The Meaning of Health and Help-Seeking Behaviours Among Refugees Who Have Experienced Collective Violence Prior to Emigration: A Canadian Perspective

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ABSTRACT

An interpretative phenomenological approach with a purposive sample of 3 men and 3 women was employed to explore the meaning of health and help-seeking behaviours of refugees living in Canada who have experienced collective violence in their countries of origin. Prior to migration, the participants' meaning of health and help-seeking behaviours were fashioned by their embodied experience of life as nonexistent and meaningless. Post migration, their past lived experience of collective violence continued to shape their perceptions of their health and help-seeking behaviours. Participants call for a restructured system offering specialized mental health services for this population.

Keywords: phenomenology, violence, health promotion, mental health, trauma, health services

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RÉSUMÉ

Une approche phénoménologique interprétative auprès d'un échantillon par choix raisonné de 3 hommes et 3 femmes fut employée pour explorer le sens de la santé et le recours aux soins des réfugiés et réfugiées vivant au Canada, victimes de violence collective dans leur pays d'origine. Avant la migration, la signification de la santé et du recours aux soins fut façonnée par une vie qui semblait inexistante et insignifiante. Après leur arrivée au Canada, l'expérience de violence collective continua à façonner la perception de leur état de santé et leurs recours aux soins. Les participants et participantes réclament une restructuration du système offrant des services spécialisés de santé mentale adaptés à cette population.

Mots clés : phénoménologie, violence, promotion de la santé, santé mentale, traumatisme, services de santé

INTRODUCTION

In many parts of the globe, on a daily basis, "violent conflicts between nations and groups, state and group terrorism, rape as a weapon of war, the movement of large numbers of people displaced from their homes, and gang warfare" occur, causing devastating effects in terms of deaths, physical illness, disabilities and mental anguish (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 21). The World Health Organization (WHO) report on violence identifies collective violence as violence directed by authoritative figures such as states and organized political and terrorist groups (Krug et al., 2002).

In the context of this study, a refugee is defined as an individual who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable to or, owing to such fear, unwilling to return to it" (UN Refugee Agency, 1951, p.16). This study explored the meaning of health and help-seeking behaviours, pre and post migration, of refugees living in Canada who have experienced collective violence.

REVIEW OF THE LITERATURE

The majority of the literature on refugee health status is from the United States (Eisenman, Gelberg, Liu, & Shapiro, 2003; Gordon & Gonzalez, 1998; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009) and the United Kingdom (UK) (Bhatia & Wallace, 2007; Heptinstall, Kralj, & Lee, 2004; Joels, 2008). Of the relevant articles reviewed, close to one-third were produced in Canada (Berman, Giron, & Marroquin, 2006; Downar, Baily, & Kagan, 2014; Gagnon, Tuck, & Barkun, 2004; Guruge & Khanlou, 2004; Kirmayer et al., 2011; O'Mahony & Donnelly, 2007, 2010, 2013; Pottie, Batista, Mayhew, Mota, & Grant, 2014; Redwood-Campbell, Fowler, Kaczorowski, Molinaro, Robinson, Howard, & Jafarpour, 2003; Stanbrook, 2014; Wales & Rashid, 2013). Within the Canadian literature, the themes explored included refugees' access to primary care and health coverage (Downar et al., 2014; O'Mahony & Donnelly, 2010; Pottie et al., 2014; Stanbrook, 2014); postnatal depression and violence associated with pregnancy among women (O'Mahony & Donnelly, 2010; 2013); the influence of culture on immigrant women's mental health experiences (O'Mahony &

Donnelly, 2007); the effects on refugees of the recent cuts in the Interim Federal Health Coverage (IFHC) (Stanbrook, 2014); and the mental health problems of refugees and those associated with mandatory detention (Kirmayer et al., 2011; Wales & Rashid, 2013).

