC in context section) compound the necessity to “scrutinize the complex interplay of [my]
own personal biography, power and status, interactions with participants, and [the]
written word” (Rossman & Rallis, 2003) :93). From a field note:

Our team of foreigners sometimes gets stares – even though our neighbourhood has a
population equivalent to a third of Canada’s population in an area roughly the size of
greater Toronto, ethnic diversity is not common, and people often assume I’m
Chinese. This may be a product of a French colloquialism (kind of like how the
English phrase used to go “It’s all Greek to me”), but I’m also cognisant of the
emotion which accompanies. Obviously as an outsider to this culture, a certain
amount of “I don’t know you” is inherent; however here, given Chinese and Japanese
investments into hydro and water treatment plants within the past few years, there are
suspicions of these foreign investments as a third wave colonialism. Time has not
tested these relationships yet. But foreign investment has not been kind to the
Congolese, and there is no proof that these investments will be any different.

The act of witnessing as co-constructed experience

Romeo Dallaire has spoken publically and at length of his own PTSD sustained
from witnessing the Rwandan genocide, most notably in his autobiographical account
Shaking Hands with the Devil (Dallaire, 2003); see also (Manzer, 2000). Some scholars
have critiqued his accounts, suggesting the centeredness of his experience obfuscates the
lived realities of the Rwandans directly affected (see (Marchetti & Ransley, 2005;
Razack, 2004; Razack, 2007) . One scholar questions:

Believing ourselves to be citizens of a compassionate middle power who is largely
uninvolved in the brutalities of the world, we have relied on images [such as
Dallaire’s] to confirm our own humanitarian character. However, I suggest that our
witnessing of Rwandans’ pain has mostly served to dehumanize them further, and in
the process, to reinstall us as morally superior in relation to them. How does it
happen? Can it be otherwise? That is, how do we feel their pain and see their
humanity? Most of all, how do we recognize our own complicity and move through
outrage to responsibility? (Razack, 2007):376

This analysis suggests that individuals possessing humanitarian spirit would do well to interrogate their position (of privilege, and as an outsider), recognising their status, like Dallaire’s, as “an observer not of the landscape”, and motivated to act with a self-congratulatory “politics of rescue” (pp 380 and 381, respectively).

I echo some of these admonitions for increased self-reflexivity in movements contracting humanitarian endeavour, as relief initiatives have often been borne of civilisation missions and remnants of colonial judgment (Anderson, 1999; Leebaw et al., 2007; Orbinski, 2008). However I offer within this work that witnessing can be a differently located act, where bodies and professions may co-create and reciprocally author meanings of experience, including pain.¹⁵

One moment in Kinshasa has stayed with me, in my memory distilled of time and of place, and I carry it as a symbol of the inextricably shared but private space the act of witnessing holds.

It happened on a day we went to market. I wanted to buy whole tomatoes for our compound. I only slightly registered the presence of a political campaigner nearby, standing on a plastic overturned milk crate, speaking animatedly and quoting biblical passages about adversity. I did not pay much attention, as it was two weeks before the national election, and this kind of sighting was not unusual: in Kinshasa alone, a city with

¹⁵ Psychotherapy literature has coined the term ‘vicarious trauma’ which trauma workers often report experiencing when working with trauma survivors as clients in psychotherapy over time. This transference is based on notions of disrupted spiritual resilience, mechanised by prolonged, heightened, and intense periods of empathy (see (McCann & Pearlman, 1990, Staub & Vollhardt, 2008) .
a population of 10 million, 1280 candidates were registered, and the voting ballot was reported to be 42 pages.

As I handed over money for that bag of whole, perfectly ripe tomatoes, there came a careening of what sounded like / what I will remember as screeching tires; this followed by four loud, successive blasts. I remember a palpable silence following in my ears, despite the commotion my eyes could register. The sudden scattering of people in what seemed to be mass exodus directed my attention to the political campaigner, now lying crumpled and motionless on the ground. As our hosts grabbed my arm, the bag of tomatoes fell away from my grasp. I can recall the tomatoes rolling away on the ground vividly, and I wanted to reach out to reclaim them. But my eyes then held focus on a splat of red blood on the plastic bag I had just held. The bag swirled on the ground, intact but trampled, as people continued their scatter.

I stood there registering the scene for what felt like minutes but was likely not even a second, motionless in the surrounding scurry, until I was led away by my
accompanying host and colleagues. While our group included medical doctors and a surgeon, we did not respond or intervene.

What still strikes me in this memory is that I did not register any blood next to the man himself, or see his blank stare looking in my eyes. So in my mind socialised by media depictions and visual cultures of death, beyond the targeted act, I was shocked and saddened that the death actually happened. I don’t know to this day what happened to the man who was campaigning; our commune did not discuss what his fate had been, or who had been his enemy. “C’est mieux de ne rien savoir / it’s better not to know,” our host families would say. It was safer to have endured the incident as a random and anonymised memory.

But memory has stayed with me, palpable for a long time after I left Kinshasa. While I have not spoken of this moment publically, it has solidified for me the contextual solidarity of “what happens” when witnessing embodies and intersects with total empathy (L. J. Kirmayer, 2010; Mathews et al., 2008; Raphael, Stevens, & Dunsmore, 2006; Staub & Vollhardt, 2008). I relate this incident now to suggest that the notion of sharing landscape can be met, regardless of difference. As with Dallaire, rage is not the only mechanism whereby one can act responsibly.

Anti-racism as a service model

The service agency Access Alliance Multicultural Health and Community Services in Toronto serves immigrants to Toronto with the aim of improving health outcomes, by facilitating access to services and addressing systemic inequities. Access Alliance acknowledges that poorer health outcomes may be linked to race, ethnicity, creed, class,
gender, sexual orientation, gender orientation, and immigration status, and are systemic in Canadian society. It thus takes up anti-racist philosophy as a service framework, stating that a reflexive understanding of power relations is essential for healing and social change (Access Alliance, 2014):

In-depth anti-racism education goes beyond cultural sensitivity to include a critical analysis of power relations, personal values, beliefs and attitudes. Key components of anti-racism education would include acquiring an understanding of one's location and identity, relative power and privilege, as well as an awareness of what is racism, how racism manifests itself and what strategies are needed to deal with it. If agencies are to be truly able to offer services for different groups in society they need to understand the impact of oppression and racism on individuals. This is more than simply the need to develop services that do not inadvertently re-traumatise individuals or promote racism and oppression. The antiracism anti-oppression model aims to bring these issues front and centre when setting up services.

![Figure 3. Anti-Racism Framework Model at Access Alliance (Toronto, 2014).](#)

The assumptions inherent in anti-racist mental health work include the following key points (my own summary; see also (Access Alliance, 2014; Bhui et al., 2004; Dei, G., & Kempf, A., 2006; K. McKenzie & Bhui, 2007a; K. McKenzie & Bhui, 2007b; C.
C. Williams, 2001b): (a) that racism, or unequal relationships of power based on race, can manifest negative impacts on a person’s mental health and wellbeing; (b) racism is both an individually learnt and institutionally ingrained practise; (c) social change is possible, through unlearning individual perceptions and transforming institutions; (d) all members of community need to work reciprocally (it is a process of give-and-take) to redress the ill effects of racism; and, (e) healing / recovery is not achievable without systems transformation or education. **Figure 3** encapsulates the manner in which anti-racist intervention components link together at *Access Alliance*. Simply put, the philosophy at *Access* seeks individual recovery as part of systems which must actively reject the status quo creating racialised divisions.

*Access Alliance* does not purport that racism is a casual factor of all forms of mental stress or illness, but that racialisation is linked to poorer health and educational outcomes,

**Anti-colonial theory for systems change**

Given psychotherapy’s genesis in Eurocentric, patriarchal, enlightenment thought, anti-colonial theories are of significant relevance to this work. Literature suggests that in non-Western and low-income contexts where ‘therapy’ is introduced, groups have regarded the act as as a new colonial exploit (see(Blackwell, 2003; Summerfield, 2002b; Summerfield, 2004; Watters, 2010)and questioned interventions’ epistemological dominance. Joseph Gone, an aboriginal clinical psychologist, suggests that “acceptable forms of culturally competent psychotherapy will necessarily involve a substantive synthesis or integration of local healing traditions and conventional psychotherapeutic
practices” (Gone, 2010: 169). Anti-colonial thought would challenge the dominance of the current PTSD paradigm, thus legitimising space to equalise the bell curve of voices on the margins (Cesaire, A. (J. Pinkham, trans.), 1972/2000; Dei, G., & Kempf, A., 2006; Fanon, 1967) 16.

METHODOLOGY

Rationale for a qualitative approach

Design for this enquiry needed to accommodate open-ended responses to exploratory questions. I felt a qualitative process would permit the space needed for open-ended discussion, as well as build trust inherently required for potentially difficult

16 A note: Differentiating between post-colonial and anti-colonial theories / why I chose anti-colonial over postcolonial thought for this work. Postcolonial thought (specifically, the writings of Loomba, 2005, and Said, 1978, 1993) may be very relevant to this project, and to some degree I am more comfortable in / identify with this area intellectually. Further, post-colonialism does lend insight about inter-subjectivity and legitimise space for subaltern heterogeneity, which are key interests in my work. It was a lengthy and difficult decision to deflect focus away from the potential of postcolonial contributions. However, one of post-colonialism’s main constructs that colonialism is past, situating voice at levelled coexistence in conjunction with other voices. My work cannot assume levelled coexistence between groups and countries when it comes to speaking of the DRCongo.

Beyond the naming / locating of colonial injury, postcolonial theory also left a bit of a gap wherein to move beyond allocations, designations, and tension in fields – and there are many areas to reconcile: ecological, ideological, physical, social, and societal – where voices may exist and interact in reality. In sum, postcolonial theory focussed on what struggle looked like: how it is undertaken, and how (and where, why, and by whom) it is represented. It further posits that moving beyond injury is a struggle to re-claim power. While I do pay attention to these dynamics, and while struggle certainly may be relevant (see Findings on geopolitical tensions section), I seek and value emphasis on transformation, within a framework of reciprocity.

For the purposes of this study (and for the subjects whom I will engage in it), post-colonial assumptions may not be as relevant as anti-colonial ones. The following cannot yet be assumed of the DRCongo: (a) that colonial injury is past; (b) that subjectivities of status between refugees and other host systems (education, health, or immigration) coexist; or (c) that refugees are represented enough in current systems to express or make decisions relevant to the managing of their ‘care’. Because I seek an authentic as possible representation of voice (or set of voices) for the Congolese refugee experience, anti-colonial theory simply offers more possibility: to exploring resistance, in addition to struggle; at looking at subverting power, further to the transfer / transaction of sharing it; and in emphasising dislocations in voice, more than identifying voice location. These may perhaps lend stronger argument or reflection for the ‘voix de sans voix’ (‘voice of the voiceless’, as is said in the DRC).
and deeply personal subject matter. I additionally felt that the diagnostic criteria for traumatic stress and PTSD were already sufficiently orientated towards closed-answer response formats; which, even if familiar format to the participant, would likely be limited in contributing in-depth, unknown knowledge to the treatment paradigm. Most significantly to this study, however, was the justification that qualitative research “is indispensable for addressing structural health inequities affecting the less powerful” (Annecino, 2011). Clarence Tam, an epidemiologist with the London School of Health & Tropical Disease, similarly states that “health needs of migrants, although themselves important, are merely symptoms of deeper structural processes that are intrinsically linked to equity and human rights … [S]imply focussing on health issues will be insufficient to address these social pathologies” (2006:14).

As this study presupposed that narrative would facilitate greatest access to unknown dimensions of personal experience and/or opinion, a qualitative method seemed simply the most appropriate (Cohen & Crabtree, 2008; Elwood & Martin, 2000). Further, descriptive analysis required open-ended answers, to capture aspects or conceptualisations of illness using exploratory models. A qualitative framework also provided enquiry into perceptions of symptoms as deficits, meanings of illness, with also the space to permit more mutually defined relationships or ways of interrelating that were flexible, or at least not unyielding in disciplinary power (Elwood & Martin, 2000; Foucault, 2003; Onwuegbuzie, A. J., & Leech, N. L., 2007; Rossman & Rallis, 2003). – the idea being that reciprocity in research relationships would enable findings to be more fully (culturally, psychologically, socially, spiritually) informed and representative of voices not in the majority.
Questionnaire design

Three questionnaires were selected and adapted for study participant interviews. The first questionnaire was adapted from the John Hopkins Community Questionnaire (John Hopkins University Centre for Communication Programs and Behavioural Analysis, 2010), designed to better understand pathways to care: which supports are preferred, how friendly or stigmatising services might feel, and what may be done to make help easier to access for particular circumstances or hard-to-reach populations.

The second questionnaire was adapted from Australia (Commonwealth of Australia, 2010) which looked at mental health discourse in schools. This enquiry would be considered relevant so as to better understand or direct resources appropriately for youth. I also felt it important to understand how youth perceived about mental health services, and what people told them mental

The third questionnaire was adapted from Kleinman’s (Kleinman, Eisenberg, & and Good, 1978) Explanatory Model of Illness, to find out more about conceptualisations of trauma in the treatment of traumatic stress. Given review findings indicating high drop-out rate / loss of participation in follow-up, finding out whether systems considered and named chief complaints the same way as clients seemed a relevant and appropriate point of departure.

Kleinman’s eight questions provide a framework to explore perceptions of illness, and elucidate phenomenological experience and beliefs across cultural paradigms. Kleinman’s model of illness has also been applied to non-Western populations who have experienced political violence (see (Das, 2003; Kleinman et al., 1978; Kleinman et al.,
Eliciting the patient’s (explanatory) model gives the physician knowledge of the beliefs the patient holds about his illness, the personal and social meaning he attaches to his disorder, his expectations about what will happen to him and what the doctor will do, and his own therapeutic goals. Comparison of patient model with the doctor’s model enables the clinician to identify major discrepancies that may cause problems for clinical management. Such comparisons also help the clinician know which aspects of his explanatory model need clearer exposition to patients (and families), and what sort of patient education is most appropriate. And they clarify conflicts not related to different levels of knowledge but different values and interests. Part of the clinical process involves negotiations between these explanatory models, once they have been made explicit.

Questionnaires may be found in Appendix F, G, and H.

Sampling methods and recruitment processes

Recruitment strategy.

My recruitment strategy initially intended referral from formal clinical and school settings (see Letters of invitation + consent appended in Appendices C & D). However, as the next sections will review, recruitment ended up implementing purposeful, theoretical sampling, with some snowballing and word-of-mouth referrals. While directorates from formal institutions invited me to submit an ethics application and expressed interest in the subject-matter, many felt ill equipped to assist, or did not want their Congolese clientele to feel “targeted” or “favoured” over other migrant groups, or did not have sufficient population base of migrants who were attached to mental health services. Some school boards felt they could not permit access, citing support systems already at capacity. From one superintendent:
Votre projet de recherche semble fort intéressant. Cependant, nous avons des défis de ressources humaines au niveau du secteur santé mentale et nous arrivons à peine à combler le minimum demandé. Ajouter un projet à ce moment-ci ne serait pas juste pour personne.

Your research project seems very interesting. However, our human resources are already at capacity in providing the minimum mental health supports we require. To add to this demand would not be fair to anyone.

Given the limitations of this study as a research project and my status as an independent student researcher, I was unable to assure school direction that supports were in place and easily accessible, should pathways be required. While the boards themselves had resources for students, they were not in a position to be on-call or provide immediate support. I was only equipped with a piece of paper with numbers and names of services – see Appendix L – while these were current and specialised, the assurances the school boards needed were outside my scope.

Community-based health clinics were also approached; from each, I was redirected to interview counsellors or staff working with directly with Congolese clients. In these instances, staff did not have capacity or feel comfortable (citing confidentiality concerns and limited availability) liaising referral. Some staff also felt that some of their clients had not been attached to services sufficiently long enough and that my study would be more appropriate post-settlement.

So in the end, community buildings, language learning and friendship centres, and settlement agencies (usually not providing formal mental health supports) became recruitment settings, as they had access and context to meet participants.
Consent as a family / collective issue.

As with many cultures, asking permission to speak with individual family members required permission from the heads of family or chief of household. In some instances (for example, at the church congregation), I also requested permission from the community authority. Consent from the collective unit being the natural social order of things, it seemed an appropriate tradition to follow (Bhugra & McKenzie, 2010). Most heads of families would respect the individual’s desire to move forward or decline interview; however instances where families did not wish to disclose highlighted the stigmas associated with being weak / less than whole, or unwell.

Data collection strategies

Integration with the community & data sampling.

Negotiating entry. Data collection was a negotiated process. Being community-oriented – intending to work with a group to generate information about that group, with the intent to benefit that group – and considering that interview narratives could contain fairly personal and highly charged elements, I felt it crucial that interviews be predicated upon relationships of trust. It made sense (was aligned with my own epistemological position) that in order to recruit research subjects within the community, I needed to be integrated in some way, giving back. While ethics did require a $30 honorarium to each participant, reciprocity seemed a significantly more personal acknowledgment.

But this also evolved to mean that finding points of entry required privileged access. From a researcher’s perspective, such entry point was hardly ideal, as it would compromise evidence-based objectivity; and from a practitioner’s perspective, also not
the best conduct, as the clinical relationship is not properly framed when it becomes infused with personal. I had lived in Montréal previously, and had had quite a few friends in the Congolese community; recruitment was thus somewhat straightforward and snowballed naturally when I reached out there, given affiliation with an already formed network. But in Toronto, I needed to engage non-traditional and diffuse strategies to build points of connection and establish relationships of trust before a recruitment phase could take place.

**Theoretical and purposive sampling.** So I frequented community centres, African grocery stores, hair salons, dance events, cultural film screenings, a mining protest, and a commemorative event. I sought out Francophone congregations, and stores where pirated Congolese music discs are sold. I established connections, and started opening doors informally: I met families, babysat children, tutored teenagers, swept kitchen floors, stocked dried fish on shelves and helped carry bags of food back from various specialty stores. I connected with settlement bureaus and volunteer-translated for appointments. I even carried a “YOUR SMART PHONE = MY COUNTRY’S BLOOD DIAMOND … SAY NO TO COLTAN FROM THE CONGO” protest sign. I also played football (or soccer, as it’s more humbly known in Canada) and played the part of a flagpole for a community workshop.

I did this for a couple months. Over time, I scored goals in football. I answered questions about my life. I continued to stock dried fish on grocery store shelves. The strategy realised some fruitful points of connection: I did find some families willing to sit...

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17 « Toronto’s Congolese community rallies downtown ». See [toronto.ctvnews.ca/toronto-s-congolesi-community-rallies-downtown-1.802675](http://toronto.ctvnews.ca/toronto-s-congolesi-community-rallies-downtown-1.802675)
for interview. Thus, my recruitment strategy relied on community networking, purposeful and theoretical sampling, and snowballing.

**Triangulation.**

My intent with interviewing was to target three different perspectives where possible, so as to triangulate perspective points – for example, a child at school, his or her parent, and the teacher – however (and as mentioned in the previous section), I was ultimately unable to conduct triad interviews. I did interview perspectives independently, within the function of an individual’s community or family role, even if not in relation to the other perspective points within their group. I also recruited some dyads who were willing to interview.

The dyad interview process had been part of my initial interview scheme as a control in interviewing children, but as it turned out, such format as point of entry into families was simply appropriate. I realised I had designed interviews based on assumptions and familiarity with how things worked in the DRCongo – there, my access was restricted to, largely, women and children only, where I had no place with heads of families or chiefs or places where leadership was maintained. But here in Canada, my point of connection to accessing / being given permission to interview the family was mitigated through heads of families, who were often the fathers or eldest male figures in the household. This gatekeeping process may have had impact on the number of people who ultimately retained consent to be included in this study.
Interview process.

