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Meanings of home and mental well-being among Sudanese refugees in Canada

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Objectives. This article examines family and social factors that affect refugee mental health during resettlement by presenting qualitative analysis of the concept of home and its functional and psychological meanings based on findings from research with Sudanese refugees in Canada.
Design. Data were collected in two successive multi-method, community-based studies between 2003 and 2007 with Sudanese refugee participants in Ontario and Alberta, Canada. The first study used survey methods with 220 participants in seven sites and the second, in-depth qualitative interviews with 30 community members in three sites.
Results. In the first study, economic hardship and family adaptation challenges were reported to affect Sudanese mental well-being. The second study explored cultural aspects of Sudanese family and community well-being in greater depth. Meanings of home emerged from data as a key concept linking social support, resettlement, and mental health. Findings highlight how the presence or absence of the social supports associated with home affect refugees' mental health during resettlement. The analysis focuses on four themes: emotional support; fulfilling social roles and expectations; problem solving and conflict resolution; and dignity and growth, as well as perceived impact on community mental health.
Conclusion. Qualities of home that Sudanese lack during resettlement points to critical gaps that must be filled by mental health and other service providers to promote positive refugee mental health in countries of resettlement.

Keywords: refugees; mental health; home; family; social support; conflict resolution; Sudanese

Introduction

As refugee migration and resettlement have become more pressing global concerns, approaches to refugee mental health have become less medical and more attentive to associated social and cultural factors. In the 1990s, research and practice tended to focus on identifying and treating refugee trauma and psychological disorders (Ingleby 2005). However, refugees more often need social care than psychiatric treatment and a standard biomedical model of care is inadequate (Watters 2001, Mollica *et al.* 2002, Ekblad and Jaranson 2004, Bala 2005). Refugee health research

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has shifted toward identifying interacting post-migration social and cultural determinants of mental health (Beiser 2005, Porter and Haslam 2005) using ecological approaches that include the individual, the family, the community, and society (Miller and Rasco 2004).

In this article, we argue that conceptualizations of home are important for promoting resiliency and positive mental health for resettled refugees, because fundamental components of mental health are rooted in its protective functional and psychological meanings. Two rationales support this argument: first, loss of home is a more commonly shared, defining experience among refugees than is the experience of trauma (Papadopoulos 2002); recreating a sense of home is therefore essential to refugees' sense of well-being. Second, shared definitions of mental health, home, and family cannot be taken for granted in ethnocultural health research. Mental health and illness may be defined in cultural terms that reflect family and social relations rather than in biomedical or psychological terms (Karasz 2005). Investigating refugees' perceptions of these concepts requires sensitive, interpretive methodologies (Ahearn 2000). Based on findings from community-based research with Sudanese refugees in Canada, this article examines conceptualizations of home and settlement experiences in relation to mental well-being.

Refugee mental health, home, and family

Post-migration stressors pose risks to mental well-being as significant as pre-migration trauma. A global review of social factors associated with poor mental health among refugees found that worse mental health outcomes were experienced by refugees living in institutional accommodation and experiencing restricted economic opportunity (Porter and Haslam 2005), conditions that apply to most resettled refugee populations. In contrast, only about 10% of refugees are diagnosed globally with post-traumatic stress disorder, and only 4–6% experience depression (Fazel *et al*. 2005). Quantitative studies about the mental health of Sudanese refugees have found high rates of psychopathology; however, Sudanese refugees report more concern with post-migration stressors such as family problems than with trauma (Tempany 2009). Thus, there is a need to investigate cultural and social factors that affect Sudanese refugee mental health.

For refugees as for others, the idea of home is multidimensional. Home is a source of emotional support, a wellspring of identity, a physical connection to one's past, and a potent symbol of continuity (Warner 1994, Magat 1999, McMichael 2002). Ideas about what constitutes 'home' often diverge among refugees and policymakers (Black 2002). For many refugees home is more than one place, but it is often 'neither here nor there' (Al-Ali and Koser 2002). Refugees feelings about home may be contradictory (Sussman 2000, Muggerridge and Dona 2006). The 'myth of return' assumes that refugees' thoughts of home are 'givens,' but the meaning of attachments vary and depend upon relationships with the home and the host countries (Al-Rasheed 1994). For many diaspora populations, transnational ties to home provide vital social support (Stone and Lipnitsky 2005), an important determinant of mental health. Yet, little is understood about the powerful psychological and experiential ties that bind refugees to their kin and homelands abroad (Lewin 2001).