In terms of refugee overall health, many studies revealed that the experienced trauma was the main impediment to good health. Of these, mental health issues, depression, and post traumatic stress disorder (PTSD) were the most prominent (De Haene, Grietens, & Verschueren, 2010; Kirmayer et al., 2011; Mollica, McInnes, Sarajlic´, Lavelle, Sarajlic´, & Massagli, 1999; Schwarz-Nielsen & Elklit, 2009). De Haene and colleagues (2010) identified that at the root of these diagnoses are the preflight and postflight stressors of war, violent loss, persecution, family separation and cultural uprooting. For the most part, psychiatric comorbidity amongst refugees is highly correlated with physical disability, independent of the effects of age, trauma, and overall health (Mollica et al., 1999).

Bhatia and Wallace (2007) suggest that family physicians should be better educated on supporting and providing health care to refugees in order to help them develop more appropriate help-seeking behaviours. Joels (2008) also calls for a better-informed general public to reduce hostility towards refugees. With better-informed health care professionals, policy-makers, and the general public concerning the life experiences of refugees, specifically those who have experienced collective violence in their home countries, prejudices against this population may diminish. In addition, increased awareness of the varying social and economic differences among immigrant groups would enable health care professionals to provide services accordingly and improve accessibility of mental health care services, particularly for immigrant women (O'Mahony & Donnelly, 2007; Kirmayer et al., 2011). Concerning methodological frameworks used in previous studies, Gordon and Gonzalez (1998) posit that, as a result of the lack of coherence amongst studies on the use of questionnaires or quantitative measures surrounding the measurement of health status for victims of collective violence, it would be essential to explore other, innovative data-collection methods, such as qualitative approaches in which individuals have the opportunity to voice their perspectives.

METHOD

Analytical Framework

An interpretative phenomenological approach based on the work of Merleau-Ponty (1962) was used in this study. The aim of the study was to "systematically attempt to uncover and describe the internal meaning structures" (Van Manen, 1990, p. 10) of the informants' lived experience and to obtain essential truths about this phenomenon, grounded in their lived experience (Polit & Hungler, 1997). The goal of this research was to portray the meaning of health and help-seeking behaviours as they were and continue to be lived in the participants' collective everyday existence, their *lifeworld*.

In applying Merleau-Ponty's interpretative phenomenology, the aim was to return to a pre-reflective life world, which occurs before one can think about it or articulate its meaning (Merleau-Ponty, 1962; Finlay, 2006). In other words, the description of the meaning of health given by these refugees was of the everyday world as it is immediately experienced. In Merleau-Ponty's philosophical view, people exist in a "pre-given world" (Sadala & Ardono, 2002, p. 286) in which their existence consists of the simultaneous process of being born from and in this never fully finished world where they learn about themselves. Within the context of this

study, a focus was placed on understanding the meaning of health and the help-seeking behaviours, pre and post migration, of refugees living in Canada as beings or "historical persons" who have experienced collective violence in their home countries. This "historical person" is the body as the perceiving entity, discovering the world's stance in a time-and-place structure, and acting in the world in which it lives (Sadala & Ardono, 2002).

Sample

A purposive sample consisting of three male and three female participants between the ages of 25 and 70 who had been living in Canada for at least three years was recruited from community agencies that provide counselling to individuals who have experienced collective violence. Inclusion in this study required that participants have first-hand experience with war or genocide in their midteens to adulthood (by the time they were at least 15 years old). The age of 15 was selected as the minimal acceptable age, since traumatic events are often not well remembered in childhood (Mukamana & Brysiewicz, 2008).

The participants' countries of origin represented sub-Saharan Africa and the Middle East. Half were interviewed in French (Paul, Jack, and Jane), and the other half were interviewed in English (Martha, Peter, and MP). The names listed above are pseudonyms assigned to each participant in order to ensure anonymity and confidentiality. Participants' length of stay in Canada ranged from a little over three years to almost seven years.