Each participant had two formal interviews. The first interview was to obtain consent formally, provide opportunity for any questions to be asked of me or of the study, and to administer the Community Support Questionnaire. The second interview comprised of open-ended questions adapted from the Kleinman’s Explanatory Model of Illness (see Appendix H for questionnaires in full). For the most part, interviews were held at informal meeting points, and in areas where we often crossed paths socially (as I navigated integration pathways), during which times one of us would follow up or take a few minutes to touch base. Though honoraria were not given beyond the two sit-down-for-an-hour-or-so meetings, frequent social proximity often facilitated interaction. It should also be noted that, as such, interview locations were not in formal institutional (research) spaces – we would met under a tree in the soccer/footie field, or in the back utility space of the grocery store, or a hair salon, or in the car while a family member had an appointment.

Requests for interview were often met with hesitations. While participants found the Community Support Questionnaire relatively easy, providing context to discuss coping strategies and pathways to care, the follow-up interview was generally a big ask. Most reasons expressed were consistent with procedural deficiencies already described in the literature: perceptions that treatments assumed a non-African distress response (Snider et al., 2004); a preference to focus instead about other social and cultural supports (Bhui et al., 2004); (Summerfield, 2008a); stigma (Simich, 2010); lack of political motivation or will to sustain participation in an individual-level treatment (Summerfield, 1998); or, not feeling entitled to talk about or evaluate experience as clients (B.
Vasilevska, Madan, & Simich, 2010) A few women who had otherwise very strong and vocal opinions about gender-based violence and the systematic use of rape in war were hesitant to disclose experience or even discuss ideas on an individual level. This will be discussed in greater detail at the end of this section.

**Data management and coding schemes**

Interviews were recorded, stored on a password protected hard drive, and analysed using NVivo.

Original coding schemes for interviews may be found in Appendix K. The coding table evolved post-analysis; overlap permitted some collapsing of the themes. Table 5 lists the coding categories as they emerged and were emphasised differently. For the Community Support Services Questionnaire, findings will review the mean average of scales, without modification or linking them to a theme.

**Methodological limitations**

**Instruments.**

While the tools (questionnaires and interview templates) I utilised for data collection are known reference materials to improve cultural competence, and while each has been applied to populations for research aims similar to my own, I am cognisant that they were developed by researchers working in systems which legitimise patriarchal,
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<th>LEVEL I ANALYSIS (pre coding)</th>
<th>LEVEL II ANALYSIS (post coding)</th>
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<td>1. Social determinants of health</td>
<td>REFUGEE AND SETTLEMENT PROCESSES / ACCESS TO CITIZENSHIP</td>
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<td>l. Health behaviours</td>
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<td>m. Physical environments</td>
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<td>n. Public health indicators</td>
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<td>2. Political contexts</td>
<td>GEOPOLITICAL TENSIONS / TACIT AND FELT INFORMATION</td>
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<td>a. Colonisation</td>
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<td>b. Economy</td>
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<td>c. Education</td>
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<td>d. Hopelessness</td>
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<td>e. Politics</td>
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<td>f. Poverty</td>
<td>DIMENSIONS OF WAR (excluded: may be peripheral the study; much to these dimensions are known; see also previous work)</td>
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<td>g. Racism</td>
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<td>h. Reconciliation</td>
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<td>i. Sexual violence</td>
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<td>3. Mental health</td>
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<td>a. Optimal (flourishing)</td>
<td>[THROUGHOUT]</td>
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<td>b. Minimal (languishing)</td>
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<td>4. Mental illness</td>
<td>CONCEPTUALISATIONS OF TRAUMA</td>
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<td>a. Trauma</td>
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<td>b. Depression</td>
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<td>c. Other</td>
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<td>5. Psychosocial support</td>
<td>RESILIENCIES</td>
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<td>a. Church</td>
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<td>b. School</td>
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<td>c. Clinic</td>
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<td>6. Resiliencies</td>
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<td>a. Church</td>
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<td>b. Family</td>
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<td>c. Community</td>
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<td>d. School</td>
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<td>e. Personal</td>
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<td>7. Healing</td>
<td>SPIRITUALITY, ANCESTRY &amp; HEALING</td>
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<tr>
<td>a. Ancestry</td>
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<td>b. Community</td>
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<td>c. Family</td>
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<td>d. Individual</td>
<td></td>
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<td>e. Spiritual meaning</td>
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Table 5. Coding table post-analysis (collapsing of themes).
Eurocentric ways of thinking and legitimising points of view. It may be that the method, even at point of departure, may be an incompatible method of understanding views from a different cultural tradition.

Further, while I am seeking opinions from a particular subset of refugees, the refugees themselves, even if from the same country, and with the same means to immigrate, are not homogenous. Perspectives and experiences likely vary according to group membership, such as ethnicity, class, gender, location, and regional context. Writes Summerfield, on the proliferation of instruments intending mental health assistance in Rwanda:

[I]llness is not conceived of as situated in body or mind alone and taxonomies may draw on physical, supernatural and moral realms in ways totally alien to a Western citizen. Distress or disease is commonly understood in terms of disruptions to the social and moral order, which includes the influences of ancestors and spirits, and internal emotional factors per se are not viewed as capable of being pathogenic. This is not of course to say that ‘culture’ is homogenous, and that all Rwandans have the same constructions of distress and disorder because they are Rwandans: diversity also arises in relation to education, social class, urban versus rural location, for example. (Summerfield, 2005): 100-101

While specific to the Rwandan aid context, the critique applies to the notion that cross-cultural enquiry must be careful not to overgeneralise; populations are subject to multiple complex multiple realities.
**Sampling.**

Given also the small sample size of my study participants (N=9), findings will likely provide greater depth about systems treatment of a particular set of circumstances than breadth which may form curriculum models about the entire (Congolese) population.

**Myself in relation with the culture.**

I also recognised that I could be limited in ability to elicit comprehensive data from study participants. I represented the status of a foreign outsider, an unknown and as of yet untested presence, asking personal questions about weakness where strength and endurance were cultural norms (see Table 1). These nuances were mitigated through three key behaviours: (a) taking time to build relationships; (b) being consistently transparent about my intentions and goals in research; and, (c) liaising with leaders to endorse or facilitate my community entry.

**Data adequacy vs. data saturation.**

Six families / participants withdrew their consent over the process of interview. One father expressed:

*Les moments de triste mémoire que nous avions traversés sont tellement durs que nous comptons les oublier pour repartir sur de nouvelles base ici au Canada.*

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18 For people coming directly from or with current frame of reference to the DRCongo, a certain tension is present in the DRC about Asian ethnicities – water companies are being bought up by Japanese- or Chinese-owned and operated companies. It is not yet known if these foreign companies, and their foreign interests, are trustworthy. It was not uncommon for people I met in the DRC to have felt either wary or mistrustful of this new ethnic presence, not yet tested by time enough to know if they would represent a “third wave colonialism”. See also [http://www.outlookindia.com/article/India-Once-Colonised-Has-Turned-Into-A-Coloniser/278583: “India, Once Colonised, Has Turned Into a Coloniser.”](http://www.outlookindia.com/article/India-Once-Colonised-Has-Turned-Into-A-Coloniser/278583)
Voilà pourquoi, nous ne voulons plus les revivre en les racontant à des tierces personnes, encore moins en y pensant. Néanmoins, nous estimons que nous pouvons toujours vous être utiles dans d'autres domaines de collaboration.

The stuff we’ve been through [to get here] is so sad and difficult, to the point that we want to forget, leave all that behind for a new life in Canada. We don’t want to relive our memories by retelling others what happened, much less think about it again. However, we hope that we can still be useful in other collaborations.

Having spent close to twelve weeks seeking various pathways of community integration, and even with the personal introduction or endorsement of the leader, the number of people willing to be interviewed seemed to plateau off. All of the families had been approached for interview. Each of them had expressed similar feelings, independent from each other and during separate meetings / at separate times and in different community settings very similar to the father just above. I also noted I felt personally a certain amount of recruitment fatigue, as my efforts were still having me stock dried fish on food specialty stores. I was reminded of this author’s approach:

In qualitative research, there are no published guidelines or tests of adequacy for estimating the sample size required to reach saturation equivalent to those formulas used in quantitative research … Qualitative data, although initially appearing diverse and disconnected, in the process of saturation, form patterns or themes and begin to make sense. The quantity of data in a category is not theoretically important to the process of saturation. Richness of data is derived from detailed description, not the number of times something is stated. Frequency counts are out. The tighter and more restrictive the sample and the narrower and more clearly delineated the domain, the faster saturation will be achieved. (Morse, 1995) 147-149).
In reviewing the data I had collected thus far, clear and evident patterns and themes had in fact emerged. Upon review, I felt these narratives, supplemented with informal field experience, provided adequate data to form a comprehensive theoretical model.

**A pause to consider implications on the research process**

The dynamics seen throughout the recruitment process brings up interesting reflections. The potential to try to understand what my position may have been amongst the people I tried to reach – how they saw me, how we addressed difference, what it meant or felt like to be a Canadian outsider trying to access an immigrant community – may bring up interesting points to inform the research process. Being a non-Congolese was one level of difference; but it also stands to reason that my difference extended to more than that – I was a non-immigrant trying to access an immigrant community. While CCVT’s notion of *Befriending* coupled with philosophies inherent in community-based research, influenced my approach, the agenda of research even if explicitly stated, may have influenced perceptions of my presence/actions/intent as disingenuous; even if I were friendly or however personable, it would not be historically unreasonable that this agenda be perceived or felt a threat, or a dissimulative, other colonial act of exploitation,

Indigenous communities in Canada have expressed feeling thus: over-dissected, yet underrepresented, and for no resultant social change in their condition within the framework of the research process. From an allied perspective:

For me, the question ‘Who should speak?’ is less crucial than ‘Who will listen?’. ‘I will speak for myself as a Third World person’ is an important position for political
mobilisation today. But the real demand is that, when I speak from that position, I should be listened to seriously; not with that kind of benevolent imperialism…

(Spivak, 1990)

A research endeavour, even if enlisted for purposes of “an enlightened equity”, still holds colonial precedent which cannot be ignored. Memmi writes:

Whenever the coloniser states, in his language, that the colonized is a weakling, he suggests thereby that this deficiency requires protection. From this comes the concept of a protectorate. It is the colonized own’s interest that he be excluded from management functions, and that those heavy responsibilities be reserved for the colonizer. The colonized’s … ineptitude for comfort, science, progress, his astonishing familiarity with poverty … it is impossible to save the colonized from this myth. (Memmi, : 83).

It cannot also be ignored that the ideology of ‘intervention’ has been constructed around a need which the ‘less fortunate’ may not have named; that a vulnerable and marginalised population were in the first instance created by the colonial encounter, based upon a centrality of whiteness as normative. Thus this research project – even if intended towards equity, and even if community-based, and even if I practised reciprocity – could arguably be perceived, with reason to have at its core continued colonial reification … My outsider status on all levels – as a non-Congolese, as a “normative Canadian,” and as part of an institutional / systemic process – may have represented and could have been felt as a colonial (re)construction, except this time on more tacit, dissimulative, and intimate (personal, historical, and interrelational) levels.
RESEARCH PARTICIPANTS

The DRCongolese in Canada

While migrants from the DR Congo comprise the largest group of French-speaking migrants to Canada, their numbers as communities are diffuse in settlement catchment areas. According to the UNHCR, more than 5700 Congolese applied for refugee status in Canada between 1996 and 2001, tending to settle in Montréal, Toronto, and the Niagara region (Hamilton/Wentworth/Welland/Fort Erie) (Lemoine, 2008). Trends in settlement for refugees since 2006 have not been specified by nationality or country of origin. Lemoine’s 2008 geography thesis about Congolese migrants in Canada found the following characteristics:

- Migrants from the DR Congo are the largest group of French-speaking migrants belonging to a racial minority in Toronto.
- Congolese respondents report that discrimination and affordability issues negatively affect their housing trajectories.
- Congolese respondents face more obstacles when searching for housing, as they are more likely to encounter discrimination, racism and barriers caused by mismanagement of credit.
- While Congolese migrants had similar educational attainments as French migrants (from France), their unemployment rates were higher and their incomes were also lower on average. The majority (83%) of recent Congolese immigrants lived in dissemination areas where more than a third of the population lived below the poverty rate and where the unemployment rate is at least 15 percent.
- Recent Congolese migrants tended to reside in [urban] areas with high levels of poverty and high unemployment rates. [They] were also more likely to live in neighbourhoods with low levels of homeownership. [Settlement patterns demonstrated that, compared to other French-speaking migrants with similar}
educational attainments and SES backgrounds, Congolese have lesser] access to wealthier neighbourhoods with convenient access to public transportation.

• Deep-rooted mistrust is prevalent in Congolese communities.

The DRCongolese in Montréal

Numbers of Congolese in Montréal have not been reliably reported since 2006. Statistics Canada last indicated highest concentrations of DRCongolese migrants in Côte-des-Neiges and Lachine (western Montréal) communities, with a high degree of residency in low-income or government-subsidised housing (Citizenship and Immigration Canada, last retrieved 21 April, 2011).

The DRCongolese in Toronto

Specific to settlement catchment areas in Toronto, Demoine (2008) reported:

• Recent Congolese immigrants living in Toronto are too dispersed … to [determine a community catchment area]. Congolese congregate to a very limited extent. Even though many live in poorer neighbourhoods, they do not settle together. The strength of their social networks will determine … [eventual] settlement patterns …

• [Congolese are seen in greater numbers in three] specific neighbourhoods throughout Toronto: downtown Toronto (southeast: specifically in Cabbagetown, Regent Park North, and South Riverdale), Parkdale, and Scarborough. Collectively, these areas are home to a quarter of all DRCongolese arriving to Toronto between 1996 – 2001. The concentrations are also the location of a few Congolese stores and services such as hairdressers and clothing stores. While this is an important concentration with regards to the [creation of a] Congolese community, it is not an example of residential segregation (defined with regards to a group's predominance in an area)… Congolese settlement patterns are still too diffuse to determine where most Congolese tend to live, eat, and work.
The highest concentration of Congolese living in Toronto is found around Dundas Street East and Sherbourne Street, but Congolese only account for 2.9% to 4.5% of the population in these dissemination areas. Due to the small size of the Congolese community, the Congolese are not an important minority group in any dissemination area, even though a fourth of recent Congolese immigrants reside along Dundas East (see Figure 4).

The catchment areas outlined in Lemoine’s work and Figure 4 reflect the areas where I spent much of my data collection time making efforts to connect with Congolese communities. (It is important to note, however, a significant community also exists in the northeast Toronto / Scarborough area as well. Pattern data are not pictured here.)

**Participant profiles in the study**

Seven participants maintained their consent for the study. Two were based in Québec, had been mental health service users or family members of mental health users,
where one had to me previously and one had been referred to me through snowballing; five participants were based in Ontario (three in Toronto), and were not known to me previously: three were immigrants or refugees who had lived in Canada for less than two years, one was a settlement worker after having come to Canada six years earlier, and one a special education schoolteacher who also taught a number of Congolese child refugees in her classroom.

Of these seven, four participants were male, three female, and only three held full-time jobs. One was a government-assisted refugee (GAR), although all the others said they had been GAR status in previous years. Four of the seven were also dyad interviews. Two had migrated to Canada whilst still a child. More than one expressed being motivated financially.

To achieve best attempts at saturation, I also supplemented these seven interviews with two additional expert interviews, who were overseas and reconciliation workers (one a law student, one a psychologist) in the DRC.

The next section reviews the study findings.
PART THREE: FINDINGS

Here we pray every day, even every hour. But seems to me God is sleeping.

He does not listen to us.

~Participant 8

I first present the findings to the questions ranking service pathways (Community Support Services Questionnaire) evoked, as they provide an overall portrait of how mental health services are perceived, and a pathways to care response for people who are Congolese. Following this, I will present the interview findings and how they link up to approaches in the treatment of post-traumatic stress.

Initial participation levels were higher than those ultimately captured here for analysis. Along the way, people dropped out, hesitant about a number of things: others coming to find out what they themselves were trying to escape/forget; not knowing who the ultimate audience would be for this work; other people in their community assuming or wondering about the content of our interviews. Being that the entry parameters to access participants was very casual, that available meeting spaces were never very private, and that the research process symbolically and/or structurally may have felt
unusual … while the number of participants over the work became “perilously few” (Summerfield, 2014), the depth of what participants expressed holds clinical utility and significance.

**Community Support Services Questionnaire: Navigating settlement**

Seven participants completed the adapted *Community Support Services* questionnaire. In this questionnaire, participants were asked which supports were most appropriate for specific instances: if they needed help finding a job, when they might feel sad, or if they were to experience family problems. The questionnaire also asked participants to rank, on a sliding scale, some characteristics which would describe the process of seeking support. Following are the summary of responses:

*For finding a job:* Just over half of questionnaire respondents held jobs, representing better percentages than Lemoines’ (2008) findings of 64% unemployment in the greater Toronto area for DRCongolese. The most frequently selected words to describe needing to find work included: Scary; Expensive; and, Okay / approving. Participants expressed that they had no difficulties going to local organisations such as the YMCA which is well established, but would also feel okay trying at a job bank, a public library, or settlement program.

The supports respondents expressed to enable increased economic participation were largely practical considerations, but one participant spoke openly of francophone racism. Six of the seven respondents suggested free training for service or entry-level work and a campaign to recognise foreign credentials. One participant expressed English language learning classes as particularly valuable, as the French-Canadian system was
perceived to be discriminatory towards an African accent. Another participant expressed that volunteering for odd job requests at church had led to informal working, paid opportunities. All respondents agreed that job searching was not an easy climate, but they were motivated to keep up their efforts.

Four respondents additionally indicated they felt transport tokens would help subsidise the costs of job searching, and two mentioned public transport was a deterrent altogether. These respondents expressed that getting inevitably lost or delayed when they took public transport to appointments was demoralising. Strict formalities of appointment making were in some instances something new, and transport systems were rarely easy to navigate or reliable. Logistical difficulties in these instances compounded pressures when time management felt already stressful. However, overall, seeking employment was considered as a worthy and valuable goal, so respondents were not ashamed to ask for assistance in this area.

Getting help for feelings of sadness was another matter. The most frequently selected words to describe seeking help for emotional support included: Difficult; Embarrassing; and Scary. Six of the seven participants expressed there were fewer attractive options for emotional support than for job assistance. All participants expressed some degree of hesitation in talking to a complete stranger about « la douleur intérieure » / interior pain, saying they would rather choose other pathways if they were obliged. One participant responded:

Nowhere in fact [would I go]. The only solution is my friend, who is like my sister. But I would not burden her with it. We all have weight to bear. (Participant 1)
Another participant responded:

[I would go to] a place where people know my capacities. If that’s not here, maybe a phone call or Skype [back home] to bring that place to me. I don’t have internet, so I use my phone. But I can’t use it as often as I would like. Phone calls are very expensive. I didn’t know you had to pay so much. [My first phone bill came as] a shock. (Participant 2)

(Simich, 2010) has similarly written about newcomers to Canada who were unprepared to incur the high costs of long-distance phone calls. Her study participants reported feeling worry and loneliness from being cut off from family overseas, which was then compounded by the stress of having credit ratings be adversely affected, which in turn precluded opportunity for car or home ownership. Participant 2 continued, along the theme (to be also later discussed) of geopolitical tensions:

We’ve already been exploited for all our coltan so smart phones can be brought over here for the businessmen to use … Am I now paying for their network? Because I can’t. I’ve paid enough, I have no more.