The concept of home evokes two essential ideas: place and people. Anthropologists recognize that cultures cannot be physically located nor spatially bounded (Gupta and Ferguson 1992, Malkii 1992). Home similarly is understood less as a fixed place and more as a matter of identity, 'where one best knows oneself' (Rapport and Dawson 1998, p. 9). Home may be reconstituted by daily routines and cultural practices (Dyck and Dossa 2007). This social constructionist view rightly emphasizes individual agency, but rests primarily on 'home-making' in a space, rather than on relationships with people. We define home as nodes of social relations as they unfold in everyday life (Olwig 1998, pp. 235–236), that is, as perceived by refugees themselves. Social functions, family roles, and relationships are central to the re-creation of home and affect refugee mental health profoundly. Indeed, where resettled refugees feel 'at home' has a great deal to do with proximity to supportive social relationships, which are important determinants of refugee mental health (Mollica *et al.* 2002, Simich *et al.* 2005, Schweitzer *et al.* 2007). Conceptualizations of family across cultures are as various as ideas of home. Mental health research often examines associations between mental health and family relationships within North American norms with little regard for sociocultural variations (Umberson and Williams 1999). Sudanese and other African families are typically larger, extended and more interdependent (Kamya 1997, Nogid 2003). African conjugal roles are also understood differently from the North American ideal type, with differences in division of labor and decision-making.

Most refugee and immigrant families undergo positive and negative changes after leaving their home countries. On the one hand, the adaptation process may foster 'creative culture building' (Foner 1997, p. 961). On the other hand, immigrant family transformations frequently involve loss, which affects the capacity for resiliency (Falicov 2003). Sudanese refugees who have experienced significant familial disruptions due to war and migration rely for social support mostly on other Sudanese, churches, and organizations that recreate idioms of kinship (Abusharaf 1997, Goodman 2004). For refugees with limited resources, extended families can be a vulnerability factor when many adults are absent or dead, and those who remain struggle to fulfill family responsibilities (De Jong 2002). These and other challenges that refugee families face are sometimes portrayed in refugee studies literature, but feelings about home and how they affect mental health during resettlement are seldom explored. Findings from two successive studies with Sudanese refugees presented below seek to show how the concept of home links refugee resettlement, social support, and positive mental health.

Sudanese migration to Canada and study background

Most Sudanese are in Canada because of the brutal civil war and long-term environmental destruction in Sudan, which has killed and uprooted millions with severe social and psychological impacts (Ibrahim 1995, Pardekooper *et al.* 1999, Hutchinson and Jok 2002). The repressive military regime that has been in power since 1989 has exacerbated north–south differences. When rebel military groups actively opposed government forces, civilians were caught in between. In 2005, a peace accord was signed, but hostilities have continued.

Over 35,000 Sudanese currently reside in the Toronto area and cities in southern Ontario. The majority are government-assisted refugees who were selected as

convention refugees for resettlement in Canada, where they receive permanent residence status and financial support for one year. In 2004, our research team completed the first community-based survey of settlement needs and barriers among recently arrived Sudanese in seven Ontario cities with funding from Citizenship and Immigration Canada (CIC) (Simich and Hamilton 2004). In the process, we gained insights into how Sudanese women and men settling in Canada struggle to fulfill their family roles and obligations, as will be discussed. Relevant data about families were difficult to capture with survey methodology alone, because Sudanese consider these private matters and interpret them from within a cultural framework different from the Canadian norm. To study important family issues in greater depth, we conducted a second qualitative study in 2006 about conceptions of family and community mental well-being with funding from the Social Sciences and Humanities Research Council of Canada and Canadian Heritage. For comparison, we expanded the geographical scope to two additional study sites in the Western Canadian province of Alberta where Sudanese have also settled: the city of Calgary and the small town of Brooks. In Calgary there are approximately 7300 Sudanese residents, the largest African newcomer community in the city. In both Calgary and Toronto, gaining meaningful employment is a major integration challenge. Sudanese with university or some higher education are underemployed working in low-paying and low-skilled jobs. Racial discrimination is a significant problem, although lack of English language proficiency is also a major barrier to employment. Brooks (pop. 13, 000) is home to approximately 1500 Sudanese within a black African refugee population of 3500. Unlike in Toronto and Calgary, employment is not a major issue, because most Sudanese work as manual laborers in the meat-packing industry. According to service providers and Sudanese informants in all sites, alcoholism, domestic conflict, and psychological disorders are increasingly reported.