All of the participants, except for one, were recruited by staff members of one particular community agency. The exception was MP, who had heard about the study through word of mouth and contacted the primary researcher, as she desired to share her life experience. Prior to conducting the interview with MP, the primary researcher ensured that she was registered within a community agency. Recruitment from community agencies was chosen by the authors to ensure that participants had in fact been recognized as having experienced collective violence in their lifetime and that they also had the available support services.

Procedures

Data were collected via electronically recorded semistructured interviews in which the participants were asked open-ended questions describing their experiences in relation to their previous and current health (see Table 1). During the interviews, many context-specific questions arose, depending on individual participants' stories and openness (see Table 2). The interviews ranged from 25 to 75 minutes in length. Van Manen (1997) offers six interactive approaches for interpretative phenomenological inquiry and analysis of the data, which served as signposts along the way in this phenomenological journey towards understanding the meaning of health and help-seeking behaviours among participants.

The data collection and analysis processes occurred simultaneously. The emerging themes were reflected upon throughout the research process according to the four existentials outlined by Merleau-Ponty (Van Manen, 1997): 1) spatiality (lived space); 2) corporeality (lived body); 3) temporality (lived time); and 4) communality (lived human relation). Understanding the realities of the informants' lives by reflecting on the existentials allowed the findings to be grounded in "the fundamental lifeworld themes which probably pervade the lifeworlds of all human beings, regardless of their historical, cultural or social situatedness" (Van Manen, 1997, p.101).

Table 1

Semistructured Interview Guide

Question Type	Interview Questions
Primary research question	What is the meaning of health and help-seeking among refugees living in Canada who have experienced collective violence in their countries of origin?
Additional question # 1	Please describe your meaning of health before arriving in Canada.
Additional question # 2	What does health mean to you in your current situation?
Additional question # 3	Please describe your experiences of help-seeking within the Canadian health care system.
Additional question # 4	What are your suggestions for improving help-seeking within the Canadian health care system?

Table 2

Context-Specific Questions

Category	Interview Questions
Meaning of health premigration	• What did health mean to you during this war? • How long did you live in these conditions of war? • What would you describe as a tortured mind?
Help-seeking behaviours premigration	• What did you do when you needed health care during the war? • What kind of health care were you able to obtain from the available hospitals?
Meaning of health postmigration	• What has contributed to you being a different person in Canada? • How would you describe this depression that you are saying you have been feeling? • What kind of things would you say trigger those emotions of stress, fear, and suffering that you would feel during the war?
Help-seeking behaviours postmigration	• When you arrived in Canada, how were you oriented to health care services? • Had you not undergone your experience of war, do you think your help-seeking would have been different? • If the Canadian health care system could be improved, based on your experiences, what would you suggest?

Authenticity

To ensure the rigour of the study, Guba and Lincoln's (1994) authenticity criteria of fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity were utilized. To ensure fairness, male and female participants were recruited in equal proportions, providing for a fair representation of both genders. Diversity of nationalities, sociocultural backgrounds, and languages were also accounted for in the recruitment phase, and participants' narratives were included on the basis of the richness of the provided meanings and descriptions of the theme being explained.

In order to help informants to create "more sophisticated understandings of the phenomenon being studied" (Seale, 1999, p. 469), also known as *ontological authenticity*, a dialectic relationship between the primary researcher and the participants was established, allowing participants to reflect on new ways of perceiving the meaning of health and help-seeking. This was particularly evident when one participant expressed a shift in her understanding of health in the context of the experience of collective violence, as she came to realize that the mental or psychological aspect of health seems to be the most influenced and disrupted.

Educative authenticity, the study's potential to help informants appreciate each other's views and/or experiences, was ensured by asking the participants to voluntarily meet with the researcher at a mutually convenient time and location after the analysis of data, for a discussion on both the overall findings of the study and the thematic analysis of their particular interview (Lincoln & Guba, 2003; Seale, 1999; Finlay, 2006). In terms of the study's potential to stimulate some form of action among participants (*catalytic authenticity*), participants were enabled to propose some changes to the health care system which would promote health among refugees and might provide financial returns to the government. The last authenticity criterion, *tactical authenticity,* which is the study's potential to empower participants to be involved in some form of social or political action, was not a central tenant in this study as it was more aligned with the critical theorist paradigm (Lincoln & Guba, 2003). However, the interview process employed in this research, in and of itself, was found to be empowering for some of the participants, as it provided them with the opportunity to openly share their stories.