Respondents’ comments about seeking assistance for emotional difficulties reflected a general theme that sadness (or coping) was designed to be a private matter; as such, family members and prayer were the preferred and natural support mechanisms for participants. I wondered during the later phases of my analysis if perhaps sadness was conceptualised as something to *endure* rather than *overcome*. It seemed predominantly to be a spiritual condition. I will return later to these thoughts in the Conceptualisation of trauma section.
Seeking help for **family problems** was a bit of a paradox: family harmony was valued, but help-seeking to obtain harmony was not. Words selected to describe the experience of family therapy included: Difficult; Embarrassing; Good; Helpful. All participants said they could see the value in receiving assistance for family difficulty, but none had actually reached out for such a service, and most said they wouldn’t even if they needed to. One participant added a row with the word “Realistic”, marked it at a ‘0’, and added:

> To my knowledge, there isn’t any kind of structure / service here for the Congolese community specifically, for these types of things … If I had to go, I would go to see someone who was neutral (does not know much about my situation and who is not close to my immediate family members), Congolese or not. The community is too small, I don’t want them to know my problems. *(Participant 1)*

Another participant wrote:

> I would encourage [family members] to talk frankly, honestly, and with love in their heart. Be together and appreciate relationships. Or, I should say, the relationships one has left. *(Participant 4)*

The losses Participant 4 had sustained as a result of the wars were likely numerous, but she never once over the course of our interviews talked about what they were. For her it seemed that the idea of family repair was synonymous with family lost, mentioning only that she was motivated by duty, and her ancestors’ memory (much like the Rwandan motto, of the *devoir de mémoire* / duty to remember fallen ancestors). One participant returned to church and spiritual connection as being their preferred helping mechanism:
I would go to church. Sit down next to [that] family member. Worship is important. But we are also sitting next to each other. One cannot remain angry when one knows that they helping each other feel closer to God. God is where we'll find home.  
(Participant 5)

I found Participant 5’s closing line – about finding home – particularly poignant and reflective, alluding to injuries sustained to both home and ancestry, a dislocatedness from ancestral and terrestrial bodies. In a culture where spiritual communion is found in earth, air, ancestry, and sky (Bagilishya, 2000) – he had lost all inheritances.

Themes from interview: Tales of traumatic journeying

Six main themes presented themselves throughout the interviews, which may hold clinical implications. Table 6 demonstrates the possible relationships between themes and clinical relevance. While themes may indeed have broader applications, I will focus discussion here according to relevant treatment levels: Individual level, group level, and (I added this level; it is not clinically relevant or used as an approach) global / geopolitical levels.

On the individual treatment level, themes of how trauma is conceptualised and resonated were related; specifically, that trauma has more spiritual than psychological impacts, and that the experience of war was not as present as the experience of migration. Hope was a big factor for individuals. While symptomology from “loss of hope” arguably extended to other levels of treatment, intervention is most relevant with the individual.
On the **group and family** treatment level, loss of Ancestry, home, and family members were prevalent. And on the **global / geopolitical** level, discourses of socioeconomic injustice and rights to participate or exercise citizenship were key factors for what people felt were relevant to their traumas.

The most salient themes from interview narratives were broadly painted portraits and snapshots of loss. Though participants did not sing their grief, as (Bagilishya, 2000) : 346) writes, for those left behind to mourn, there may be little solace. Many spoke of possessions and family members, though what seemed to be more significant was loss of land and legacy. These were major contributing factors to feeling loss of hope.

**Theme 1: Loss of Ancestry**

Ancestry acts to symbolically provide connection or reflect Afrocentric principle where the collective is responsible for individuals (see (James et al., 2010) . Death is also
conceptualised as ideally a peaceful passage, where, once past the veil of mortality, ancestors may protect the living. Disrupted cycles of mourning may therefore add significant and additional implications: an unnatural or interrupted death requires that those left behind find a restful burial place, and the absence of proper burial means the dead are unprepared for their new role, and without having been given passage, will be left to wander. An improper mourning, burial, or even care for the dead can be legitimate cause for great distress for living families. Said one participant:

We just left, like that, one had to leave. I wasn’t able to say goodbye. My mother, for example. I wonder where she is, and if she can see me now … Probably, yes, I think so; I only hope that she has found peace to rest. That question haunts me, but I know she will understand. (Participant 7)

Some participants similarly expressed feeling insufficient fulfilment of ancestral duty, which seemed to create ambivalence towards the future. One participant also suggested:

… For those who died without a song to sing, that responsibility, is mine [now] to correct. But how can I, from so far away? And life is so different now.

(Participant 4)

As an existential dimensions of loss, sadness was described as an internal, spiritual pain, where the burden was clearly theirs to carry until ancestors found rest and relief.

**Theme 2: Loss of connectedness**

Not unlike the loss of legacy or lineage, the disruption of social fabric and community could make life feel slow and lonely. Beyond the dimension of living collectively, there was loss about shared social responsibility. One participant explains:
I come home to an empty house ... It is too silent and too empty. I fill it with thoughts, which make me feel lonelier, or food, kinds which I don’t know how to cook. I turn on the TV so I understand what people on the subway might be talking about. But I have no-one to talk to myself, or teach me new things, or help fill my home with life. (Participant 5)

Another participant relates:

Being here alone without family is one thing [level of difficulty], but being here alone and pregnant is even more difficult. This is the time to celebrate with joy, but there is no community to celebrate with, or anyone to help me … This must be what they mean when they say your burdens are only yours to have to bear. I know God is there, but feel like I am carrying mine alone someties. (Participant 7)

The disconnectedness and loss expressed by these participants compound past ancestral loss with present and future loss of community. To reprise a statistic cited earlier, the death toll from the war in the DRCongo approximates one person lost per every five, which in turn translates to roughly one person per family; this further carries a 50% chance that the death in that instance is of a child. Each of the participants recruited for this study spoke of losses, but did not specify name, age, or relationship. Participant 5 was no exception, however I suspect what heightened his loneliness was the knowledge and practise (Bagilishya, 2000; Diallo & Lafrenière, 2006) that for some groups, when a person dies, their name is erased that name from the memory and discourse of those who remain.

**Theme 3: Trauma as a spiritual designation**

For most participants, ‘trauma’ was perceived to be a spiritual designation – not something marking a spiritual possession, but reflective of their spiritual relationships.
One participant who had been referred to mental health supports for PTSD, but who had never completed treatment, stated the following:

I don’t entirely trust the opinion that I am traumatised. I am grateful to know my problems have causes which are not due to my lack of ability to overcome … but how is seeing a doctor going to change the stuff which makes my health deteriorate? And who defined my seemingly inevitable response? People who, I’m not certain, have understood my context … Or, at the very least, have profited [again, and continue to profit] from designating my state of victimcy. (Participant 1)

The act of naming felt like additional injury. Some participants expressed:

I was diagnosed as depressed. I was in hospital for three weeks. But I had nothing to look at, nothing to do, and nothing to occupy my mind, no way to calm my worries. That didn’t help. It made me more depressed, when I think about it. And the last thing I wanted was to face another bill. But at least in hospital I knew what time would be my next meal. (Participant 6)

For those who had sustained multiple losses, the idea of being ‘traumatised’ provided no clarity:

I was hospitalised [for depression]. They told me it would help, and they seem to think it did. But I was worried the whole time I was [inside] about what was happening to my children. And life didn’t change at all when I got out…

They say one man’s adversity is another man’s trauma. What does it mean if I am a woman? (Participant 7)

Idioms participants used to identify what they identified as trauma included:

- ‘What is trauma?’
- ‘La douleur intérieure’ / interior pain
- ‘Une douleur spirituelle’ / spiritual pain
- ‘La vie ne va pas bien’ / Life is not going well
• ‘Inability to replenish daily bread’
• ‘Without family’

Participants expressed that, while physical symptomologies were not absent, they were not as important or distressing as lack of spiritual happiness. It is likely that the crux of treatment for individuals thus lies in a broadening of clinical understanding that trauma is conceptualised as spiritual in nature. This will be revisited in the concluding chapter.

**Theme 4: Loss of hope**

Beyond fundamental displacement, beyond losing a community, beyond a historical loss of self, is a sense of wandering and trying to find (but lacking) a meaningful trajectory.

One participant expressed:

> I lack confidence in myself and I’m not the most trusting of my surroundings. I’m also pretty protective of my family, even though we don’t express it; like I never say I’m feeling glad that they are there. It’s not, you know, *in style* to be all sentimental about it. But if I’m not at home, close to my family, I start to get worried. *Participant 2*

He went on to quote a particular song, saying it had spoken to him the first time he had heard it:

> This song’s on my playlist, I was just listening to it, maybe it’s sad but it kind of describes it. “Leave me at the altar, throw me in the landfill”. That’s what it says. Like the way [the war] went on over there, I wasn’t meant to be someone worth anything. Entire communities were being killed, even kids who’d never done anything, based on their nose or forehead, stuff like that … Stuff you didn’t really get but everyone was saying it, and even people you’d known all your life and you’d always thought you’d [got along] okay … When you hear so many people
saying stuff like that, and see people doing stuff like that … When the universe just goes dark … or off… You kind of start to believe it doesn’t want you there.

Recovery models identify hope as an important internal condition to get better (Jacobsen & Greenley, 2001). The loss of hope, as described by Participant 2, is a palpable expression of sorrow. Fanon (1961; 1967) has contextualised like feelings within the process of dehumanisation stemming from the broader impacts of colonisation. He asserts:

When colonization remains unchallenged by armed resistance, when the sum of harmful stimulants exceeds a certain threshold, the colonized’s defenses collapse, and many of them end up in psychiatric institutions. In the calm of this period of triumphant colonization, a constant and considerable stream of mental symptoms are direct sequels of this oppression … The truth is that colonization, in its very essence, already appeared to be a great purveyor of psychiatric hospitals. (Fanon, 1961)

This theme seemed to suggest that violence, tearing people from the foundation of their communities, and by extension, themselves, left a sense of helplessness as the new foundation from which the future would erode.

**Theme 5: Loss of citizenship**

For many of the participants, their lives and interests had been defined by politics and social change. Limiting political opinions or activities in some ways was difficult. While some participants were content to retreat into a curtain of anonymity, others felt that the inability to participate, with the designation as non-status as a refugee, made settling in their new home difficult and reductive. All participants had been through the process of statelessness. Three reflect:
My worth is stated only by this paper I carry – it identifies me even though I don’t wish to identify with what it says about my life. I miss my community who knows me, who supports me with respect. But this paper is how I must now make a new way, build dreams with my new family. So I tolerate it. Do you want to see? (Participant 1)

I was politically active in my country, but speaking out was not safe ... The stakes of safety are lower now, but the system still disregards anything I have to say. Maybe one day I will be able to speak. (Participant 5)

What’s helped me … has been to come here to Canada, to be free, to be recognised as a person of worth … But it’s still a bit ironic that while my community and my country struggle to seize opportunities for learning and development, and have as many rights as possible … I am unable to fill my own right to work. (Participant 2)

**Theme 6: The refugee process**

Participants were no fans of the refugee system. While they were grateful, for the most part, that they were being assisted, the system itself seemed to predetermine their social and economic participation in their new communities. While their life-trajectories and country of origin’s circumstances had presented one set of consequences, the broader system of refugee designation in Canada seemed to hold an additional ensemble. The recurring theme about being a refugee painted an unpleasant and difficult process, with little dignity. Said one participant:

I have to be content with being given things. But I was never asking for that. I would rather have chance to prove my own value and opportunity. (Participant 6)
Another participant felt that her narrative preceded any contribution she was able to make as an individual, and that what she felt about her narrative was inconsequential (she did not have the agency to determine her recovery):

> You come here to escape war but then you have to explain what that means, and even then it depends who will listen to you … Only if your story conforms with what [the immigration tribunal] knows about that war will you be heard and pass asylum. Government is the same all over, it seems. *(Participant 5)*

Participants also discussed a certain amount of conditioning which paved an acquired passivity, or learnt helplessness similar to theme 4 / loss of hope. A last participant relates:

> I am grateful to be here, but being labelled a ‘refugee’ makes me feel that I am in exile. Options to work are limited and sustained over such time … to the point you feel incompetent or without value to contribute to society. *(Participant 6)*

Whether the refugee system creates or sustains commodified loss may be the subject of another enquiry; however, not unlike the principle of humanitarian aid, participants expressed feeling unable to mobilise individual agency.

**Theme 7: Colonial legacy**

As discussed earlier, the Belgian colonial rule left behind outsourced resources, extreme poverty, and underdevelopment. Colonisation was a theme which underpinned our conversations, a tacit consideration (see my reflections in the section *A pause to consider implications on the research process*), and upon reflection I wonder if I should have explicitly asked more questions about the subject, for more specific elucidation. Sounding not unlike literature about the black colonised body and the process of colonisation on the spirit (Cesaire, A. (J. Pinkham, trans.), 1972/2000; G. Dei & Johal,
It all started with colonisation, they say. But then Obama comes along and says ‘Africa can no longer blame colonisation for its problems’. Just like that. To that, me, I say: Fuck him. Fuck all the people who theorise about it [pointing]. He doesn’t know, none of you know, what it was like to leave that war … Okay, look at me now, I have come here to escape that country. Maybe I was one of the lucky ones, they tell me. But I’m years behind. You see? I haven’t finished school. I have no family, I have no [inheritance] that will come to me, I have no property, not even a book that’s mine to read. I’m not allowed to work or have Canadian experience, my skin’s too dark, and my French is African French … [what do I mean by that?] I mean, even the language they gave me is undesirable. I was behind before in the Congo, but here? I have to run so fast to catch up that there’s no way I can move ahead … [Pause.] [Laughs.] And there I am. Talk about baggage. (Participant 2)

So in sum, findings thematically relate seven main themes, which indicate that current stressors may not pertain to war narratives – symptomology was not discussed or disclosed so much as desires for belonging and contributing to a new community.
PART FOUR: CONCLUSIONS AND RECOMMENDATIONS

The task is to produce, if not a “new person”, then at least a “new gaze”, a sociological eye. And this cannot be done without a genuine conversation … a mental revolution, a transformation of one’s whole vision of the social world. This new sociological “gaze” is underpinned by a relational mode of thought.

(Bourdieu & Wacquant, 1992) : 251, emphasis added)

So what can these findings tell us, more broadly, about the (Canadian) systems intended to support mental health for people affected by regime brutality and the brutality of state-sanctioned violence? What, indeed, are specific implications of the findings for people on both side of the therapeutic relationship? While data may not be generalisable, what we can understand from participants’ experiences may be transferable to other like population subsets of refugees. The DRCongo war may act as a lens to provide recommendations and better understand how to improve supports for people whose lives have been impacted by protracted conflict and state-imposed violence. Three main lessons follow.
Lesson 1: Conceptualisations of trauma have spiritual and relational frames of reference. Some injuries feel political more than traumatic

Discussions of conflict in the DRCongo seemed often inseparable from discussions about diamond and coltan mines. Most participants expressed happiness about being in Canada, and being away from the stress and insecurity back in the DRCongo. However, themes of social justice were certainly evident, especially at the lack of international support to care about the conflict, which has clear genocidal tendencies and remains rooted in the corrupt regime\textsuperscript{19}. Said one participant:

\begin{quote}
The Congo is a particular instance [of war]. Rwanda received, and continues to receive, a lot international support. But the international community … seems to have forgotten the Congo. I don’t know what we, the Congo did to the world. And that hurts. (Participant 9)
\end{quote}

One expert participant, who taught trauma and psychoeducation techniques in the DRC, mentioned that the concept of traumatic stress had no indigenous equivalent:

\begin{quote}
We are just now starting to hear the word ‘trauma’ being used. For most people I work with [from the village], they will have never heard of trauma … really there is no local translation, no way that's used to express this, or something equivalent …
\end{quote}

\begin{quote}
When people say ‘He is traumatised’, what most of the community will think may not help: they may think that he is either seeking compensation, or giving excuse because he cannot work, or that he will come to the reconciliation cell [and eat all the food for free]. All of these may be privileges… Not everyone in the community can
\end{quote}

\textsuperscript{19} This is exacerbated by many Congolese’s perceptions that the current President’s right to rule is based on a highly contested domestic vote, and that the international community welcomes him to power so as to maintain their vested interests in mining opportunities.
participate in a peace cell, unfortunately. So there is the one aspect, people think it is good to learn about trauma: because maybe there is something to it, it will give them hope, they can learn they're not at fault, they can maybe change life, if they are unhappy. But on the other hand, trauma is maybe something else that can reinforce the social order. (Participant 8)

Participant 8’s comments echo reflections suggesting that the act of importing ‘trauma’ is also tied to a particular (neo-liberal)(institutionalised hegemonic) epistemology:

There is a serious possibility that the Western trauma discourse imported into the lives of people whose meaning systems have been devitalized by war and forced displacement might impair their struggle to reconstitute a sense of reality, morality and dignity. After all, the trauma discourse introduces elements that are not mere surface phenomena but core components of Western culture: a theory of human development and identity, a secular source of moral authority, a sense of time and a theory of memory. (Summerfield, 2005): 100-101.

This point is perhaps one of the most salient and broad of all the recommendations, yet lies at the heart of this study. For survivors from the DR Congo wars, their recovery was inextricably linked to political justice and a certain amount of activism. The following poem was written by one of the sons of a female participant. He did not wish to be interviewed, but wanted to relate his history: he was a child of war, conceived from rape, and had never known his father; with his mother he went in and out of hospitals as she battled AIDS, depression, and chronic pain. His poem, entitled ‘Blood Money’, discussed the mining of coltan. He was careful to provide a brief introduction to how he wanted his poem to be told:

Canadians must know that Congolese people die each day because of coltan, which serves to benefit them and their lifestyles, but not the Congo.
Timothy’s poem may be found in Appendix M. He asks:

[Who will remember] the worth of a diamond
[Who will remember] the worth of gold
[Who will remember] the worth of blood
of those who have died and gone?

For him, and for many of the study participants, the DR Congo’s conflict was inextricably linked with global tensions relating to the exploitation not only of his land, but of his ancestry, his people, and by his own extension, his own self.

**Lesson 2: What DR Congolese express they need has synergies with recovery-oriented, strengths- and rights-based models**

Study respondents agreed that alternate pathways to care for greater emotional support could include community links as intermediaries, with activities in schools or neighbourhoods, at sporting events, in churches, or at barber shops. It was also considered of important to provide trauma-informed, and not necessarily trauma-focussed, care. One participant drove the point home about how she perceived what would be most helpful:

> According to what [doctors] say, it helps to talk about what happened. I would rather face the future. I must focus on hope now. But they [the doctors] would not hear of it. *(Participant 7)*

Recovery models place hope, healing, empowerment, and dimensions of human rights to be of primary importance in fostering as a culture oriented towards spiritual growth and connection (see (Jacobsen & Greenley, 2001; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Similarly, most of the questionnaire respondents expressed that being able to feel hope and resiliency were more important than understanding the
nature of their symptoms. Stress management, informal group meetings and psychoeducation, as well as nutrition groups, were all reported as sounding very useful dimensions of treatment. These approaches as informed by trauma, but not specifically focussing on trauma, help provide more comprehensive context for healing.