Methods

The data presented in this article are from both studies, which received ethics approval at authors' respective universities. Objectives of the initial survey were to obtain a profile of Sudanese immigrants arriving between 2000 and 2003 and residing in seven Ontario cities to assess settlement service needs and utilization. Survey data were also gathered on demographic characteristics, pre- and post-migration experiences, sources of social support, and general health and well-being. The core research team, an interdisciplinary group of scientists and Sudanese professional women, worked with community leaders in the research sites. Sudanese co-researchers originated from diverse ethnicities and regions of Sudan and were therefore able to engage a representative group of study participants. Combined cluster and snowball sampling and recruitment resulted in a sample of 220 Sudanese adults. Forty trained community researchers conducted face-to-face interviews in one of the six Sudanese languages (English, Arabic, Juba Arabic, Dinka, Nuer, and Bari). Twelve key informant interviews were conducted to assist with data interpretation. Details of sampling, community-based research methods, and quantitative methods of analysis appear elsewhere (Simich *et al*. 2006) and are not discussed here due to space limitations.

The second, in-depth qualitative study examined factors that affect family adaptation and community well-being. Qualitative researchers used a pragmatic

research design and applied research methods without prior reliance on theory (Patton 2002, p. 145), which allows flexibility in determining research strategies providing they are used ethically. The study design had two components: first, 30 confidential, semi-structured interviews lasting 1–1.5 hours were conducted with adult community members in Toronto, Calgary, and Brooks (10 each site), who were recruited using purposive and snowball sampling. All study participants were 20–60 years old, and a majority were married with children. The Toronto sample included equal numbers of men and women, but male study participants outnumbered female in Calgary and Brooks, because of labor migration patterns and the male gender of researchers in those sites. All interviews were audio taped with permission, translated as needed, and transcribed in English. Second, focus groups with professionals who work with Sudanese in settlement services, social work, public health, education, and police services were held in all sites to discuss study findings.

An inductive approach was used for data analysis (Lincoln and Guba 1985). First, a directed a-priori coding framework for organizing interview data was constructed of 31 categories based on seven interview topics: migration and settlement (arrival, feelings about Canada, challenges, and opportunities); concepts of family (definitions, roles and decision-making, impact of changes); concepts of health (community health, healthy families, illness causes and responses, changes in health); social support interventions (barriers, impact, supports needed); and perceptions of the roles of community and government. Responses were coded and analyzed using Nvivo and Atlas-ti qualitative analytic software. Second, additional *in vivo* coding and higher level analysis highlighted common themes across sites, one of which was the concept of home and its associated meanings. Narrative descriptions of home were seen to interact with ideas of family structure, conflict, and cohesion. Studying the interrelationships of these data revealed tensions and gaps in resources that contribute to mental health.

Results

In this section selected findings from the two studies are presented. First, descriptive statistics, frequencies, and key findings from the survey of settlement needs are summarized briefly. Qualitative data from the second study are then presented to illustrate concepts of home and associated factors perceived to affect mental well-being.

Overview of survey findings

Findings from the survey identified family adaptation and economic integration as prevalent community concerns, as well as a common desire to have a place for social gatherings and problem-solving. High rates of economic hardship were reported: a majority (77%) of survey respondents who received government income support felt that it was inadequate to meet basic needs; 31% reported worrying about having enough money for food or prescribed medicine. Family separation and reunification challenges due to low income created ongoing emotional stress. Worry about family not in Canada was the greatest challenge during the first year in Canada reported by 68% of survey respondents. The majority (80%) of respondents were trying to bring family members to Canada, specifically parents (46%), a spouse (18%), or children

(15%). A significantly greater proportion of those trying to reunify with family members reported losing sleep due to worry than those not trying to bring family members. The continuing obligation to support extended family members may be one reason for this. For 59% of the study sample, the number of people that they had helped support while living in Sudan ranged from 1 to 23. Among those who helped to support others, the average number supported was 7.5.