Ethical Considerations

Ethical approval was obtained from the Ethics Review Board of the affiliated institution. In order to protect the identities of the study participants, anonymity and confidentiality were insured via the use of pseudonyms. Informed consent was sought from the informants by means of a letter explaining the goals and objectives of the study. Throughout the study, process consent was also sought. In this, informants were advised that they were free to withdraw from the study at any point if they no longer wished to be a part of the study. Additionally, if they felt unable to answer a particular question, they were advised that they could refuse to respond. The major risk associated with this research study included the potential to relive the unpleasant experiences associated with being a victim of collective violence, especially when giving an account of past events, feelings, and circumstances. As a way to offset this risk, following the interviews participants were provided with the option to consult a counsellor in order to ensure that the hardships of participating in this project could be minimized.

RESULTS

Eight themes emerged from the analysis of the meaning of health and help-seeking behaviours among refugees pre and post migration to Canada. The themes that emerged from the participants' respective interviews are described below and followed by a mediated phenomenological description building towards a structured thematic analysis.

Pre Migration

Health under the constant threat of death. The participants' meaning of health and help-seeking was deeply influenced by the experience of collective violence in which they found themselves. Living in places that had been massively destroyed by war and bombardments meant that the quality of their health was under the constant threat of imminent death and, thus, help-seeking became an impossible endeavour. The experience of collective violence reveals itself as an extremely complex and life-changing situation in which individuals find life to be nonexistent, meaningless, and worthless.

No life. Martha, the Palestinian female, expressed that there was no life when they were surrounded by death and the fear of dying at any moment:

> It was unsafe because you know; everything you see is death, every day, every moment. Like you can't live, because almost every moment you feel like you can die, you or your children, your husband, and the people around you.

Her embodied experience in the lived space she found herself in, in relation to lived time and her human relations, was one that lacked the boundaries of safety and, as a result, death of the body became a constant threat. Even what she called "home" became a place where her life was endangered, similar to being in an open, unknown space. The thought of becoming stranded, lacking the communal support of her family and friends in such a dangerous lived space, intensified her feelings of fear and gave birth to a sense of living a purposeless life.

Death as the best alternative. Martha further elaborated on how a purpose for living is lost in such conditions and one prefers to die, rather than live and endure the sufferings associated with collective violence. As a body in this treacherous lived space, Martha's temporal landscape was disrupted due to the eventuality of a bomb exploding at any time. The idea of a future was hard for her to envision and was embraced with a fear of the unknown, the fear of having her lived body abolished in the time to come, of becoming one with the dead.

A worthless lived body. Within the experience of collective violence, there is a dichotomous feeling of being both a living and a dead corporeal being. The participants experienced a sense of powerlessness in the face of their persecutors and felt as though they had been reduced to nothing; that is their lived body was a dying, worthless entity in and of itself. Paul described the experience of his lived body as a worthless entity when comparing who he was and what his lived body possessed in relation to his past lived time. After escaping from the rebels in the forest in which he had been held captive for three months, Paul found himself empty, without his family, possessions, shoes, or any clean clothes. He then realized how worthless he had become, and how his life had been reduced to a sense of nothingness.

Constant suffering with the instability and imbalances of collective violence. As their lives and sense of well-being were endangered by the constant threat of impending death, the participants' meaning of health was one of constant suffering with the instability and imbalances of living with collective violence. Such an imbalance and instability shaped their experience of health as a destabilizing one, an experience in which escape becomes the only way to preserve their life. For MP, the instability came about after her family home was destroyed and she was separated from her parents. She had been running alone from the age of eight to the age of 19, following various neighbours. For Jack being healthy meant, "being physically and emotionally stable, and before I came here, that's what I lacked."