The anti-racist treatment model of Access Alliance very similarly regards illness as more than a set of symptoms, but an ensemble set of experiences, shaped by locations, events, perceptions, and meanings – all of which change according to time and context. Study participants similarly expressed that preoccupations or chief distresses of life after war were not the physical residual symptoms or even troubling memories, but social and emotional impacts of a person in relation to other people. Write Snider and al., in reference to intervention with survivors of political violence in Peru:

As Western-trained mental health professionals tend to focus on clinical psychiatric problems alone [in treating contexts of war], the cross-cultural validity and context relevance of their approaches have been called into question. The expression, recognition and treatment of mental disorders are rooted in culture and social context. Psychiatric diagnostic schemes and treatment approaches reflect an individualist context that may be inappropriate for collectivist societies … political conflict is imbued with unique meaning for the communities involved. For these communities, trauma may be felt as a collective experience, and psychosocial recovery of individual members related to restoration of the community’s cultural and social traditions. As some experts argue, when the wounds of war are communal, approaches to healing should also be communal. (Snider et al, 2004: 390)

It follows that healing from genocidal injury would benefit from addressing racial inequity, misperceptions of race, and reorienting of power in relationships. Participants expressed feeling devalued as a result of racial encounters, manifest in sadness, helplessness, hopelessness, lack of confidence, and anger; this is congruent with research
on mental health in racialised populations (Dei, G., & Kempf, A., 2006; James et al., 2010; K. McKenzie & Bhui, 2007b; C. C. Williams, 2001a) Mental health providers should also recognise the limitations of current concepts and approaches which attempt to capture full meaning of events without social or political reference.

**Lesson 3: Understanding political and structural inequities would improve health outcomes and be helpful to better serve DRCongolese realities**

The import of psychiatric knowledge as expert witness (‘war trauma equals symptom $x$ and phenomenon $y$’) is problematic: it imposes a new hierarchy of superiority, where understanding is an act qualified through authority, with canon like control of what constitutes recovery. There is further an ideological divide in privileging treatment that’s pharmaceutical: drug therapies can be seen as a manufactured economy, funded by companies whose interests are vested in being ill, and where the desire for profit will keep generic treatments out of reach. It could be that the ‘right’ to treatment is ‘a social process, involving power, and should be analysed as such and not assumed to be beneficial’ (Short, 2005: 276). The *No-Nonsense Guide to World Poverty* further addresses the need for caution with regard to international intervention:

To extinguish alternatives [in intervention] is as intolerant as it is violent.

Globalisation is ideology made material: ideology not as theory but in relentless, inflexible practise. To say: “There is no market for it” – whether “it” means some commodity or service, or whether it means compassion, wisdom, self-sacrifice or
some form of expression – is to condemn areas of vital human experience to silence and non-existence. (Seabrook, 2003)

**Broadening the conceptualisation of trauma to improve the treatment of post-traumatic stress**

While evidence-based standards intend to apply invariably across contexts, how people ‘cope’ or ‘solve problems’ is not universal. While those designing intervention for psychological relief may have genuine intent, care should be taken to note ways in which intervention is actually desired. If treatment or intervention has limited community or cultural relevance, consequences may foment additional symbolic or territorial atrocities. The Centre on Law & Globalization writes (Center on Law & Globalization, 2011):

All genocides are different. However, four ideologies commonly preoccupy perpetrators of genocide: racial and ethno religious hatred, cults of antiquity, cults of agriculture and territorial expansion. These ideologies serve to both foment and justify genocidal atrocities. When we see these ideologies being touted, we should keep in mind that genocide has sometimes waited in their shadow.

Orienting mental health services for improved treatment of traumatic stress will require a systems transformation (Bhui et al., 2004; Bracken, Giller, & Summerfield, 1997; Leamy et al., 2011; C. C. Williams, 2001b) permitting migrants to contribute as social and political participants in their new communities, and for their desires for spiritual connectedness to be legitimised within recovery models. As effectiveness to this end may be difficult to determine based on current research paradigms, a greater taking up of anti-racist considerations can help to lay ground for empirical enquiry. Access Alliance’s model may provide one such helpful example. The experience of trauma as we
understand it within Western treatment models is shaped by the social realities of our Western worlds. Questions McKenzie:

The experience of trauma is fashioned by the social reality that people live in. How people think about their previous experiences is given a shape and meaning by the new society and what they want to achieve there. The fact that trauma is a currency in negotiating immigration would seem to produce a difficult situation for refugees. The label is useful for them if they want to get what they need from the system but may not be that useful for them with regards to personal development and wellness. Could the system be producing victims rather than building resilience? (K. J. McKenzie, 2013, August)

Writes King (2011), one of McKenzie’s mentees and a Rwandan, reflects further:

We live in a broken world. We can all be involved in actions and attitudes that promote healing, truth, justice, understanding and peace. There is no room for compromise. (King, 2011)

**Reflections on the study and points for further enquiry**

Because the focus of this work was largely exploratory, and because the exploration was among a handful of participants, much of the impact here may seem unclear (or, at best, limited). The process itself, as discussed from the point of view as a researcher, was an intake which did not seem to be considered a trustworthy endeavour. Neither did the act of asking questions seem a trustworthy process; and who was I to ask questions? My questioning symbolised more than outsider status. It signified that I had no constraints on my opinions or identity, and also that I had the power to further stigmatise. While I held international legitimacy as someone who was not Congolese, and access to a
system where the newly arrived Congolese person to Canada may have sought connection, answering open-ended and highly personal questions was not a safe process, and I may have represented someone / something larger than my student self. And to the extreme, asking questions could be exploitive, or put host families at risk. Trust was certainly no commodity: In many instances, it had killed. And who was I to re-present these communities?

For study participants, their troubles and complexities were not mine to live, or endure consequence (this is most clearly reflected in Participant 2’s statement in the Colonial legacy section). This work and my actions suggest that what may be desired, is perhaps nothing to do with a health intervention, but witnessing and advocacy. My experience was also that bearing witness in an empathetic way opened doors where traditional clinics or clinicians, however helpful, were left a bit short.

In sum, my positionality, what I and what research represented, why I was sharing space (or asking to share space) became central issues for this study. Perhaps this is not a wrong outcome – it reinforces the need for community-based, participatory research. At no time should pity or sorrow or exclusion be the intent of any research endeavour, or towards any participants, but there is potential for the interpretation be felt, based on historical and social (and intellectual!) precedent. But wounds suffered collectively may benefit from being repaired collectively; engagement is thus necessary, but cannot be defined through the “compassionate but uninvolved observer” (Razack, 2004) : 26).

So were I to conduct the study again, I would consider more participatory methods, for a point of departure with more mutually determined dimensions of mental
health. Sadness and depression may have been my own projections / interpretations / prioritisations. While ‘sadness’ or depression is a common mental health disorder among refugees generally, perhaps there are other idioms of distress to more adequately capture the conceptualisation of an absence of happiness for someone from the DRCongo. This might also open up more connecting with the literature with respect to resilience, instead of literature linking to a loss of hope – itself a colonial interpretation.

Further points to look at would be how trauma as a spiritual designation might be more fully accommodated within mental health services; or if, this being the case, trauma is a useful category at all for someone who is Congolese? Cultural relevance may also provide a comparative enquiry – how culture responds to spiritual injury, and how this may be relevant to care pathways. Participants in this study sought out care or support, but perhaps not in the ways or from the people who Canadian systems / mental health professionals may have wanted them to. From a practical perspective, this also opens the door for greater task shifting and training – possibly from a mental health professional to an allied one, but from a knowledge perspective, a more rewarding endeavour may be found in seeking front-line experience and literature from other disciplines (anthropology, for example) to inform and strengthen educational modules in this area. The conclusion that trauma is too narrowly conceptualised is not yet broad enough in psychiatric literature. Therein we circle back to how knowledge is constructed, and how people’s voices may not feel there is space or safety for them to be represented.
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APPENDICES
Humankind has not woven the web of life. We are but one thread within it. Whatever we do to the web, we do to ourselves. All things are bound together. All things connect.

~Chief Seattle

Nteza means ‘I’m expecting’ in Kinyarwanda, the central Bantu (people’s) language of Rwanda, Burundi, and northeast DR Congo. I share her story for three reasons: first, in her own words, because “[she endures] witness for the people of [her] home” – a witness, as I would come to learn, which was a vitally important and compelling one. Second, Nteza’s narrative is one that has touched me both personally and professionally, motivating my research. So in a very real sense – and the third reason for sharing – her story has become mine as well.

Nteza was a 27-year-old Tutsi Rwandaise woman who came to Canada as a refugee via the Congo. She was referred to me by a colleague, her nurse, who felt she could benefit from emotional support through her pregnancy. Nteza had been diagnosed with war-induced PTSD by a previous medical practitioner. The nurse told me that during her first appointment, Nteza started crying in her office when she told Nteza the baby was a boy. Nteza had been in Canada for four months, and was almost six months pregnant. She also had a 4-year-old daughter.

Nteza was at first hesitant to discuss her pregnancy with somebody new, but her nurse introduced me as “une amie sur son équipe / a friend on her team”. I elaborated that the nurse had told me a bit about her situation, about being a refugee in Canada; that I was there to help, that I was there to talk about “internal sorrows”. I told her I understood her pregnancy was the result of having been raped in the Congo, that her husband was in prison for political reasons, and that hers must be a very difficult emotional load to carry. I wondered aloud that perhaps she did not have to carry that load herself; and I assumed that talking about her load might be helpful.

Nteza smiled very shyly, and responded, with eyes downcast, that life carried with it new dreams here; that the “devoir de mémoire, ici, n’est pas pareil / the duty to remember and honour ancestors, here, is not the same20”. She said she missed her family: Her

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20 “The duty to remember [and honour ancestors], here, is not the same” (trans.). “Le devoir de mémoire” is a Rwandan phrase of commemoration specific to the 800,000 killed in the 100-day genocide, not unlike “Lest we forget” marks Remembrance Day and the remembrance of WWI and WWII veterans and fallen soldiers in Canada, the United Kingdom, Australia, and New Zealand.
mother and brothers were dead; her husband was “in prison\textsuperscript{21}” without permission to contact her; she knew nothing of any friends or community. She had fled Rwanda at 13 with an uncle, Uganda at 18 with a family friend, and the Congo at 26 with her daughter – each instance of flight had been due to brutal circumstances of war and exclusion.

Nteza’s social support in Canada was small, but considerable: She had started involvement with a church group, shared a house with her pastor, and had recently befriended a neighbour from Haiti who had a daughter the same age as her own. However, she said that the pregnancy was difficult, both in physical and emotional weight and impact. Her biggest loss was not having community during this time of preparation.

Nteza reflected that she struggled most with feelings of conflicted interests. She felt anger and regret at having discovered abortion would have been an option just four weeks ago; torment that she would have considered such a “discretion non-humaine / inhuman act of will”; and sick that she was at present carrying, and preparing to care for, the seed of hate. The idea of adopting seemed equally horrendous as it was welcoming. She was surprised that the Canadian system didn’t have orphanages, and learnt about foster parents with an air of fascination and curiosity. She was also worried about how to explain the potential loss of a sibling to her 4-year-old daughter, who expressed enthusiasm about being a big sister. In the end, Nteza decided to keep the baby.

Nteza came regularly to therapy throughout the pregnancy. She liked Beethoven, dreamt of playing the piano, and loved to walk alongside the Canal; its waters, she said, were calming, and she loved to listen and find “peacefulness” as she watched them flow. She spoke quietly and with eyes downcast, and I became very familiar with her shy, private smile. She unfailingly kept appointments, reliably navigating herself, her visibly heavy belly, and her daughter on the hour-long bus ride without complaint. At times when home visits were pre-empted due to unplanned clinic needs, she would always say, “D’accord. Je vous accueillirai prochainement. / Okay. I will welcome you next time”. Her humility touched me. I reflected that perhaps I was not the most ideal source of support for Nteza: I was a stranger in a strange land; my privilege cast me as unable to identify, really, with her day-to-day struggles; and however likeable our rapport, I was more like a sister than an elder helper. The constructs of my office, with all its care about “confidentiality” and “professionalism”, offered no pride to her. But I recognised that I was, despite all these things, a woman, and one of colour; these were enough to give me privileged access.

\textsuperscript{21} Often, euphemism for death by unnatural circumstances. I suspect that being a widow, and a victim of rape, were not favourable considerations of status in Nteza’s communities of origin. These ramifications, or these considerations, I did not discuss.
Two weeks after the birth, Nteza’s nurse and a visitation worker contacted me after a home visit, concerned about the level of despondency they had observed. Nteza “n’était pas dans la zone / seemed out of it” while breastfeeding, with demonstrated difficulty in responding to the infant’s cries; they also reported her energy level and affect seemed very low overall. I had noted Nteza seemed withdrawn the last time that I had seen her; I shared with the nurse that she had expressed feeling overwhelmed with caring for the child, about whom she had felt ambivalent even carrying. The visitation worker shared that the infant was noticeably underweight, and that she was concerned about the lack of attachment between Nteza and the baby. Nteza had also not yet chosen a name.

The nurse scheduled an in-clinic follow-up for Nteza and the children, and during this appointment felt Nteza was “so symptomatic” that she was concerned. The nurse called me into her office to speak with Nteza. Nteza said her stress was “au point que j’ai besoin de quitter . . . je ne partirai jamais, mais la paix de la fleuve . . . j’aimerais flotter loin d’ici, loin de ces difficultés / to the point where I need to get out … I would never leave, but the river’s peacefulness … it would be nice to float away, far from here, far from these hardships”. I tried to translate to the nurse that Nteza had always found the river peaceful, in fact liked to take walks and meditate there; but it was decided this was of sufficient concern to necessitate intervention. The nurse referred Nteza for psychiatric emergency evaluation for post-partum depression, citing a suicidal plan with access.

Mental health policy has a way of defining procedures, for the purposes of clarity in crisis; unfortunately, they do not always translate well or tailor to the situation at hand. Systemic regulations, while designed for prevention and crisis management, in fact only served to bring up new crises. Nteza’s symptomology, and specificity of her “plan”, qualified medically as “severe”. She was referred for emergency psychiatric evaluation, which necessitated ambulance transport to the emergency ward; this in turn necessitated foster care placement for her children because standard placement was for 24-hours or overnight observation. I was given charge to explain the intervention system to Nteza: why the ambulance was being called, why child protection was being involved, links between post-traumatic stress and feelings of sadness or stress; I also thought I might maybe explain a little bit about what “hospitals here” looked like, and what relief we thought a “post-partum depression diagnosis” could bring.

Even though agencies are not required to offer such explanations, and ill-equipped to have the time or resources sufficient to do so, to this day I cannot say there was any “humanity” in this task. Nteza expressed repeatedly not understanding why she didn’t have a choice to go to the hospital, why her children and I couldn’t go with her, and that she did not want to be diagnosed as depressed. I could only offer lame responses of “C’est la loi / It’s the law” about the ambulance, “Tu nous inquiètes / We’re worried
about you” about the depression, and “Vos enfants seront corrects / Your children will be okay” about being placed. I asked for my supervisor’s approval to negotiate being able to meet Nteza at the hospital emergency room; with Nteza, I suggested to child protection arranging foster placement that the children please be placed under the care of her pastor. In both instances I was told my recommendations would be considered, but that these were things that ultimately the respective agencies now involved would decide. It was then that the ambulance driver arrived to bring Nteza on board. Nteza looked at me and said, “Ceci ne va pas m’aider / This is not going to help me”. As the ambulance personnel carried her away, I could hear her crying out for her mother.

Nteza was already admitted when I reached the hospital; triage personnel said that they didn’t have consent for me to accompany her admission, even if they could tell me what room she was in. Three days later, we were informed Nteza had been admitted under suicide watch and released 17 hours later, during which time she received a diagnosis of post-partum depression and one sample of an anti-depressant. The brief noted that she had been non-compliant to treatment. Child protection services united Nteza with the children after she was released, though they continued to monitor her regularly for some months after about “parenting”. Nteza never returned, either to our clinic or the hospital, for services.

APPENDIX B: Steps in reviewing PTSD treatment literature.

Retrieving the literature on mental health interventions for people affected by state-sanctioned violence living now in Canada.

Key search parameters focused on Canadian initiatives in the last 15 years, with people coming from (as Tables 2 and 3 corroborate) Rwanda, the DR Congo, the former Yugoslavia, and Darfur. Table 4 lists the search engines consulted.

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<th>SCHOLARLY LITERATURE SEARCH</th>
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<tr>
<td>1  Campbell Collaboration</td>
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<td>2  Cochrane Database of Systematic Reviews</td>
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<table>
<thead>
<tr>
<th>GREY LITERATURE SEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>9  Canadian Centre for Victims of Torture (CCVT): Publications</td>
</tr>
<tr>
<td>10 Canadian Evaluation Society Unpublished Literature Bank</td>
</tr>
<tr>
<td>11 CERIS: Ontario Metropolis Centre</td>
</tr>
<tr>
<td>12 Google Scholar</td>
</tr>
<tr>
<td>13 OpenSIGLE: GreyNet / GreyNet Conference-Based Collections</td>
</tr>
<tr>
<td>14 Réseau documentaire sur la région des grands lacs africains</td>
</tr>
<tr>
<td>15 search-pdf.com</td>
</tr>
<tr>
<td>16 vivo.org</td>
</tr>
</tbody>
</table>

The results were then filtered according to the following six criteria:

a. articles written in French or in English;
b. literature concerned with mental health treatment;
c. treatments affiliated with a Canadian institution or agency;
d. health concerns focused on refugee trauma (not combat PTSD or operational stress disorders within the military);
e. target countries of origin / conflicts specific to areas of extreme violence or UNHCR concern within the past 15 years; and,
f. articles written in the last ten years.

Three searches were implemented for each database.

Search 1 keywords: PTSD and genocide and canad*
Search 2 keywords: PTSD and refugee and (intervent* or treat*) and canad*
Search 3 keywords: (ptsd or traum* or traum* stress) and refugee and (intervent* or effect*) and canad*

French databases (Réseau documentaire sur la region des grands lacs africains, Google.fr, and the Canadian Evaluation Society Unpublished Literature Bank) included French keyword equivalents. A partial search was conducted on Google (general search engine) with Search 3 keywords + the keyword “pdf”, which yielded a small number of community agency-generated briefs not retrieved in Google Scholar. Following this, recurring author names were contacted, requesting for any additional relevant material. A total of 62 articles were retrieved.

**Abstract sift for relevance.** From the 62 articles, a series of questions was applied to extract relevance. Where the abstract provided insufficient information to assess any one question, the full paper was also retrieved. In instances where website information lacked specificity (most often in articles comprising group treatment or where service provisions were being summarised), relevant individuals were contacted through personal follow-up.

<table>
<thead>
<tr>
<th>Questions for abstract sift</th>
<th>Result (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the article:</td>
<td></td>
</tr>
<tr>
<td>1) Written in French or in English?</td>
<td>61</td>
</tr>
<tr>
<td>2) Affiliated with a Canadian institution or agency?</td>
<td>38</td>
</tr>
<tr>
<td>3) Relevant to refugees (not combat PTSD)?</td>
<td>19</td>
</tr>
<tr>
<td>4) Specific to genocide/UNHCR concern within the past 15 years?</td>
<td>18</td>
</tr>
<tr>
<td>5) Specific to intervention?</td>
<td>12</td>
</tr>
<tr>
<td>6) Written within the past 10 years?</td>
<td>10</td>
</tr>
</tbody>
</table>

Abstract sift result (N) filtered the 62 articles down to 1022.