Community meetings and interviews reinforced the idea that Sudanese were deeply concerned about family-related problems, family reunification, stable marriages, and parenting. Changing gender relations strained Sudanese families during settlement, as women became more aware of their legal rights and became household providers, while Sudanese men often remained underemployed or left their families for employment elsewhere. Unmarried Sudanese struggled to re-create support networks normally provided by extended family members. Prolonged family separations were reported to affect quality of life and mental well-being. Obligations to extended family members who remained in Sudan imposed additional emotional and financial stress. Concerns about family dissolution, divorce, and child custody arose frequently. Sudanese attributed problems to cultural differences in Canada, post-migration gender role change and resistance to change, stress related to underemployment, and discrepancy between reality and expectations of a better life in Canada.

In general, survey respondents rated their overall health as good. However, in open-ended responses many reported persistent psychological stress during settlement, including signs of depression and trauma. For example, participants reported, 'I do not want to think about the past,' 'I am always thinking of life's pressures,' 'I am sick and depressed all the time,' and 'Since coming to Canada my health has deteriorated.' In subsequent data analysis, we found mental distress to be associated with economic hardship and unmet expectations in Canada. Individuals who were experiencing economic hardship were between 2.6 and 3.9 times as likely to experience loss of sleep, constant strain, unhappiness and depression, and bad memories as individuals who do not experience hardship (Simich *et al.* 2006). What seemed most interesting was why this was so. Underlying mental distress was the need to support family in Canada and 'back home.' The reason for psychological distress was not simply economic hardship per se, but rather how it diminished one's ability to fulfill obligations to family in Canada and those still at risk in the homeland or refugee camps (Simich *et al.* 2006, p. 435).

Findings from the qualitative study

The second study compared Sudanese experiences in the provinces of Ontario and Alberta and investigated perceptions of family and community well-being in greater depth. Analysis of qualitative data from all three sites revealed common patterns in how Sudanese refugees referred to home, a term that was almost never used to describe life in Canada. Rather, study participants used the term in a comparative context, contrasting positive images of 'back home' (*in vivo* usage) with the loss of salient characteristics of home in Canada. Associations with home emerging from the data evoke what is actually needed to reestablish a sense of mental well-being in Canada. For Sudanese refugees in all three sites, narrative descriptions of home tended to be associated with four specific functional and psychological factors essentially related to the definition of home as a 'node of social relations' (Olwig 1998): emotional support;

fulfilling social roles and meeting social expectations; solving problems and resolving conflicts; and dignity and growth. By contrast, refugees talk about home life in Canada as marked by absence of support from extended family; inability to fulfill social roles and meet expectations; increased family conflict and lack of means to resolve conflict; and lack of dignity and opportunities for growth. These four qualities, which emerged consistently across sites as prominent recurring themes associated with perceived functions of home, are illustrated below.

Emotional support

For Sudanese, the lack of social support received from extended family members who are not in the resettlement country contributed to a sense of loss and displacement. As study participants explained:

> Most of us share the same issues, because we have relocated from one country to the other and . . . that emotional support that we usually get from our mothers, aunts and uncles is not here anymore. (Female participant in Toronto)

> You have nobody to contact because you are always lonely and you are always trying to do a lot of things, and also you are thinking back about your relatives who live in the war zone in Sudan. (Male participant in Calgary)

Increased safety in the country of refuge was perceived as scant comfort considering the loss of customary social support. As another participant said:

> There is a saying, 'there is nowhere like home.' It's good that you are here [in Canada]. I'm not worried about getting shot by a bullet, but the problem is, you miss your own people. (Male participant in Toronto)

Fulfilling social roles and expectations

The concept of home was also described positively in terms of family roles and responsibilities to extended family members. Many participants commented in this way:

> In the family back home, the head of the family is responsible for everything . . . You work for your family all the time. When somebody is sick, you have to take care of that person . . . Secondly, you have to make sure that everybody is safe in the family. When there is a problem in the place you are, you move to another place to make sure that people are safe. (Female participant in Calgary)