As a result of collective violence, the participants have attributed different meanings to their health. For MP and Jack, their meaning of health is established in relation to a temporal landscape. These participants highlight that in their past, before coming to Canada, they lacked emotional and psychological stability, and therefore their health was not 100 %.

Health in the shadow of trauma: the inception of the cancerous cell. Among the participants, there were various consequences that resulted from the trauma in their lives. For some it was the fear caused by the uncertainties of what life would hold the next day, fear of being taken away, of being killed and of being raped. For others, it was the powerlessness that resulted from victimization or the threat of it. Peter expressed that the uncertainty of not knowing what could happen to one's lived body at any moment made him "very nervous and anxious." On the other hand, physical abuse and victimization were the source of Jane's trauma:

> I was attacked in my home by the rebels that came looking for my husband. . . . After they had not found him they burned me. My forearms, in both arms, they attacked me so that I could reveal to them where my husband went. I was really, really traumatized. And now I'm left with big scars.

Though Jane recalled the events that led to her victimization as being in the past, the memory of them continued into her present and future, as her lived body carries the scars. In the lives of those who have experienced collective violence, the meaning of health is overshadowed by their traumatic experiences, which they are usually left to deal with for the rest of their lives.

Trauma is like a cancerous cell being formed in a person's body with the potential to metastasize to the rest of the body and have long-lasting ill-health effects if not identified and dealt with in time. For MP, as her experience of trauma began in early childhood, she felt that her past lived time had been prolonged due to the ever present traumatic experiences she was constantly exposed to and the lack of human relations with parental figures that framed the degree of trauma she experienced. The time at which these events took place is highly significant as it was from her childhood to her early adulthood. She mentioned that her personal identity continues to suffer and she is in constant need of counselling as a result of having experienced collective violence at such critical times in her life:

> I was eight years old, so that was the beginning I would say, really of mental problem, you know, trauma. Not having parents, seeing people being killed. I was mentally disturbed because it has been a consistent situation, what I saw as a little girl and I grew up always from the age of eight to 19 seeing this you know, just reseeing. People dying, always no improvement at all! For sure, there was no improvement. People who have lost completely, their parents, their sisters, they are killed right in front of them, but there was nothing to be done. They just have to suffer there, this trauma. So that kind of life, obviously, has something to do with you know, low emotion, you know. People are miserable, you don't grow up with the freedom and here we are talking about young children you know. Teenagers who are, you know, growing up supposed

> to be happy, interacting, they are supposed to feel their mind healthy but no. I noticed when I also faced a problem here when I came, it's just kind of reconnecting, I have been faced with a lot of difficulties, it's like a cycle . . . like personally, I'm receiving counselling, up to today, everyday, I'm receiving counselling, because you know, my life journey, you know what I saw, I'm still going for counselling.

Trauma, like a cancerous cell, has left long-lasting effects on MP's life. Her mental problems from witnessing collective violence require ongoing, perhaps lifelong counselling.

Help-seeking as a restricted option. For different reasons, seeking help was a restricted option for these individuals throughout their experiences with collective violence. The lack of an established and structured health care system presented itself as a challenge for all the participants in their respective countries of origin. Available health care systems were characterized as being unaffordable, lacking sufficient and adequate medical equipment, and being untrustworthy due to the corruption that was taking place. Participants found themselves alone, vulnerable, and unsupported as there was simply nowhere to run to and no one to cry to for help, as MP explained:

> Like people who have spent 13, 14 years in the refugee life, there is nobody, there is no one who has ever come forward and asked what happened. Nobody asks you that question ever but that question alone saying, "What happened? What exactly is happening? How do you feel? Can I help or do you need help?" would have made a huge difference.