Thus, the search retrieved 11 relevant sources: one randomised study, two intervention manuals, two research summaries of intervention approaches, and six agencies providing source information about their interventions through personal correspondence. 51 articles were excluded.

---

22 One article (Schaal, Elbert, & Neuner, 2009), retrieved from the grey literature base viva.org, was not originally included for review as it did not meet Canadian-based criteria. However, upon reviewing other sources, I felt that inclusion was justified for the following eight reasons: (1) a number of other sources referenced the authors; (2) it was found to be quite robust under actual review; (3) it satisfied the other five criteria; (4) the therapeutic modality under discussion complemented those in other articles included for review; (5) Germany and Canada’s healthcare systems share some similarities22; (6) Germany and Canada are of similar rank in contributions to the UNHCR GAR program (ranking 7 and 9, respectively: (United Nation High Commissioner for Refugees, 2010, United Nations, 2009) ; (7) Germany and Canada, as host societies, also welcome equivalent percentages of their population (8%; ibid.) under UNHCR concern; and (8) no other randomised controlled study (RCT) specific to genocide-affected populations qualified for this review.
Ranking the articles. Following abstract sift, the Quality Assessment Tool (QAT) (G. Butler, Hodgkinson, Holmes, & & Marshall, 2004) was implemented to assess robust methodology. Each of the eleven studies was reviewed using the QAT and ranked according to sample selection, bias, data collection, and data analysis. Deductions for each category permitted up to four points, and subsequently added together to provide an overall score for the study. Studies with the fewest deductions ranked as the most methodologically robust; studies with deductions ranking 11 or higher ranked as methodologically unreliable. Table 5 lists the methodological ranking scheme according to the QAT.

<table>
<thead>
<tr>
<th>Score /20</th>
<th>Methodological rating</th>
<th>Result (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 – 7</td>
<td>Strong</td>
<td>3</td>
</tr>
<tr>
<td>7 – 9</td>
<td>Average</td>
<td>4</td>
</tr>
<tr>
<td>9 – 11</td>
<td>Weak</td>
<td>2</td>
</tr>
<tr>
<td>11+</td>
<td>Unreliable</td>
<td>2</td>
</tr>
</tbody>
</table>

The search retrieved 11 relevant sources: one randomised study, two intervention manuals, two research summaries of intervention approaches, and six agencies providing source information about their interventions through personal correspondence. Nine studies were identified by the QAT scale as methodologically reliable: two child-specific reviews, three interventions facilitated at community agencies, two summaries of interviews, and two intervention manuals.

APPENDIX C: Letters of Invitation to Participate

C-1: School Boards

APPENDIX A-1: GENERAL LETTER OF INVITATION TO PARTICIPATE:
SCHOOL BOARD

<table>
<thead>
<tr>
<th>Name of Superintendent</th>
<th>SENT BY POST AND BY EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of School Board</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City, PR. Postal Code</td>
<td></td>
</tr>
</tbody>
</table>

Date

Dear [NAME OF SCHOOL BOARD]:

I am a PhD fellow at the University of Toronto, undertaking a research project called “State-sanctioned violence and mental health: Implications for learning and treatment”, which seeks to improve school-based support for child survivors of war. I am contacting [NAME OF SCHOOL BOARD] for assistance in recruiting suitable participants for interview.

What participation looks like

I would like to interview elementary school students and their parents with [-] whose country of origin is the Democratic Republic of the Congo (DRC). I would ideally like to recruit 3 to 4 students per school, at 3 or 4 schools, for a total of 12 interviews. I would also like to interview the school principals, and one teacher at each school working with the students directly. While other conflicts may be represented within the student body of [-], I am limiting my focus to the DRC.

The total time investment will be about four (4) hours for students and their parents, one and a half (1.5) hours for staff / teachers, and 45 minutes for the principal.

Benefits of participation for the [NAME OF SCHOOL BOARD]

Upon completion, this study promises the following:

1. A brief description of discourse of mental health at sampled schools;
2. Support resources and professional development training for teachers about trace effects and impacts of extreme political violence on learning, and social and emotional development;
3. Recommendations on how to better respond to or accommodate these needs, both pedagogically and systematically; and,
4. Identification of pathways to additional supports for students’ parents or families.

After completion of interview, a framed portrait photo of each student and his/her parent will be offered to the student’s family at no cost or obligation. If the families so choose, a
framed photo of the group of student participants will also be offered to the School (or [NAME OF SCHOOL BOARD]) for an employee exhibition/demonstration.

Proposed timeline

Over a period of six (6) weeks, for 2 days per week, I propose the following involvement at [NAME OF SCHOOL]:

Week 1 Observation and informal presence in classroom (2 days)
Week 2 Questionnaire 1
Week 3 Questionnaire 2
Week 4 Semi-structured interviews
Week 5 Closing interviews & photos
Week 6 Informal presence, present photo prints to students & goodbyes

Forms for approval from the [NAME OF SCHOOL BOARD]

Cover letters, questionnaires, and interview questions are attached for your review.

Approval from the University of Toronto

The University of Toronto’s Research Ethics Office has reviewed and approved this study. For any modifications or for additional questions, you may contact me by email at athena.madan@utoronto.ca. You may also contact the University of Toronto Research Ethics at ethicsreview@utoronto.ca.

I trust this study will be of interest to the Board, and strengthen support for some of the most vulnerable of its student body.

With appreciation, and kind regards

[signature]

---

Athena Madan, PhD candidate
Supervisors: George Del PhD | Kwane McKenzie MD MRCPsy Ch
University of Toronto | Centre for Addiction and Mental Health
Sociology and Equity Studies in Education | Health Systems & Health Equity Research
athena.madan@utoronto.ca

Ontario Institute for Studies in Education of the University of Toronto
252 Bloor Street West, Toronto, ON M5S 1V6
Nom du Suiveur d'Étude

Nom du Conseil scolaire

Adresse postale

Ville, PR : Code postal

Date

Cher(e) [-],

Je suis doctorante à l’Université de Toronto et j’entreprends un projet de recherche intitulé "Violence politique et santé mentale : implications sur l’éducation et la santé", dont l’objectif est d’améliorer le soutien scolaire aux enfants ayant survécu à la guerre. Je souhaite [-] afin de solliciter de l’aide pour le recrutement de participants aptes à prendre part à des entretiens.

Détails de la participation

Je souhaiterais interroger des élèves du primaire ainsi que leurs parents avec [-] dont le pays d’origine est la République démocratique du Congo (RDC). J’aurais besoin idéalement de recruter 3 à 4 élèves par école, dans 3 ou 4 écoles, pour un total de 12 entretiens. J’interrogerai également dans chaque école le Principal et un enseignant travaillant directement avec les élèves. Bien que d’autres conflits puissent être représentés dans la population d’élèves de [-], mon enquête ne porte que sur la RDC.

La durée totale investie sera d’environ quatre (4) heures pour les élèves et leurs parents, une heure et demie (1,5) pour le personnel ou les enseignants et 45 minutes pour le Principal.

Avantages de la participation pour [-]

Une fois cette étude terminée, les points suivants sont assurés :
1. Une brève description du discours sur la santé mentale des écoles échantillonnées de [-],
2. Des ressources de soutien et des formations de perfectionnement professionnel destinées aux enseignants dans le but de reconnaître les effets et les répercussions de la violence politique sur l’apprentissage ainsi que sur le développement social et affectif,
3. Des recommandations visant à mieux répondre à ces besoins, de façon pédagogique et systématique ; et
4. L’identification de voies d’aide additionnelles pour les parents ou la famille des élèves.

Ontario Institute for Studies in Education of the University of Toronto
252 Bloor Street West, Toronto, ON M5S 2V6
Après l’entrevue, un portrait encadré de chaque élève et de son parcours sera offert à la famille de l’élève sans frais et sans obligation. Si la famille le souhaite, une photo encadrée du groupe d’élèves participants sera offerte à l’école pour être accrochée dans ses locaux.

Calendrier proposé

Pendant une période de six (6) semaines, à raison de 2 jours par semaine, je propose le calendrier suivant [•••]

- Semaine 1: Observation et présence informelle dans les salles de classe (2 jours)
- Semaine 2: Questionnaire 1
- Semaine 3: Questionnaire 2
- Semaine 4: Entretiens semi-structurés
- Semaine 5: Entretiens de culture et photos
- Semaine 6: Présence informelle / remise des photos imprimées aux élèves et conclusion

Formulaires d’approbation

Veuillez trouver ci-joint les lettres de consentement, les questionnaires et les questions qui seront posées lors des entretiens.

Approbation de l’Université de Toronto

Le Bureau d’éthique de la recherche de l’Université de Toronto a examiné et approuvé cette étude. Pour toute modification ou pour des questions supplémentaires, veuillez vous adresser à l’adresse : athena.madan@utoronto.ca. Vous pouvez également contacter le Bureau d’éthique de la recherche de l’Université de Toronto à l’adresse : ethics.review@utoronto.ca.

J’ai la conviction que cette étude intéressera le Conseil et renforcera le soutien aux membres les plus vulnérables de sa population d’élèves.

Veuillez accepter mes remerciements et mes meilleures salutations,

Nom du Surintendant

[signature]

Athena Madan, OC, PhD candidate
Supervisors: George Delz PhD, Kwame McKenzie MD, MRCPsych
University of Toronto | Centre for Addiction and Mental Health
Sociology and Equity Studies in Education | Health Systems & Health Equity Research
athena.madan@utoronto.ca

Ontario Institute for Studies in Education of the University of Toronto
252 Bloor Street West, Toronto, ON M5S 1V6
APPENDIX A 2: GENERAL LETTER OF INVITATION TO PARTICIPATE: INDIVIDUAL SCHOOL

Name of Principal
Name of School
Address
City, P.O. Postal Code
Date

Dear [NAME OF SCHOOL]:

I am a PhD fellow at the University of Toronto, undertaking a research project called “State-sanctioned violence and mental health: Implications for learning and treatment”, which seeks to improve school-based support for child survivors of war. I am contacting [NAME OF SCHOOL] for assistance in recruiting suitable participants for interview.

What participation looks like

I would like to interview elementary school students and their parents with [NAME OF SCHOOL] whose country of origin is the Democratic Republic of the Congo (DRC). I would ideally like to recruit 3 to 4 students at [NAME OF SCHOOL], you as the school principal, and one teacher who works with the students directly. While other conflicts may be represented within the student body at [NAME OF SCHOOL], I am limiting my focus to the DRC.

The total time investment will be about four (4) hours for students and their parents, one and a half (1.5) hours for staff / teachers, and 45 minutes for you, the principal.

Benefits of participation for the [NAME OF SCHOOL BOARD]

Upon completion, this study promises the following:
1. A brief description of discourse of mental health at sampled schools.
2. Support resources and professional development training for teachers about trace effects and impacts of extreme political violence on learning, and social and emotional development.
3. Recommendations on how to better respond to or accommodate these needs, both pedagogically and systemically; and,
4. Identification of pathways to additional supports for students’ parents or families.

After completion of interview, a framed portrait photo of each student and his/her parent will be offered to the student’s family at no cost or obligation. If the families so choose, a
framed photo of the group of student participants will also be offered to the School (or [NAME OF SCHOOL BOARD]) for in-house exhibition/display.

Proposed timeline

Over a period of six (6) weeks, for 2 days per week, I propose the following involvement at [NAME OF SCHOOL]:

- **Week 1**: Observation and informal presence in classroom (3 days)
- **Week 2**: Questionnaire 1
- **Week 3**: Questionnaire 2
- **Week 4**: Semi-structured interviews
- **Week 5**: Closing interviews & photos
- **Week 6**: Informal presence / present photo prints to students & goodbyes

Forms for approval from [NAME OF SCHOOL]

Consent letters, questionnaires, and interview questions are attached for your review.

Approval from the University of Toronto

The University of Toronto’s Research Ethics Office has reviewed and approved this study. For any modifications or for additional questions, you may contact me by email at athena.madan@utoronto.ca. You may also contact the University of Toronto Research Ethics at ethics.review@utoronto.ca.

I trust this study will be of interest to [NAME OF SCHOOL], and strengthen support for some of the most vulnerable of its student body.

With appreciation, and kind regards

[signature]

---

Athena Madan, PhD candidate
Supervisors: George Del, PhD | Kwame McKenzie, MD, M.R.C.Psych
University of Toronto | Centre for Addiction and Mental Health
Sociology and Equity Studies in Education | Centre for Health Systems & Health Equity Research
athena.madan@utoronto.ca
Nom du Directeur
Nom de l'École
Adresse postale
Ville, PR Code postal

Date

Cher/Chère [-],

Je suis doctorante à l'Université de Toronto et j'entreprends un projet de recherche intitulé « Violence politique et santé mentale : implications sur l'éducation et traitement », dont l'objectif est d'améliorer le soutien scolaire aux enfants ayant survécu à la guerre. Je vous contacte afin de solliciter de l'aide pour le recrutement de participants aptes à prendre part à des entretiens.

Détails de la participation

Je souhaiterais interroger des élèves du [ primaire ] ainsi que leurs parents avec [-] dont le pays d'origine est la République démocratique du Congo (RDC). J'aurais besoin idéalement de recruter 3 à 4 élèves. J'aimerais également interroger vous, le Directeur, et un enseignant travaillant directement avec les élèves. Bien que d'autres conflits puissent être représentés dans la population d'élèves de [-], mon enquête ne porte que sur la RDC.

La durée totale investie sera d'environ quatre (4) heures pour les élèves et leurs parents, une heure et demie (1,5) pour le personnel / enseignants et 45 minutes pour vous, le Directeur.

Avantages de la participation pour [-]

Une fois cette étude terminée, les points suivants sont assurés :
1. Une brève description du discours sur la santé mentale des écoles déchirées par [-].
2. Des ressources de soutien et des formations de perfectionnement professionnel destinées aux enseignants dans le but de reconnaître les effets et les répercussions de la violence politique sur l'apprentissage ainsi que sur le développement social et affectif ;
3. Des recommandations visant à mieux répondre à ces besoins, de façon pédagogique et systmatique ; et
4. L'identification de voies d'aide additionnelles pour les parents ou la famille des élèves.

Ontario Institute for Studies in Education of the University of Toronto
252 Bloor Street West, Toronto, ON M5S 1V6
Après l'entretien, un portrait encadré de chaque élève et de son parent sera offert à la famille de l'élève sans frais et sans obligation. Si la famille fait ce choix, une photo encadrée du groupe d'élèves participants sera offerte à l'école pour être accrochée dans ses locaux.

**Calendrier proposé**

Pendant une période de six (6) semaines, à raison de 2 jours par semaine, je propose le calendrier suivant à [ ]:

- Semaine 1: Observation et présence informelle dans les salles de classe (2 jours)
- Semaine 2: Questionnaire 1
- Semaine 3: Questionnaire 2
- Semaine 4: Entretiens semi-structurés
- Semaine 5: Entretiens de clôture et photos
- Semaine 6: Présence informelle / remise des photos imprimées aux élèves et concluded

**Formulaire d'approbation**

Veuillez trouver ci-joint les lettres de consentement, les questionnaires et les questions qui seront posées lors des entretiens.

**Approval de l'Université de Toronto**

Le Bureau d'éthique de la recherche de l' Université de Toronto a examiné et approuvé cette étude. Pour toute modification ou pour des questions supplémentaires, je vous invite à me contacter à l'adresse: athena.madan@utoronto.ca. Vous pouvez également contacter le Bureau d'éthique de la recherche de l'Université de Toronto à l'adresse: ethics.review@utoronto.ca.

J'ai la conviction que cette étude intéressera le Conseil et renforcera le soutien aux membres les plus vulnérables de sa population d'élèves.

Veuillez accepter mes remerciements et mes meilleures salutations,

[name]

---

Athena Madan, CCC, PhD candidate
Supervisors: George Del, PhD, Kwanz McKenize, MD, MRC Psych
University of Toronto | Centre for Addiction and Mental Health
Sociology and Equity Studies in Education | of Health Systems & Health Equity Research
athena.madan@utoronto.ca

Ontario Institute for Studies in Education of the University of Toronto
252 Bloor Street West, Toronto, ON M5S 1V6
APPENDIX A-3: GENERAL LETTER OF INVITATION TO PARTICIPATE:
COMMUNITY MENTAL HEALTH AGENCY

Clinical/Executive Director
Name of Agency
Address
City, PR: Postal Code

Date

Dear [NAME OF AGENCY]:

I am a PhD fellow at the University of Toronto, undertaking research to improve mental health support for child survivors of war. My project, called “State-sanctioned violence and mental health: Implications for learning and treatment”, explores survivors’ conceptualisations of healing alongside discourses of trauma in mental health. I am contacting the [NAME OF AGENCY] for assistance in recruiting suitable participants for interview.

What participation looks like:

I would like to interview 3 to 4 families at [NAME OF AGENCY] whose country of origin is the Democratic Republic of the Congo (DRC). I’d also like to interview a member of your staff who works with the clients directly. While other conflicts may be represented at [NAME OF AGENCY], I am limiting this study’s focus to the DRC.

The total time investment will be about four (4) hours for families, and one and a half (1.5) hours for your staff.

Benefits of participation for [NAME OF AGENCY]:

Upon completion, this study promises the following:
1. Identification of [NAME OF AGENCY]’s expertise in this subject area of study;
2. Information for non-specialist agencies about conceptualizations of trauma specific to cultures from the DRC;
3. Recommendations on how health systems can provide more comprehensive support to host institutions in Canada, and;
4. Identification of additional community pathways which may foster optimal mental health.

After completion of interview, a framed portrait photo of each dyad (parent / child) will be offered to the family at no cost or obligation. If the families so choose, a framed photo...
of the group of student participants will also be offered to the [NAME OF AGENCY] for in-house exhibition/display.

Proposed timeline

Over a period of six (6) weeks, I propose the following involvement at [NAME OF AGENCY]:

- **Week 1**: Introductions
- **Week 2**: Interview 1, with staff as desired or appropriate
- **Week 3**: Interview 2, individually
- **Week 4**: Casual follow up and preparation for focus group
- **Week 5**: Focus group & photos of dyads
- **Week 6**: Return prints of dyads & goodbyes

Forms for approval

Content letters, questionnaires, and interview questions are attached for your review.

Approval from the University of Toronto

The University of Toronto’s Research Ethics Office has reviewed and approved this study. For any modifications or for additional information, you may contact me by email at athena.madan@utoronto.ca. You may also contact the University of Toronto Research Ethics at ethicsreview@utoronto.ca.

I trust this study will be of interest to [NAME OF AGENCY]. Findings will highlight your expertise and provide learning for non-specialist agencies whereby optimal mental health can be fostered more systematically.

With appreciation, and kind regards

[surname]

---

Athena Madan, CCC PhD candidate
Supervisors: George Des PhD, Kwame McKenzie MD MRCPsych
University of Toronto | Centre for Addiction and Mental Health
Sociology and Equity Studies in Education | Health Systems & Health Equity Research
athena.madan@utoronto.ca
Directeur(trice) clinique/exécutif(ve) ENVoyé PAR LA POSTE & PAR COURRIEL
Nom de l'Agence
Adresse postale
Ville, PR. Code postal

Cher Chère [-],

Je suis doctorante à l'Université de Toronto et j'entends mener un projet de recherche visant à améliorer le soutien offert aux enfants ayant survécu à la guerre en matière de santé mentale. Intitulé « Violence policière et santé mentale : implications sur l'éducation et traitement », mon projet explore les conceptualisations des survivants vis-à-vis de la guérison parallèlement aux discours liés aux traumatismes en santé mentale. Je contacte [-] afin de solliciter de l'aide pour le recrutement de participants aptes à prendre part à des entretiens.

Détails la participation

Je souhaiterais interviewer 3 à 4 familles (parents et enfants) à [-] dont le pays d'origine est la République démocratique du Congo (RDC). J'aurais également interroger un membre de votre personnel travaillant directement avec ces clients. Bien que d'autres conflits puissent être représentés à [-], mon enquête ne porte que sur la RDC.

Le temps total investi sera de quatre (4) heures pour les familles et une heure et demie (1,5) pour votre personnel.

Avantages de la participation pour [-]

Une fois cette étude terminée, les points suivants sont assurés :
1. L'identification de l'expertise de [-] dans ce domaine d'étude ;
2. Des informations pour les organismes non spécialisés sur les conceptualisations des traumatismes spécifiques aux cultures de la RDC ;
3. Des recommandations sur la façon dont ces systèmes de santé peuvent fournir un soutien plus complet en tant qu'institutions accueillant des enfants au Canada ; et
4. L'identification de voies communautaires supplémentaires visant à promouvoir une santé mentale optimale.

Après l'entretien, un portrait encadré de chaque dyade (parent/enfant) sera offert à la famille sans frais et sans obligation. Si la famille le souhaite, une photo encadrée du groupe d'hérités participants sera offerte à [-] pour être accrochée dans les locaux de l'école.

Calendrier proposé

Ontario Institute for Studies in Education of the University of Toronto
252 Bloor Street West, Toronto, ON MSS 1V6
Pendant une période de six (6) semaines, je propose le calendrier suivant à [-]

Séance 1 : Présentations
Séance 2 : Entretien 1
Séance 3 : Entretien 2
Séance 4 : Suivi informel et préparation du groupe de discussion
Séance 5 : Groupe de discussion et photos des dyades
Séance 6 : Résumé des photos impression des dyades et conclusion

J’ai la conviction que cette étude intéressera [-]. Ses conclusions mettront en valeur votre expertise et fourniront des connaissances aux organismes non spécialisés, qui leur permettront de promouvoir une santé mentale optimale de façon plus systématique.

Veuillez accepter mes remerciements et mes meilleures salutations,

[signature]

Athena Madariaga, CCC PhD candidate
Supervisors: George Del, PhD | Kwame McKenzie, MD, MRC Psych
University of Toronto | Centre for Addiction and Mental Health
Sociology and Equity Studies in Education of Health Systems & Health Equity Research
athena.madariaga@utoronto.ca
APPENDIX D: Letters of Consent

APPENDIX B: INFORMED CONSENT LETTER: PARTICIPANTS

Dear [FRIEND / MEMBER / PARENT],

As a [FRIEND / MEMBER / PARENT] at [NAME OF SCHOOL OR COMMUNITY AGENCY], you are invited to participate in my University of Toronto study called “State-sanctioned violence and mental health: Implications for learning and treatment”.

Objectives of the study

Medical and psychological services currently in place for people affected by political violence have limited effectiveness. Most adults drop out of clinical treatment before resolving chief complaints, and special programs at schools aren’t actually helping children learn. So, schools, and people providing services need to understand how supports could be more effective.

What participation looks like

Participation in this study consists of two individual interviews and one group interview, with other Congolese parents/adults at [NAME OF AGENCY]. Total time investment will be about four (4) hours over a period of six (6) weeks.

This study is for educational purposes only. There is no government or commercial interest. Participation is voluntary; you may withdraw from the study at any time, without any negative consequences to you or your family. You may also choose not to answer any given question. Interviews will be tape-recorded, only to be listened by me, and later transcribed, only to be reviewed by me, for purposes of analysis informing my write-up. If any of your statements are cited in my report, you will review and approve them. You will also choose a fictional name to describe you.

I will also ask to take a portrait photo of you and your child. These photos will be used for professional development at the Toronto District School Board, or for teacher / medical professional training at the University of Toronto. Pictures will not be sold or published for any monetary value. You will receive print copies of all photos. Similar to your interview, you will also choose a fictional name to describe you.

Benefits to participating in the study

Your participation in this study will help inform and improve social and emotional support for your children, their school communities, and other families who are building new lives in Canada.
During the interviews, you will be able to talk about your opinions in a friendly, accepting, and positive setting. If desired, you can receive a summary of the study’s conclusions (electronically, in the mail, or through [NAME OF AGENCY]) after the write-up is finished.

Your participation in this study will be compensated $20 per interview, for a total of $60. Payments will be given to you in cash at the completion of each interview.

After completion of the study, you will also be offered a framed print of your photo, at no additional cost or obligation. If you so choose, a duplicate photo will also be offered to the [NAME OF AGENCY] for in-house exhibition/display.

Risks to participating in the study

There is very little risk to participating in this study. No part of this study or its results will be used to evaluate you. You will also have direct input as to how you and your opinions are represented. As indicated above, you may withdraw from the project at any time without any negative consequences to you or your family.

Since one interview will take place in a group, responses in that group cannot be guaranteed complete confidentiality; however, all written and electronic recordings of your participation will only be accessible by me. All recordings, transcripts, and images will be saved until the end of June 2014 [on a secure server at the University of Toronto]. After this time, they will be permanently destroyed.

About the Researcher

I am a doctoral candidate at the University of Toronto in the Department of Sociology & Equity Studies in Education. During the months of November and December of 2011, I spent some time in Kinshasa, observing the election, tutoring children and working in reconciliation/peace cells. I am a certified mental health therapist with the Canadian Counselling & Psychotherapy Association, whose interests are to improve psychosocial support in schools for survivors of war and also for people of colour.

For more information

If you would like more information about this project, please contact me by telephone at [HERE], or by email at ahona.madze@utoronto.ca. You may also contact the University of Toronto Research Ethics at ethicsreview@utoronto.ca.
If you agree to participate, please complete and sign this consent form. I will also give you a copy for your own records.

**Consent form (PARENTS)**

I, ____________________________________________________________________________, have read this letter of information and agree to participate in the research project being conducted by Athena Madan, called: “State-sanctioned violence and mental health: Implications for learning and treatment.”

Name of parent: __________________________________________________________________

Name of student: __________________________________________________________________

Signature: _____________________________________________________________________ Date: __________________

**Consent form (TEENAGERS OR ADULTS with no children)**

I, ____________________________________________________________________________, have read this letter of information and agree to participate in the research project being conducted by Athena Madan, called: “State-sanctioned violence and mental health: Implications for learning and treatment.”

Name of adult: __________________________________________________________________

Signature: _____________________________________________________________________ Date: __________________
If you agree to participate, please complete and sign this consent form. I will also give you a copy for your own records.

Consent form (STUDENT / CHILD)

I, ____________________________, have read this letter of information with my parent(s) and agree to participate in Athena’s project.

Name of student: ____________________________
Name of parent: ____________________________
Student signature: ____________________________ Date: ______________

Consent form (TEACHER)

I, ____________________________, have read this letter of information and agree to participate in the research project being conducted by Athena Madan, called: “State-sanctioned violence and mental health: Implications for learning and treatment.”

Name of teacher: ____________________________
Name of school: ____________________________ Class: ______________
Signature: ____________________________ Date: ______________
Cher/Chère [AMMÉMÈRE/PARENT],

En qualité de [AMMÉMÈRE/PARENT] à [NOM DE L’AGENCE], vous êtes invité(e) à participer à mon étude pour l’Université de Toronto intitulée « Violence politique et santé mentale : implications sur l’éducation et traitement ».

Objectifs de l’étude

Les services médicaux et psychologiques actuellement en place pour les personnes affectées par des violences politiques ont une efficacité limitée : la plupart des adultes abandonnent le traitement clinique avant de résoudre leurs principaux maladies, et les programmes spécialisés au sein des écoles ne soutiennent pas réellement l’apprentissage des enfants. Les cliniques, les écoles et les prestataires de services doivent comprendre comment améliorer l’efficacité de leur soutien.

Détails de la participation

La participation à cette étude consiste en deux entretiens individuels et un entretien en groupe, avec d’autres parents/adultes congolais à [-]. La durée totale investie sera d’environ quatre (4) heures.

Cette étude est destinée à des fins exclusivement éducatives. Elle n’a aucun intérêt gouvernemental ou commercial. La participation est volontaire, vous pouvez donc choisir de vous retirer de l’étude à tout moment, sans conséquence négative pour vous ou votre famille. Vous pouvez également choisir de ne pas répondre à une question donnée. Les entretiens seront enregistrés, je serai la seule à les écouter, puis ils seront transcrits, et je serait à même les visiter, à des fins d’analyse pour renseigner mon rapport. Si je cite vos déclarations dans mon rapport, je vous les ferai lire et je les soumettrai à votre approbation. Vous choisirez également un nom fictif pour vous décrire.

Je vous demanderai également de m’autoriser à prendre un portrait/photo de vous et de votre enfant. Ces photos seront utilisées dans le cadre de formations de perfectionnement professionnel au sein du Conseil scolaire de district de Toronto, ou pour la formation des enseignants et des professionnels de santé à l’Université de Toronto. Ces photos ne seront ni vendues, ni publiées pour une valeur rémunérateure. Vous recevrez une copie imprimée de toutes les photos. Comme pour votre entretien, si l’une des photos est utilisée dans le cadre d’une présentation, votre autorisation vous sera demandée au préalable. Vous choisirez également un nom fictif pour vous décrire.

Avantages de la participation à l’étude

Ontario Institute for Studies in Education of the University of Toronto
252 Bloor Street West, Toronto, ON M5S1V6 Canada
www.iose.utoronto.ca
Votre participation à cette étude contribuera à informer et à améliorer le soutien social et affectif pour vos enfants, leur communauté scolaire et les autres familles qui démarreront une nouvelle vie au Canada.

Pendant les entretiens, vous pourrez partager vos opnions dans un environnement convivial, tolérant et positif. Si vous le souhaitez, vous recevrez une synthèse des conclusions de l'étude (par courrier électronique, par voie postale, ou par le biais de [-]) à l'issue de l'achèvement du rapport.

Votre participation à cette étude sera rémunérée : 30 $ par entretien, soit un total de 60 $. Vous recevrez le paiement en espèces à la fin de chaque entretien.

Une fois l'étude terminée, on vous offrira également une impression encadrée de votre photo, sans coût supplémentaire en obligation. Si vous le souhaitez, un double de la photo sera également offert à [-] pour être accroché dans vos locaux.

Risques liés à la participation à l'étude

Cette étude comporte très peu de risques. Aucune partie de cette étude et aucun de ses résultats ne servira à vous évaluer. En outre, vous pourrez contribuer directement à la manière dont vous-même et vos opinions seront représentés. Comme indiqué ci-dessus, vous aurez la possibilité de vous retirer du projet à tout moment sans conséquences négatives pour vous ou votre famille.

Étant donné qu'un entretien en groupe aura lieu, les réponses fournies dans ce groupe ne peuvent pas garantir une confidentialité absolue. Toutefois, je serai la seule à pouvoir accéder aux comptes rendus écrites et aux enregistrements électroniques de votre participation. Les enregistrements, les transcriptions et les images (format jpg) seront tous sauvegardés jusqu'à fin juin 2014 [sur un serveur sécurisé à l'Université de Toronto]. Ils seront ensuite définitivement effacés.

À propos du chercheur

Je suis candidate au doctorat à l'Université de Toronto au Département d'études sociologiques et dépeints dans l'enseignement. J'ai passé les mois de novembre et décembre 2011 à Kishaba, où j'avais pour mission d'observer les élections, de fournir un soutien scolaire à des enfants et de travailler dans des cellules de conciliation/paix. Je suis thérapeute agréée en santé mentale membre de l'Association canadienne de counseling et de psychothérapie, dont les intérêts sont d'améliorer le soutien psychosocial dans les écoles auprès des survivants de la guerre et également des personnes de couleur.

Recommandations complémentaires

Pour en savoir plus sur ce projet, vous pouvez me contacter par téléphone au [Nº DE TÉLÉPHONE], ou m'écrire à l'adresse [adresse email]. Vous pouvez...
également contacter le Bureau d'éthique de la recherche de l'Université de Toronto à l'adresse: ethicsreview@utoronto.ca.

Si vous acceptez de participer à cette étude, veuillez remplir et signer ce formulaire de consentement. Je vous fournirai également un exemplaire de ce formulaire que vous pourrez conserver.

**Formulaire de consentement (PARENTS)**

Je soussigné(e), ____________________________, ai lu cette lettre d'information et accepte de participer au projet de recherche mené par Athena Madan, intitulé : « Violence politique et santé mentale : implications sur l'éducation et traitement ».

Nom du parent : ____________________________
Nom de l'élève : ____________________________
Signature : ____________________________ Date : ____________

**Formulaire de consentement (ADOLESCENTS OU ADULTES sans enfant)**

Je soussigné(e), ____________________________, ai lu cette lettre d'information et accepte de participer au projet de recherche mené par Athena Madan, intitulé : « Violence politique et santé mentale : implications sur l'éducation et traitement ».

Nom de l'adulte : ____________________________
Signature : ____________________________ Date : ____________
Si vous acceptez de participer à cette étude, veuillez remplir et signer ce formulaire de consentement. Je vous fournirai également un exemplaire de ce formulaire que vous pourrez conserver.

**Formulaire de consentement (ÉLÈVE/ENFANT)**

Je soussigné(e), __________________________, ai lu cette lettre d'information avec ma mère/mon père et accepte de participer au projet d'Athena.

Nom de l'élève : __________________________________________
Nom du parent : __________________________________________
Signature de l'élève : ____________________ Date : _____________

**Formulaire de consentement (ENSEIGNANT)**

Je soussigné(e), __________________________, ai lu cette lettre d'information et accepte de participer au projet de recherche mené par Athena Madan, intitulé : « Violence politique et santé mentale : implications sur l'éducation et traitement ».

Nom de l'enseignant(e) : ________________________________
Nom de l'école : __________________________ Classe : ____________
Signature : __________________________ Date : _____________
APPENDIX E: Classroom Observation Form

APPENDIX C: CLASSROOM OBSERVATION PROTOCOL

This Classroom Observation Protocol is copyright of American Institutes for Research: www.learningpt.org/literacy/eval/observation.doc (Last retrieved 5 March, 2012).

Classroom Observation Protocol

Instructions to the Observer: The focus of each observation is a reading activity or lesson. The protocol is comprised of: (1) an initial description section, (2) focus areas, and (3) observable indicators and exemplars related to each focus area. The observable indicators form an incomplete and emergent list that should be refined during the course of the observation.

Before the Observation
- Become as familiar as possible with each indicator prior to conducting the observations.
- Conduct informal pre-observation interviews with teachers.

During the Observation
- Provide as vivid a description as possible of the lesson, answering each question with the description section.
- Provide running observation notes related to each focus area, taking care to address every indicator.

After the Observation
- Conduct informal post observation interviews with teachers.
- Annotate your observation notes as you synthesize information from the pre and post interviews and your observation notes.
OBSERVATION FORM

Date of Observation: ____________________ Grade Level: ______________

School: ______________________________ Observation #: ______________

Teacher: ______________________________

Number of Students: ____________________

Describe Groupings (if applicable): _________________________________

Other Adults Present: ________________________________

Describe Learning Activity Observed. Include subject area(s)/theme, purpose, student learning outcomes or instructional goals:

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Duration of Activity: ________________________________

Learning Space: _________________________________

Resources: (include computers, video, audio/voice, black/white boards, overhead, reference/other books, software, maps/globes, wall displays, pictures posters):

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Observation Notes: ________________________________

_________________________________________________________________

_________________________________________________________________

© American Institutes for Research: www.learningpt.org/literacy/eval/observation.doc (last retrieved 5 March, 2012)
APPENDIX F: Mental Health Supports in Schools Questionnaire

APPENDIX D: QUESTIONNAIRE #1
FOR PARENTS, STUDENTS, AND TEACHERS

Adapted from the following sources:


<table>
<thead>
<tr>
<th>SCRIPT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dear Participant:</strong></td>
</tr>
<tr>
<td>Have you ever heard people talk about mental health &amp; well-being? Do you know what this is? Read / review top section.</td>
</tr>
<tr>
<td>The following questions will help inform my research about how mental health and well-being is talked about at school.</td>
</tr>
<tr>
<td>Please answer the following questionnaire as completely as you can. There are no right or wrong answers. The questions may or may not apply to you. There is just the one page to this questionnaire.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TEXTE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cher/Chère participant(e) :</strong></td>
</tr>
<tr>
<td>Avez-vous déjà entendu parler de la santé mentale et du bien-être ? Savez-vous ce que c'est ? (Lire/passer en revue la section du haut du questionnaire.)</td>
</tr>
<tr>
<td>Les questions suivantes contribueront à éclairer ma recherche sur la façon dont on parle de la santé mentale et du bien-être à l’école.</td>
</tr>
<tr>
<td>Veuillez répondre au questionnaire suivant de manière aussi détaillée que possible. Il n’y a pas de bonnes ou de mauvaises réponses. Il est possible que les questions ne soient pas applicables à votre cas. Le questionnaire comprend une seule page.</td>
</tr>
</tbody>
</table>

QUESTIONNAIRE 1a: STUDENTS

Dear Student,

I am interested in finding out what you think about mental health and wellbeing, that is, your feelings, thoughts, relationships, and behaviour.

I greatly appreciate your time and effort in completing this survey.

Name of school: ________________________________

Your name: ___________________________ Today’s date: __ / __ / 2012

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I like coming to school</td>
<td></td>
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<tr>
<td>2. I feel safe at school</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. I have someone to talk to at school if I need help or advice</td>
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<tr>
<td>4. School rules are fair</td>
<td></td>
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<tr>
<td>5. School rules apply to me equally</td>
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<tr>
<td>6. School offers enough support for people’s problems</td>
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<tr>
<td>7. School offers enough information about mental health and wellbeing issues</td>
<td></td>
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<tr>
<td>8. I feel like I belong at school</td>
<td></td>
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<tr>
<td>9. I get to do work at school that I enjoy and find interesting</td>
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<tr>
<td>10. I have friends at school</td>
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<tr>
<td>11. I know who to go to get help with mental health and wellbeing issues if I need it</td>
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<tr>
<td>12. I am comfortable speaking with and getting help from school counsellors</td>
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<tr>
<td>13. There are teachers and other staff who understand me</td>
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<tr>
<td>14. There is at least one teacher at school I really like</td>
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<tr>
<td>15. There is at least one teacher at school who looks like me</td>
<td></td>
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<tr>
<td>16. Teachers show that my overall happiness is important</td>
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</tbody>
</table>

Thank you! 😊

Cher/cher élève,

Je m'intéresse à ce que vous pensez de la santé mentale et du bien-être, c'est-à-dire vos sentiments, vos pensées, vos relations et votre comportement.

Je vous suis très reconnaissante du temps et de l'effort que vous consacrez à cette étude.