In the context of collective violence, MP's embodied experience was disconnected from the lived human relations offered by health care professionals and the community at large in this time of need. Lacking such support systems presented her embodied experience as a lonesome entity in the world. She was responsible for herself and had to get through life without the encouragement and help of lived human relations with others. The unavailability of medical assistance in the midst of violence, victimization, and poor sanitation presented itself as an extremely unfortunate help-seeking deterrent for these participants. Although the participants were asked to describe what health meant to them when living in their home countries, what emerged was an illustration of what they faced during the experience of collective violence.

Post Migration

Health as freedom from the constant suffering of collective violence. The opportunity to resettle in a country that provided them with a peaceful and stable environment with adequate food, shelter, and universally accessible health care services, gave the participants a sense of freedom, safety, and hope. When they arrived in Canada, all the participants in this study expressed that they felt as if their lived body had been renewed and strengthened. Martha explained her experience of safety and hope as follows:

> I think it's safe, because we weren't safe in our country, especially the last weeks or the last months. This thing, it gave us more hope, you know to leave, to go outside, to get outside this country.

For MP, being in Canada has given her not only hope and peace, but also a sense of relief and freedom from the constant suffering she endured while in her home country. This was made possible by the availability of help, having people to turn to in times of need, and knowing that there is a possible solution to her problems. Though the participants recognized that they are privileged to be in Canada as it has given them back a sense of life, they continue to face challenges here. Nonetheless, having gone through such ordeals in their countries of origin has made them stronger people and has allowed them to better appreciate life. They are

essentially strengthened and empowered in knowing that what was endured in the past lived time was much worse and less bearable than their life in the present time.

Health as living with the invisible wound of trauma. Most people who live with trauma keep their pain and suffering silent, as MP noted. For them, it is easier to ignore the pain and try to forget such unpleasant and torturous events than to give them a voice. Thus, living with the invisible wound of trauma here in Canada continues to shape the participants' meaning of health. All the women included in this study affirmed that they continue to suffer from trauma; however, among the men, none explicitly mentioned that they are currently dealing with the effects of trauma. The perpetual trauma of collective violence, experienced in the past lived time, carried itself over into these women's present time, and they can see it continuing to play a role in their lives in the future.

Jane highlighted that her ability to forget and let go of the pain will only be achieved once she has fully forgiven her oppressors; however till this day, she has not yet found it in herself to fully forgive:

> For now I am ok, but when I recall what happened, it's as if someone was stabbing my heart. My forgiveness is better than before, but I do not think that it will come to completeness.

Jane's experience characterizes itself within the lived human relationship between herself and her oppressors. Not being able to let go of the negative connection shared in the past has prevented her from forgiving them for their abominable acts towards her. She would need to fully disconnect her lived bodily experiences in relation to that of her oppressors in order to liberate herself from the bitterness she still experiences.

Help-seeking options as imperfect but fair. Although most of the participants do not think that the Canadian health care system is perfect, they acknowledge that it is good and fair. Receiving universal health care coverage is a privilege that all the participants were not granted in their home countries. Having such an advantage here in Canada provides the participants with the evidence that they now live in a country with a government that cares for the needs of its population and that takes responsibility for the health care of individual citizens. Additionally, the system's fairness makes them feel valued as human beings and respected as members of Canadian society. However, for the majority of participants, this was not enough of a motivator for them to seek help and/or receive suggestions to seek help. As a result, participants highlighted some suggestions for improvement of the health care system. For the francophone participants, the interpretation services they have received in the past have been inadequate and unprofessional, increasing their level of stress and deterring them from seeking help, as they see it as a potential source of medical errors. Participants also called for well-established and structured community mental health services, specific for those who have experienced collective violence.

Uncovering the wound and seeking help. Although help is available in Canada, the majority of participants did not seek the help they needed. However, for Peter and his wife, Martha, her previous experience as a social worker enabled them to know that they must seek psychological help for the past trauma that they continued to deal with, even after immigrating to Canada. Clearly, the journey was not the same for all the participants, as they did not always recognize that they were in need of help.