Nom de l'école: __________________________

Votre nom: __________________________ Date: ____________ / __________ / 2012

<table>
<thead>
<tr>
<th></th>
<th>Tout à fait d'accord</th>
<th>D'accord</th>
<th>Pas d'accord</th>
<th>Pas du tout d'accord</th>
<th>Je ne sais pas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. J'aime aller à l'école</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Je me sens en sécurité à l'école</td>
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<td></td>
</tr>
<tr>
<td>3. J'ai quelqu'un à qui parler à l'école si j'ai besoin d'aide ou de conseils</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4. Le règlement de l'école est juste</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Le règlement de l'école s'applique à moi de façon égale</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6. L'école offre suffisamment d'aide pour résoudre les problèmes des gens</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>7. L'école donne suffisamment d'informations sur les problèmes liés à la santé mentale et au bien-être</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Je me sens intégré(e) dans l'école</td>
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<tr>
<td>9. À l'école, je travaille sur des sujets qui me plaisent et m'intéressent</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>10. J'ai des amis à l'école</td>
<td></td>
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</tr>
<tr>
<td>11. Je sais à qui demander de l'aide pour tout problème lié à la santé mentale et au bien-être</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Je me sens à l'aise pour parler et demander de l'aide aux conseillers scolaires</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. L'école compte des enseignants et d'autres employés qui me comprennent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. J'apprécie vraiment au moins un(e) enseignant(e) à l'école</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>15. Au moins un(e) enseignant(e) à l'école me ressemble</td>
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<td></td>
</tr>
<tr>
<td>16. Les enseignants montrent que mon bien-être général est important</td>
<td></td>
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</tr>
</tbody>
</table>

Merci! 😊

QUESTIONNAIRE 1b: PARENTS

Dear Parent,

I am interested in finding out what you think about your child’s mental health and wellbeing, that is, his or her feelings, thoughts, relationships, and behaviour at school.

I greatly appreciate your time and effort in completing this survey.

Name of school: _____________________________ Today’s date: __ __ __/ __ __ __/ 2012

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My child likes coming to school</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. My child feels safe at school</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. My child has someone to talk to at school if s/he needs help or advice</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. My child thinks school rules are fair</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. My child thinks school rules apply to him / her equally</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. School offers adequate support for social, emotional, &amp; behavioural difficulties</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. School offers enough information about mental health and wellbeing issues</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>8. My child feels like s/he belongs</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9. My child gets to do work that s/he enjoys and finds interesting</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10. My child has friends at school</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>11. My child knows who to go to for help with mental health and wellbeing issues if s/he needs it</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>12. My child feels comfortable speaking with and getting help from school counsellors</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>13. There are teachers and other staff who understand my child</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>14. There is at least one teacher at school that my child has positive attachment to</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>15. There is at least one teacher that my child can identify with</td>
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<tr>
<td>16. Teachers show that my child’s overall happiness is important</td>
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</tr>
</tbody>
</table>

Thank you! ☺

Cher parent,

Je m'intéresse à ce que vous pensez de la santé mentale et du bien-être de votre enfant, c'est-à-dire ses sentiments, ses pensées, ses relations et son comportement à l'école.

Je vous suis très reconnaissante du temps et de l'effort que vous consacrez à cette étude.

Nom de l'école: __________________________

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<th>Prénom de l'enfant:</th>
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<th>Je ne sais pas</th>
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<tbody>
<tr>
<td>1. Mon enfant aime aller à l'école</td>
<td>☐</td>
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<td>☐</td>
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</tr>
<tr>
<td>2. Mon enfant se sent en sécurité à l'école</td>
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<td>☐</td>
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<tr>
<td>3. Mon enfant a quelqu'un à qui parler à l'école si il/elle a besoin d'aide ou de conseils</td>
<td>☐</td>
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<tr>
<td>4. Mon enfant pense que le règlement de l'école est juste</td>
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</tr>
<tr>
<td>5. Mon enfant pense que le règlement de l'école s'applique à lui/elle de façon égale</td>
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<tr>
<td>6. L'école offre une assistance adéquate pour les difficultés sociales, affectives et comportementales</td>
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<td>☐</td>
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<td>7. L'école donne suffisamment d'informations sur les problèmes liés à la santé mentale et au bien-être</td>
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<td>8. Mon enfant se sent intégré(e) dans l'école</td>
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<td>9. Mon enfant travaille sur des sujets qui lui plaisent et l'intéressent</td>
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<td>11. Mon enfant sait à qui demander de l'aide pour tout problème lié à la santé mentale et au bien-être</td>
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<tr>
<td>12. Mon enfant se sent à l'aise pour parler et demander de l'aide aux conseillers scolaires</td>
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<tr>
<td>13. L'école compte des enseignants et d'autres employés qui comprennent mon enfant</td>
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<td>14. Mon enfant a de l'affection pour au moins un(e) enseignant(e) à l'école</td>
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<td>15. Mon enfant peut s'identifier avec au moins un(e) enseignant(e)</td>
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<tr>
<td>16. Les enseignants montrent que le bien-être général de mon enfant est important</td>
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</tbody>
</table>

Merci ! ☺

QUESTIONNAIRE 1c: TEACHERS

Dear Teacher,

I am interested in finding out what you think about your student’s mental health and wellbeing, that is, his or her feelings, thoughts, relationships, and behaviour at school.

I greatly appreciate your time and effort in completing this survey.

Name of school: ____________________________

<table>
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<tr>
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<th>Today’s date:</th>
<th>/</th>
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<td>Strongly agree</td>
<td>Agree</td>
<td>Disagree</td>
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<td>1. My student likes coming to school</td>
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<td>☐</td>
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<tr>
<td>2. My student feels safe at school</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>3. My student has someone to talk to at school if s/he needs help or advice</td>
<td>☐</td>
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<tr>
<td>4. My student thinks school rules are fair</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>5. My student thinks school rules apply to him / her equally</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>6. Our school offers adequate support for social, emotional, &amp; behavioural difficulties</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>7. My student has good opportunity to learn about mental health and wellbeing</td>
<td>☐</td>
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<tr>
<td>8. My student feels s/he belongs</td>
<td>☐</td>
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<tr>
<td>9. My student gets to do work that s/he enjoys and finds interesting</td>
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<td>☐</td>
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<tr>
<td>10. My student has friends at school</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>11. My student knows who to go to for help with mental health and wellbeing issues if s/he needs it</td>
<td>☐</td>
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<td>12. My student feels comfortable speaking with and getting help from school counsellors</td>
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<tr>
<td>13. There are teachers and other staff who understand my student</td>
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<tr>
<td>14. There are teacher(s) who my student is positively attached to</td>
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<tr>
<td>15. There are teacher(s) who my student identifies with</td>
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<tr>
<td>16. Teachers show that my student's overall happiness is important</td>
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<tr>
<td>17. As a teacher, I feel well-informed about mental health and wellbeing issues</td>
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</table>

Thank you! ☺

Cher/Chère enseignant(e),

Je m'intéresse à ce que vous pensez de la santé mentale et du bien-être de votre élève, c'est-à-dire ses sentiments, ses pensées, ses relations et son comportement à l'école.

Je vous suis très reconnaissante du temps et de l'effort que vous consacrez à cette étude.

Nom de l'école : ________________________________

Prénom de l'élève : ____________________________

<table>
<thead>
<tr>
<th>Affirmation</th>
<th>Date :</th>
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<th>Je ne sais pas</th>
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<tbody>
<tr>
<td>1. Mon élève aime aller à l'école</td>
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<td>2. Mon élève se sent en sécurité à l'école</td>
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<td>3. Mon élève a quelqu'un à qui parler à l'école si il/elle a besoin d'aide ou de conseils</td>
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<td>4. Mon élève pense que le règlement de l'école est juste</td>
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<td>6. Notre école offre une assistance adéquate pour les difficultés sociales, affectives et comportementales</td>
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<td>7. Mon élève peut facilement s'informer sur la santé mentale et le bien-être</td>
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<td>8. Mon élève se sent intégré(e) dans l'école</td>
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<td>9. Mon élève travaille sur des sujets qui lui plaisent et intéressent</td>
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<td>10. Mon élève a des amis à l'école</td>
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<td>11. Mon élève sait à qui demander de l'aide pour tout problème lié à la santé mentale et au bien-être</td>
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<td>12. Mon élève se sent à l'aide pour parler et demander de l'aide aux conseillers scolaires</td>
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<tr>
<td>13. L'école compte des enseignants et d'autres employés qui comprennent mon élève</td>
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<tr>
<td>14. Mon élève a de l'affection pour au moins un(e) enseignant(e) à l'école</td>
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<tr>
<td>15. Mon élève s'identifie à au moins un(e) enseignant(e)</td>
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<tr>
<td>16. Les enseignants montrent que le bien-être général de mon élève est important</td>
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</tr>
<tr>
<td>17. En tant qu'enseignant(e), je pense être bien informé(e) sur les problèmes liés à la santé mentale et au bien-être</td>
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</tbody>
</table>

Merci ! ☺

APPENDIX G: Community Support Services Questionnaire

APPENDIX E: QUESTIONNAIRE #2
For Parents and Students

“Community Support Services: Response Questionnaire”. Adapted from the Understanding Behavioral Response Questionnaire, Center for Communication Programs, Johns Hopkins University (2010)

SCRIPT
Dear Participant:

The following questions will help inform my research about social support services in the community. Please be honest in filling out your opinions. Your input is useful to determine how services could improve.

Please also answer as completely as you can. There are no right or wrong answers. The questions may or may not apply to you. There are three pages to this questionnaire.

TEXTE
Cher/Chère participant(e) :

Les questions suivantes contribueront à éclairer ma recherche sur les services de soutien social au sein de la communauté. Veuillez donner votre avis avec honnêteté. Vos réponses nous aideront à améliorer ces services.

Veuillez répondre de manière aussi détaillée que possible. Il n’a pas de bonnes ou de mauvaises réponses. Il est possible que les questions ne soient pas applicables à votre cas. Ce questionnaire comprend trois pages.
Community Support Services: Response Questionnaire

**COMMMUNITY SUPPORT SERVICES**
RESPONSE QUESTIONNAIRE: For parents and students

**EMPLOYMENT**

1. Where are places you can go for help in finding a job?

2. Where would you go first and why?

*Please CIRCLE the NUMBER below that BEST represents how you feel.*

3. Getting help with finding a job is:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<td>4</td>
<td>5</td>
<td>HONEST</td>
</tr>
</tbody>
</table>

4. What could be done to make it easier for someone to find a job?
MENTAL HEALTH

1. Where are places you can go for help when you feel sad?

___________________________________________________________________________

2. Where would you go first and why?

___________________________________________________________________________

Please CIRCLE the NUMBER below that BEST represents how you feel:

3. Getting help for feelings of sadness is:

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<td>DISHONEST</td>
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</tbody>
</table>

4. What could be done to make it easier for someone to get help when they feel sad?

___________________________________________________________________________

Adapted from the Center for Communication Programs, Johns Hopkins University (2010)
CHILD & FAMILY

1. Where are places you can go for help with family problems?

2. Where would you go first and why?

Please CIRCLE the NUMBER below that BEST represents how you feel:

3. Getting help for problems in the family is:

<table>
<thead>
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<td>DISHONEST</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>HONEST</td>
</tr>
</tbody>
</table>

4. What could be done to make it easier for someone to get help when they have problems in the family?

Thank you! 😊

Adapted from the Center for Communication Programs, Johns Hopkins University (2010)
SERVICES DE SOUTIEN COMMUNAUTAIRES
QUESTIONNAIRE à l’intention des parents et des élèves

EMPLOI

1. Où pouvez-vous demander de l’aide pour trouver un emploi ?

2. Où iriez-vous en premier, et pourquoi ?

Dans la liste ci-dessous, veuillez ENTOURER le NUMÉRO qui représente LE MIEUX votre opinion.
3. Obtenir de l’aide pour trouver du travail est :

<table>
<thead>
<tr>
<th>DIFFICILE</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>GÉNANT</td>
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<td>BIEN</td>
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<td>PAS EFFRAYANT</td>
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<td>CHER</td>
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<td>HONNÊTE</td>
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</tbody>
</table>

4. Quelles mesures pourraient aider une personne à trouver un emploi plus facilement ?

Adapted from the Center for Communication Programs, Johns Hopkins University (2010)
SANTÉ MENTALE

1. Où pouvez-vous demander de l'aide lorsque vous vous sentez triste ?

2. Où iriez-vous en premier, et pourquoi ?

Dans la liste ci-dessous, veuillez ENTOURER LE NUMÉRO qui représente LE MIEUX votre opinion.

3. Obtenir de l'aide pour des sentiments de tristesse est :

<table>
<thead>
<tr>
<th>DIFFICILE</th>
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<td>HONNÊTE</td>
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</tbody>
</table>

4. Quelles mesures pourraient permettre à une personne d'obtenir plus facilement de l'aide lorsqu'elle se sent triste ?

Adapted from the Center for Communication Programs, Johns Hopkins University (2010)
ENFANT ET FAMILLE

1. Où pouvez-vous demander de l’aide pour des problèmes familiaux ?

2. Où iriez-vous en premier, et pourquoi ?

Dans la liste ci-dessous, veuillez ENTOURER le NUMÉRO qui représente LE MIEUX votre opinion.

3. Obtenir de l’aide pour des problèmes familiaux est :

<table>
<thead>
<tr>
<th>DIFFICILE</th>
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<td>5</td>
<td>HONNÊTE</td>
</tr>
</tbody>
</table>

4. Quelles mesures pourraient permettre à une personne d’obtenir plus facilement de l’aide en cas de problèmes familiaux ?

Adapted from the Center for Communication Programs, Johns Hopkins University (2010)
APPENDIX H: Individual Interview Schemes (Kleinman’s Explanatory Models of Illness).

INTERVIEW GUIDE: SPECIFIC QUESTIONS

<table>
<thead>
<tr>
<th>Appendix F: Interview Protocols</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol 1: Parent</td>
</tr>
<tr>
<td>Protocol 2: Child</td>
</tr>
<tr>
<td>Protocol 3: Mental Health Professionals</td>
</tr>
</tbody>
</table>

Adapted and compiled from the following sources:

PROTOCOL 1: PARENT / ADULT INTERVIEW

PARENT / ADULT INTERVIEW 1

Questions about Schools

1. Questionnaire #1
2. Are there any responses to Questionnaire #1 that you would like to tell me more about?
3. What areas have your children been progressing well in school? What are schools doing to help your children shine in these areas?
4. What areas have your children found challenging in school? What are schools doing to help your children improve in these areas?
5. What do you think schools could be doing differently to help your children learn to the best of their potential?

Questions about Community Support

1. Questionnaire #2
2. Are there any responses to Questionnaire #2 that you would like to tell me more about?
3. Have you or anyone in your family received community mental health services? What was helpful to you? What was unhelpful?
4. Was treatment different than what you expected, or what was explained to you? What did you do to navigate?
5. Was there anything that could have made the treatment better or easier for you or your family?
6. What’s been your biggest struggle since being here in Canada? Your family’s biggest struggle since being here in Canada?
7. What do you think schools and community supports could do to help with this?
8. What do you hope for life in your new (Canadian) community?
9. What do you think schools and community supports could do to best assist these hopes?

Thank you!

End of Interview 1
### Protocol 2 (continued): Parent / adult

<table>
<thead>
<tr>
<th>PARENT / ADULT INTERVIEW 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>About war</strong></td>
</tr>
<tr>
<td>1. What do you think Canadians should know about life in the DRC?</td>
</tr>
<tr>
<td>2. What meaning does the war / life in the DRC offer you? What has it taught you? How have you carried it in your heart?</td>
</tr>
<tr>
<td>3. What do you think needs to happen globally for war to stop in the DRC?</td>
</tr>
<tr>
<td><strong>About mental health services (if applicable)</strong></td>
</tr>
<tr>
<td>1. What would you call trauma? What are the causes? Where does it hurt?</td>
</tr>
<tr>
<td>2. How does it work? What has it taken from you? What has it given you?</td>
</tr>
<tr>
<td>3. What meaning does it carry? What does it teach you?</td>
</tr>
<tr>
<td>4. Do you know anyone else who has had this? What do friends, family, or others say?</td>
</tr>
<tr>
<td>5. What are the chief problems this has caused for you? Your family? Your community?</td>
</tr>
<tr>
<td>6. Who has helped you with this? What’s been most helpful? What do you do to prevent this from getting worse?</td>
</tr>
<tr>
<td>7. How does this idea of ‘trauma’ affect getting on with your life? How your family members continue on with their lives?</td>
</tr>
<tr>
<td>8. What do you need to get better, or what helped you get better? What do you think communities need who face this?</td>
</tr>
<tr>
<td><strong>About general, relational, and collective well-being</strong></td>
</tr>
<tr>
<td>1. What is the meaning of well-being for you?</td>
</tr>
<tr>
<td>2. What contributes to it?</td>
</tr>
<tr>
<td>3. What interferes with attaining it?</td>
</tr>
<tr>
<td>4. How can it be maintained?</td>
</tr>
<tr>
<td>5. How can well-being be restored when it is absent?</td>
</tr>
</tbody>
</table>

Thank you!
End of interview #2
# APPENDIX H

## PARENT / ADULT INTERVIEW 1

<table>
<thead>
<tr>
<th>Questions sur les écoles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Questionnaire n°1</td>
</tr>
<tr>
<td>2. Y a-t-il des réponses au questionnaire n°2 sur lesquelles vous aimeriez élaborer ?</td>
</tr>
<tr>
<td>3. Selon vous, quels sont les plus grands succès que vos enfants ont acquis à l'école ? Que font les écoles pour aider vos enfants à s'épanouir dans ces domaines ?</td>
</tr>
<tr>
<td>4. Selon vous, quels sont les plus grands défis auxquels vos enfants sont confrontés à l'école ? Que font les écoles pour aider vos enfants à surmonter ces défis de manière positive ?</td>
</tr>
<tr>
<td>5. Selon vous, que pourrait les écoles faire différemment pour aider vos enfants apprendre à la hauteur de leur potentiel ?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Questions sur le soutien communautaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Questionnaire n°3</td>
</tr>
<tr>
<td>2. Y a-t-il des réponses au questionnaire n°4 sur lesquelles vous aimeriez élaborer ?</td>
</tr>
<tr>
<td>3. Est-ce que vous avez reçu ou est-ce qu'un membre de votre famille a reçu, ou été bénéficiaire des soutiens supplémentaires à l'école ou dans la communauté ? Qu'est-ce qui a été utile ? Qu'est-ce qui a été inutile ?</td>
</tr>
<tr>
<td>4. Le traitement était-il différent de ce à quoi vous vous attendiez ? Quelles explications vous a-t-on données ? Comment avez-vous vécu cela ?</td>
</tr>
<tr>
<td>5. Selon vous, qu'est-ce qui aurait pu aider à rendre ce traitement plus facile pour vous ou votre famille ?</td>
</tr>
<tr>
<td>6. Quelle a été votre plus grande épreuve depuis que vous êtes au Canada ? Quelle a été la plus grande épreuve de votre famille depuis que vous êtes au Canada ? Selon vous, quelle aide peut apporter le soutien des écoles et des communautés à cet égard ?</td>
</tr>
<tr>
<td>7. Qu'espérez-vous de la vie au sein de votre nouvelle communauté (canadienne) ? Selon vous, quelle aide peut apporter le soutien des écoles et des communautés à ces espérances ?</td>
</tr>
</tbody>
</table>

Merci !

Fin d'entretien n°1
**APPENDIX H | 159**

**UNIVERSITY OF TORONTO OISE | ONTARIO INSTITUTE FOR STUDIES IN EDUCATION**

**PARENT / ADULT INTERVIEW 2**

**Sur le sujet de guerre / conflit**

1. Selon vous, que devraient savoir les canadiens à propos de la vie quotidienne au RDC ?
2. Le conflit / la vie au RDC, quelle signification comporte-t-il pour vous maintenant ? Comment l'avez-vous porté dans votre cœur ?
3. Selon vous, que faudrait-il au niveau global pour que la guerre au RDC s'arrête ?