In MP's case, the process of working through the trauma was much more complex. She explained that she sought the needed help only when the emotional pain became unbearable. Trust becomes a huge issue for these individuals to open themselves up to a health care professional in order to be helped. For

most of the participants, the lived human relationship they experienced with health care providers back home was usually of mistrust. In order to enable refugees to seek help for the ongoing trauma of collective violence, this important aspect of their pre and post migration to Canada must be taken into consideration by health care providers.

DISCUSSION

The eight themes that emerged from the analysis of the participants' life experiences offer an understanding of the meaning of health and help-seeking behaviours both pre and post migration. Prominently, the invisible wound of the trauma from collective violence carried itself into their future. Therefore, when administering health services to such a population, trauma from collective violence must be accounted for in order to develop a health care system that fully and successfully promotes their health and well-being post migration. With better health outcomes, refugees who have experienced collective violence will be enabled to undergo a successful resettlement experience, the quality of their lives will be greatly improved, and as a result, they will be granted the opportunity to fully participate in Canadian society.

Health care practitioners, such as health care program planners, physicians, nurses, occupational therapists, counsellors, and social workers need to be aware of the needs of this population, especially the difficulties these individuals have in seeking help. As identified in this study and reinforced by Pottie and colleagues (2014), the most vulnerable migrants, such as refugees who have experienced collective violence, are more likely to encounter socioeconomic, cultural, and linguistic barriers that can hinder trust, service navigation, and access to primary health care. Although all the participants of this study received universal health coverage, the cuts to the Interim Federal Health Program (IFHP) made in 2012 have prohibited refugees from accessing primary care (Stanbrook, 2014).

It must be noted that, in a community-based primary care setting, practitioners often lack the time and cannot always assure the much-needed continuity of care to these patients (Pottie et al., 2014). Scarcity of time also plays a role in practitioners' inability to effectively coordinate their efforts with other sectors to ensure that the sociocultural determinants of health are effectively addressed. The lack of well-structured community mental health care available to refugees, as noted by the study participants, supports the need for established practice guidelines enabling the detection, prevention, and management of common mental health problems among refugees (Kirmayer et al., 2011).

Thus, in order to promote health among vulnerable migrants, the findings in this study support Canadian primary care practitioners' suggestions to:

- implement interpretation services;
- provide support for comprehensive interdisciplinary care and continuity of care;
- develop evidence-based guidelines to train and mentor practitioners ; and
- create new avenues for intersectoral care and community engagement (Pottie et al., 2014).

Specifically, intersectoral care and community engagement would enable practitioners to liaise with other sectors to ensure that their patients can obtain employment and economic stability, which are of major importance for improved health outcomes (Pottie et al., 2014; Kirmayer et al., 2011).

In light of practitioners' inability to devote more of their time to their refugee patients, it is highly essential that they focus on fostering trust through patience and empathy by attentively and intentionally listening to their patients' individual stories. Only in knowing such stories can they effectively assess an individual patient's needs.

Though it is often overlooked in practice, practitioners should adopt an *embodied* nature of care delivery with patients who have experienced collective violence and the associated trauma (Whitfield, 2004). Benner (2000) describes the embodied engagement of a caregiver with the patient as a practice that enables the patient to be liberated and strengthened as a result of the caregiver's embodied caring practices. As coined by Merleau-Ponty (1962), *embodiment* refers to the central way humans experience the world through their bodies in relation to time, space, and their relationships with others, that is, the patient's bodily responses that cannot be articulated or explained with words such as crying, silence, or pace of speech.

When continuity of care can be assured and a strong rapport is established between the practitioners and their patients, practitioners should aim to enable their patients to foresee the hope of a better future, a time in which they will be able to surpass their mental agony and distress. Essentially, this will likely give them hope, and thus facilitate the healing process. An approach that may be taken is enabling patients to develop ways by which they can foster forgiveness. Interventions aimed at forgiveness have been proven to increase feelings of hope and to improve resilience as a result of the decreased anxiety and depression in the lives of those who have been victimized (Freedman & Enright, 1996; Hebl & Enright, 1993; Worthington & Scherer, 2004). Though forgiveness, as explained above, can be an effective method for helping individuals heal from their distress and find hope for a better future, it may not be an attainable approach for all. For example, in the case of victims whose perpetrators may still be inflicting violent crimes upon other family members in their countries of origin, forgiving such criminals may be an unreachable endeavour.