**Sur le sujet des services en santé mentale (si cela applique)**

1. Quelle est votre définition d'un traumatisme ? Quelles en sont les causes ? Quel est le but ?
2. Comment cela fonctionne-t-il ? De quel traumatisme vous a-t-il servi ? Que vous a-t-il apporté ?
3. Quelle signification cela comporte-t-il ? Qu'en avez-vous appris ?
4. Connaissez-vous une autre personne qui a vécu cela ? Qu'en disent vos amis, votre famille et les autres ?
5. Quels sont les principaux problèmes que cela vous a causé ? Et à votre famille ? Et à votre communauté ?
6. Qui vous a aidé à traverser cela ? Qu'est-ce qui a été le plus utile ? Que faites-vous pour que cela ne reprenne pas ?
7. Comment cette notion de « traumatisme » affecte-t-elle votre quotidien ? Comment les membres de votre famille vivent-ils au quotidien ?
8. De quoi avez-vous besoin, ou qu'est-ce qui vous a aidé, pour que votre état s'améliore / s'est amélioré ? Selon vous, de quoi les communautés ont-elles besoin pour aller mieux ?

**Sur le sujet du bien-être général, relationnel, et collectif**

1. Selon vous, quel est le sens de bien-être ?
2. Qu'est-ce qui y a dû y contribuer ?
3. Qu'est-ce qui compte la réalisation ?
4. Comment peut-il être maintenu ?
5. Comment peut-il être restauré, une fois absente ?

---

**Merci !**

**Fin d'entretien n° 2**
PROTOCOL 2: CHILD INTERVIEW

CHILD INTERVIEW 1

1. Tell me something about you that's really special, that your friends or family or teachers really like about you.
2. Tell me something about you that's really special, that you really like about you.
3. (For children in school only) Questionnaire #1
4. Are there any responses to Questionnaire #1 that you would like to tell me more about?
5. Questionnaire #2: Are there any responses to Questionnaire #1 that you would like to tell me more about?

CHILD INTERVIEW 2

1. Tell me something that happened today / since I saw you last that's been fun.
2. Tell me something that you're looking forward to today.
3. Do you have memories of friends, family, or life at home in the DRC? Can you tell me one? What's the biggest difference you noticed about Canada when you arrived?
4. What's one thing you had to learn so far about being in Canada?
5. What about being from the Congo makes you proud?
6. Who helps you learn at school? What do they do that helps you learn best?
7. Is there anything in school that you are not learning more about, that you wish you could learn more about? What do you think helps you learn best?
8. What do you think would help you develop [refer to response from interview 1] which they found special about themselves] the most?
9. What do you want to be or do in the future?

Thank you!
## Entretiens avec les enfants

### Entretien enfant #1

1. Décis-moi quelque chose sur toi qui est vraiment spécial, que tes amis, ta famille ou tes enseignants apprécient chez toi.
2. Décis-moi quelque chose sur toi qui est vraiment spécial, que tu aimes beaucoup chez toi.
3. [Si l'enfant assiste à l'école] Questionnaire n° 1
4. Y a-t-il des réponses au questionnaire n°1 sur lesquelles tu aimeras élargir ?
5. Questionnaire n° 2
6. Y a-t-il des réponses au questionnaire n°2 sur lesquelles tu aimeras élargir ?

### Entretien enfant #2

1. Raconte-moi quelque chose d'amusant qui s'est passé aujourd'hui ou depuis notre dernier entretien.
2. Décis-moi quelque chose que tu attends avec impatience aujourd'hui.
3. As-tu des souvenirs de tes amis, de ta famille ou de ta vie chez toi au BPC ? Peux-tu me décrire l'un de ces souvenirs ? Quelle est la plus grande différence que tu as remarquée entre le Congo et le Canada, une fois arrivé ?
4. Dis-moi une chose que tu as au besoin d'apprendre pour vivre au Canada.
5. Quel aspect de ton origine Congolaise te rend le plus fier(e) ?
6. Quel est le plus difficile à apprendre à l'école ? Qu'est-ce qui peut t'aider à apprendre le mieux possible ?
7. Y a-t-il des sujets à l'école que tu n'appréhendais pas, et que tu souhaiterais mieux connaître ? Quelle est la plus grande différence que tu as remarquée entre le Congo et le Canada, une fois arrivé ?
8. Qu'est-ce qui t'aiderait à évaluer le mieux possible ? [Voir la réponse de l'entretien 1 sur ce qu'il(e) trouve de spécial chez eux.]
9. Que souhaite-tu devenir ou faire à l'avenir ?

Merci ✌️
### APPENDIX I: For mental health workers in Canada

#### PROTOCOL 4: MENTAL HEALTH PROFESSIONALS INTERVIEWS

<table>
<thead>
<tr>
<th>FOR MENTAL HEALTH PROFESSIONALS IN CANADA</th>
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</thead>
<tbody>
<tr>
<td>1. What are the contexts causing distress for the people you work with?</td>
</tr>
<tr>
<td>2. What are some of the lived experiences of the people you see? Can you give me an example of work that you do?</td>
</tr>
<tr>
<td>3. How do the people you work with consider ‘trauma’?</td>
</tr>
<tr>
<td>4. How do the people you work with consider ‘mental health’?</td>
</tr>
<tr>
<td>5. How do your clients feel about receiving mental health services / psychosocial intervention?</td>
</tr>
<tr>
<td>6. What do you think are the most effective treatments? Least effective?</td>
</tr>
<tr>
<td>7. What are the biggest barriers for people who are suffering to seek help? Receive help? Continue in therapy?</td>
</tr>
<tr>
<td>8. What do you think would help to eliminate these barriers?</td>
</tr>
<tr>
<td>9. What do you think the individuals you see need to get better?</td>
</tr>
<tr>
<td>10. What do you think their communities need to get better?</td>
</tr>
</tbody>
</table>

#### À L’INTENTION DES PROFESSIONNELS DE LA SANTÉ MENTALE AU CANADA

| 1. Quels sont les contextes qui sont à l’origine de la détresse des personnes avec qui vous travaillez ? |
| 2. Pouvez-vous évoquer quelques expériences vécues par les personnes que vous voyez ? Pouvez-vous donner un exemple du travail que vous faites ? |
| 3. Comment les personnes avec qui vous travaillez perçoivent-elles les « traumatismes » ? |
| 4. Comment les personnes avec qui vous travaillez perçoivent-elles la « santé mentale » ? |
| 5. Que pensent vos clients du fait de recevoir de l’aide des services de santé mentale ou une assistance psychosociale ? |
| 6. Selon vous, quels sont les traitements les plus efficaces ? Les moins efficaces ? |
| 7. Pour ceux qui souffrent, quels sont les plus grands obstacles pour solliciter de l’aide ? Recevoir de l’aide ? Poursuivre une thérapie ? |
| 8. Selon vous, qu’est-ce qui contribuerait à éliminer ces obstacles ? |
| 9. Selon vous, de quoi les individus que vous voyez ont-ils besoin pour que leur état s’améliore ? |
| 10. Selon vous, de quoi leurs communautés ont-elles besoin pour aller mieux ? |
À L’INTENTION DES CONCILIAURENS EN RDC

1. Pouvez-vous décrire certains des moyens utilisés par les membres de votre communauté pour solliciter de l’aide afin de faire face à des pressions sociales, spirituelles, affectives ou psychologiques quotidiennement ? Comment la cellule de paix encourage-t-elle ou soutient-elle cela ?
2. Selon vous, quelles aides sont les plus efficaces ? Les moins efficaces ?
3. Pour ceux qui souffrent, quels sont les plus grands obstacles pour solliciter de l’aide ? Recevoir de l’aide ? S’engager dans votre action au sein de la cellule de paix ?
4. Selon vous, qu’est-ce qui contribuerait à éliminer ces obstacles ?
5. Selon vous, de quoi les individus ont-ils besoin pour que leur état s’améliore ?
6. Selon vous, de quoi les communautés ont-elles besoin pour aller mieux ?
APPENDIX K: Tables & Coding schemes

APPENDIX G: THEMES / CODING SCHEMES

The following tables identify proposed coding schemes for data analysis which will be applied to transcripts using NVivo. Some themes may become redundant while others may emerge or need clarification, as data will determine.

Table 1. Proposed coding scheme for **Classroom observation + Principal Interview**
(Adapted from the Boston College Teachers for a New Era (BCTNE) Classroom Observation Protocol).

<table>
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<tr>
<th>1. Content</th>
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</thead>
<tbody>
<tr>
<td>(Level and availability of resources and materials)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Teacher Pedagogy</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Activities and strategies in which the teacher engages students; values of learning in the classroom)</td>
</tr>
<tr>
<td>a. Activities / Strategies</td>
</tr>
<tr>
<td>b. Questions about the world</td>
</tr>
<tr>
<td>c. Connectedness to the world</td>
</tr>
<tr>
<td>d. Social Supports to Achievement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Pupil Learning &amp; Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Pupil behavior that suggests engagement and progress in learning skills and content. This may include academic, social and emotional outcomes. Assessment includes any opportunity, formal or informal, in which the teacher/candidate is establishing the skill and knowledge base of students, or ability to utilize information that is being presented.)</td>
</tr>
<tr>
<td>a. Engagement</td>
</tr>
<tr>
<td>b. Outcomes: Academic</td>
</tr>
<tr>
<td>c. Outcomes: Social/Emotional</td>
</tr>
<tr>
<td>d. Connectedness to the World</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Social Justice</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Identifies activities/opportunities where teaching for social justice, or social justice issues are apparent in the classroom.)</td>
</tr>
<tr>
<td>a. Cultural Content</td>
</tr>
<tr>
<td>b. Diversity</td>
</tr>
<tr>
<td>c. Social Supports to Achievement</td>
</tr>
<tr>
<td>d. Connectedness to the World</td>
</tr>
<tr>
<td>e. Indigenous Knowledge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Relationships &amp; Classroom Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Interactions in the classroom between and among members of the school community that are represented. This is reviewed as a key to classroom community and context, support for learning, and addressing social/emotional elements of the learning experience, and the organization and routines to support learning)</td>
</tr>
<tr>
<td>a. Teacher-to-student</td>
</tr>
<tr>
<td>b. Peer-to-Peer</td>
</tr>
<tr>
<td>c. Social Supports to achievement</td>
</tr>
</tbody>
</table>
CODING SCHEME 2:
Proposed coding scheme for Parent + Child Interviews (my own creation).

<table>
<thead>
<tr>
<th></th>
<th>Social determinants of health</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>a. Access to community</td>
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<tr>
<td></td>
<td>b. Access to housing</td>
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<tr>
<td></td>
<td>c. Access to public services</td>
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<tr>
<td></td>
<td>d. Education and literacy</td>
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<td></td>
<td>e. Good food / food security</td>
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<td></td>
<td>f. Income</td>
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<td></td>
<td>g. Wealth distribution</td>
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<tr>
<td></td>
<td>h. Job security</td>
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<tr>
<td></td>
<td>i. Working conditions</td>
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<td></td>
<td>j. Leisure and recreation opportunities</td>
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<tr>
<td></td>
<td>k. Personal health</td>
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<td></td>
<td>l. Health behaviours</td>
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<td></td>
<td>m. Physical environments</td>
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<td></td>
<td>n. Public health indicators</td>
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<thead>
<tr>
<th></th>
<th>Political contexts</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>a. Colonisation</td>
</tr>
<tr>
<td></td>
<td>b. Economy</td>
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<tr>
<td></td>
<td>c. Education</td>
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<td></td>
<td>d. Hopelessness</td>
</tr>
<tr>
<td></td>
<td>e. Politics</td>
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<td></td>
<td>f. Poverty</td>
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<td></td>
<td>g. Racism</td>
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<td>h. Reconciliation</td>
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<tr>
<td></td>
<td>i. Sexual violence</td>
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<table>
<thead>
<tr>
<th></th>
<th>Mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Optimal (flourishing)</td>
</tr>
<tr>
<td></td>
<td>b. Minimal (languishing)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Mental illness</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>a. Trauma</td>
</tr>
<tr>
<td></td>
<td>b. Depression</td>
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<tr>
<td></td>
<td>c. Other</td>
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<thead>
<tr>
<th></th>
<th>Psychosocial support</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>a. Church</td>
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<tr>
<td></td>
<td>b. School</td>
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<tr>
<td></td>
<td>c. Clinic</td>
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<thead>
<tr>
<th></th>
<th>Resiliencies</th>
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<tbody>
<tr>
<td></td>
<td>a. Church</td>
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<td>b. Family</td>
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<td></td>
<td>c. Community</td>
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<td></td>
<td>d. School</td>
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<tr>
<td></td>
<td>e. Personal</td>
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<tr>
<th></th>
<th>Healing</th>
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<tbody>
<tr>
<td></td>
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<td>c. Family</td>
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<td></td>
<td>d. Individual</td>
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<td></td>
<td>e. Spiritual meaning</td>
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CODING SCHEME 3:
Evolution of coding themes.

<table>
<thead>
<tr>
<th>LEVEL I ANALYSIS (pre coding)</th>
<th>LEVEL II ANALYSIS (post coding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Social determinants of health</td>
<td></td>
</tr>
<tr>
<td>a. Access to community</td>
<td>REFUGEE AND SETTLEMENT</td>
</tr>
<tr>
<td>b. Access to housing</td>
<td>PROCESSES / ACCESS TO CITIZENSHIP</td>
</tr>
<tr>
<td>c. Access to public services</td>
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<tr>
<td>d. Education and literacy</td>
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<td></td>
</tr>
<tr>
<td>2. Political contexts</td>
<td></td>
</tr>
<tr>
<td>a. Colonisation</td>
<td>GEOPOLITICAL TENSIONS / TACIT AND FELT INFORMATION</td>
</tr>
<tr>
<td>b. Economy</td>
<td></td>
</tr>
<tr>
<td>c. Education</td>
<td></td>
</tr>
<tr>
<td>d. Hopelessness</td>
<td>DIMENSIONS OF WAR</td>
</tr>
<tr>
<td>e. Politics</td>
<td>(excluded: may be peripheral the study; much to these dimensions are known; see also previous work)</td>
</tr>
<tr>
<td>f. Poverty</td>
<td></td>
</tr>
<tr>
<td>g. Racism</td>
<td></td>
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<tr>
<td>h. Reconciliation</td>
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<td>i. Sexual violence</td>
<td></td>
</tr>
<tr>
<td>3. Mental health</td>
<td></td>
</tr>
<tr>
<td>a. Optimal (flourishing)</td>
<td>[THROUGHOUT]</td>
</tr>
<tr>
<td>b. Minimal (languishing)</td>
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</tr>
<tr>
<td>4. Mental illness</td>
<td></td>
</tr>
<tr>
<td>a. Trauma</td>
<td>CONCEPTUALISATIONS OF TRAUMA</td>
</tr>
<tr>
<td>b. Depression</td>
<td></td>
</tr>
<tr>
<td>c. Other</td>
<td></td>
</tr>
<tr>
<td>5. Psychosocial support</td>
<td></td>
</tr>
<tr>
<td>a. Church</td>
<td>RESILIENCIES</td>
</tr>
<tr>
<td>b. School</td>
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<tr>
<td>c. Clinic</td>
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<tr>
<td>6. Resiliencies</td>
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<td>a. Church</td>
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<tr>
<td>e. Personal</td>
<td></td>
</tr>
<tr>
<td>7. Healing</td>
<td></td>
</tr>
<tr>
<td>a. Ancestry</td>
<td>SPIRITUALITY, ANCESTRY &amp; HEALING</td>
</tr>
<tr>
<td>b. Community</td>
<td></td>
</tr>
<tr>
<td>c. Family</td>
<td></td>
</tr>
<tr>
<td>d. Individual</td>
<td></td>
</tr>
<tr>
<td>e. Spiritual meaning</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX L: Handouts of community support services:
Referring a participant for help should they experience distress

Primary referral:
CANADIAN CENTRE FOR VICTIMS OF TORTURE

MAIN OFFICE                      Phone: 416-363-1066
194 Jarvis Street, 2nd Floor
Toronto, ON
M5B 2B7

SCARBOROUGH OFFICE                Phone: 416-750-3045
2425 Eglinton Ave East, Suite #218, 220
Toronto, ON
M1K 5G8

THE HUB                          Phone: 647-847-2336, 416-750-9600
1527 Victoria Park Avenue, 2nd floor
Toronto, ON
M1L 2T3

The CANADIAN CENTRE FOR VICTIMS OF TORTURE provides individual and family counselling, support groups, crisis intervention, and professional settlement services within a coordinated network which includes doctors, lawyers, social service workers, and volunteers.

INFORMATION / HANDOUTS

The following publications from the Centre for Addiction and Mental Health will also be on hand:

1. Asking for help when things are not right / Demander de l’aide quand rien ne va plus
2. About mental health and mental health problems / La santé mentale et les problèmes de santé mentale
3. Coping with stress / Comment gérer le stress
4. Did you come from a country affected by war, political conflict or disaster? (PTSD brochure) / Venez-vous d’un pays touché par la guerre, les conflits politiques, les désastres ? (dépliant SSPT)
## GENERAL SUPPORT SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Toronto Distress Centre</strong></td>
<td>416-408-4357</td>
</tr>
<tr>
<td><strong>Centre for Addiction and Mental Health (CAMH)</strong></td>
<td>416-595-6111  1-800-463-6273</td>
</tr>
<tr>
<td>McLaughlin Information &amp; Referral Centre</td>
<td></td>
</tr>
<tr>
<td><strong>Community Resource Connections Ontario</strong></td>
<td>416-482-4103  <a href="mailto:crct@crct.org">crct@crct.org</a></td>
</tr>
<tr>
<td>366 Adelaide St. East Suite 230,</td>
<td></td>
</tr>
<tr>
<td>Toronto, Ontario M5A 3X9</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Services Information Ontario</strong></td>
<td>1-866-531-2600</td>
</tr>
<tr>
<td><strong>Canadian Mental Health Association (CMHA)</strong></td>
<td>416-289-6285 x243  416-789-688</td>
</tr>
<tr>
<td>Toronto East</td>
<td></td>
</tr>
<tr>
<td>Toronto West</td>
<td></td>
</tr>
<tr>
<td><strong>2-1-1 Toronto</strong></td>
<td>2-1-1</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.211toronto.ca">www.211toronto.ca</a></td>
</tr>
</tbody>
</table>
APPENDIX M: Timothy’s poem.

LA VALEUR DU SANG

Que vaut le diamant
Que vaut l’or
Que vaut la vie d’un enfant
fauché par la mort

Nous recherchons la richesse
Nous recherchons le pouvoir
Nous semons la tristesse
et laissons du désespoir

Combien de temps cela durera-t-il
Combien de gens devront souffrir
Notre terre est fertile
Et pourtant ce sont les autres qui y viennent
s’enrichir

Il est temps de réagir
Temps de nous rendre compte
Nous tenons dans nos mains notre avenir
Laissons derrière ces atrocités qui nous
couvrent de honte

Que vaut le diamant
Que vaut l’or
Que vaut le sang
de ceux qui sont morts

BLOOD MONEY

What’s the worth of a diamond
What’s the worth of gold
What’s the worth of a child
Whose life is taken but not told

We look for wealth
We look for power
Instead we reap sadness
And what we leave is despair

How long will this last
How many people must die
We have so much richness of earth
And yet it gives us no life

It is time to react
Time to realize our future is in our hands
Let’s leave these atrocities behind us
They cover us with such shame

[So will we remember] the worth of a diamond
[Will we remember] the worth of gold
[Will we remember] the worth of blood
of those who have died and gone

~TIMOTHY, Montréal, 19 April 2013