Lastly, in providing care to those who have experienced collective violence, sociocultural sensitivity to their experiences and gender differences must accounted for. Though victims of collective violence share many similarities in terms of their experiences, it is important not to overgeneralize, as each one of them has distinct needs and experiences. In light of the evidence which suggests that "exposure to torture is the strongest predictor of symptoms of PTSD among refugees" (Kirmayer et al., 2011, p. E961), as argued by Watters (2001), these patients should not all be assigned Western psychiatric diagnoses, and placed under the umbrella of the PTSD diagnosis. Instead, the previous and current social, political, and economic dimensions of their lives should be primarily considered. In terms of gender, male and female refugees who have experienced collective violence should be understood and dealt with differently in health care practice. Past research (Galdas, Cheater, & Marshall, 2005; Gerritsen et al., 2006; Möller-Leimkühler, 2002) has documented that expressiveness of psychological symptoms and mental help-seeking is lower amongst males, in comparison to their female counterparts, as women are more apt to acknowledge their experience of trauma echoed in the current paper.

In relation to education, a refugee/immigrant health component incorporating the findings of this study, as well as other studies completed in the context of other countries (Bhatia & Wallace, 2007; Eisenman et al., 2003; Gordon & Gonzalez, 1998), should be instituted in nursing, medical, and public health school curricula to ensure that future practitioners will be adequately informed to work with this population.

Future work in this area needs to evaluate the presence of psychological comorbidity among refugees who have experienced collective violence. In this, peer-based counselling services and established practice guidelines should be developed and evaluated in order to assess their ability to promote refugees' health and improve their help-seeking behaviours. The relationship between level of psychological impairment and coping mechanisms in the midst of refugees' socioeconomic statuses during the post-migratory period should also be investigated.

STUDY LIMITATIONS

Though this study was successful at capturing the lived experiences of the participants as shown in previous sections, there are a few limitations that must be taken into account. With a small purposive sample taken only from two regions of the world, the meaning of health and help-seeking behaviours from the perspective of other refugee populations who have experienced collective violence may not have been captured. Similarly, experiences with the Canadian health care system may vary widely from province to province, especially in regard to the accessibility and availability of established services. Therefore, taking into consideration the life stories from refugees originating from various other provinces may add a deeper understanding of the lived experience of collective violence that may have not been captured in this study.

The nature of qualitative research does not allow for generalization of the research findings to the broader refugee populations. Thus this research is limited, in the sense that the obtained findings cannot be used as standard guidelines when dealing with the refugee population. Nonetheless, this study does provide important data that could facilitate work with immigrant and refugee populations. Lastly, selection bias might also have been a factor in this study due to the recruitment strategy. Essentially, the study aimed at recruiting refugees who were already receiving counselling from an established agency in order to prevent possible retraumatization.

CONCLUSION

The participants in this study offered a rich description of their premigration and postmigration experiences and perceptions regarding the meaning of health and help-seeking behaviours. The findings emphasize the challenges of the postmigration period for refugees who have experienced collective violence in terms of the ever-present trauma, stress, depression and barriers to accessing care as shaped by their past experience and the current health care system. As both victims and survivors of collective violence, it is very difficult for these individuals to seek help on their own although prolonged suffering can create a great number of ill-health effects in their lives. Thus, policy-makers must aim to design a health care system that facilitates access to primary care services for this population. The implications for health care practice, education, and research need to be considered and implemented in order to fully promote the health of refugees who have been victimized by collective violence. Implementing these recommendations will empower refugees to be better able to seek help and experience healing from the trauma caused by collective violence.

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