As expected, study participants also described how marriages face challenges and marital roles may change after migration:

> Back home . . . a man is the head of the family and he is the last decision maker. He is the person who is responsible for everything and everything is on his neck back home. Now here in Canada it is so different. That is the big challenge for both the man and the woman. (Male participant in Toronto)

The traditional interdependence and mutual support that is perceived to be a strength of Sudanese families can become a burden when families are divided and adults must support family members both in Canada and back home. As study participants said:

> I went to school for one year and that's it. I can't do it because I need to work to support our families back home, because they need help, too. (Female participant in Toronto)

> It's very hard to live here ... Sometime you think you want to go back to school, because you are not going work the rest of your life in a labor job ... I need to help my country, not only myself, to get a good education, to continue to do something back home. (Male participant in Brooks)

Problem solving: parent–child conflict

In contrast to ideal family life in Sudan, Sudanese households in Canada can be marred by intergenerational strife, increased anxiety, mounting frustration, and few sources of social support. Study participants expressed concerns as follows:

> It's because of the lifestyle in Canada. Kids learn fast. When they go to school, they talk to their friends and get completely absorbed into the society here ... They start asking for things that probably the parents can't provide. Those are some of the things that cause that a rift between parents and children. (Male participant in Calgary)

> Here it is so different. You just keep it to yourself until it gets worse and you start to yell at your kids, at your wife and problems arise. The police will be called and the children will be taken. It's not like back home. (Male participant in Toronto)

Problem solving: marital conflict

Significant concerns from both women and men about the stability of Sudanese marriages in Canada also emerged. Most striking was the association of increased family conflict with the loss of elders who customarily mediate to resolve such problems back home. As one woman explained:

> Let me give the example of me and my husband ... When we come together united, married, we are supervised. If you don't take care of your wife or if you behave badly, [elders] see and then they sit you down [and say], Why are you doing this? You are supposed to be nice. They are advisors. If something happens out of hand, my aunties will come in. They will talk to me. Men talk to boys. Women talk to girls. And the family is together. You don't easily divorce ... That's family in our culture. (Female participant in Calgary)

'Back home' was described positively in terms of family cohesion and traditional problem solving, but home life in Canada was associated explicitly with the harm done by other methods of handling conflict. For example:

> Back home [conflict resolution] occurs by simple traditional laws that are our own and are a very peaceful traditional way ... but here it is so problematic. Once the police get involved in family problems ... the man is not comfortable about being in the house. Some end up packing, going back home and leaving their families here. (Male participant in Toronto)

For Sudanese couples, adaptation required balancing two cultures, though preferences for traditional conflict resolution remained strong. For example, one said:

> Canada is a different country and has different laws, so we can't break them, because we respect what they have. If you make a mistake, they charge you ... If we have a problem at home I am going to call my cousin. If I am making mistake, my cousin says, 'Don't. That's wrong.' Then I cool down and everything will be okay. (Male participant in Brooks)

The idea of conflict resolution and problem solving that emerged was associated with private life, but also, because it was becoming a widespread public concern, with the

expressed desire for a community center where such needs could be addressed in a culturally appropriate way. As one person said:

> People don't have a centre to meet. They have been talking about having their own space at least to get together ... They want to educate themselves, they want to visit. It's not like back home [where] people actually look after themselves ... you can mobilize people and bring something [to help]. That is the social welfare that [Sudanese] have. (Female participant in Calgary)

Dignity and growth

Other comments show how Sudanese strove to balance the positive qualities of 'back home' with those of the new environment to help families thrive. As some explained:

> I have my wife and children ... I always explain to them the culture back home and I will try my best, because that's for them ... Sudanese in general, I think, are supposed to stick with the family and continue the culture – even Canadian culture: no abusing the children, no abusing the wife. (Male participant in Brooks)

> If the educational level is not that high and their understanding of family is not very good, adaptation to Canadian culture will break their marriage ... Here, your husband has to cook, he has to clean ... that's what breaks most of the Sudanese families, because some women took it like revenge ... They don't know how to get good things from Canadian culture and leave some of the bad Sudanese culture behind. (Female participant in Calgary)

Perceived impact on mental well-being

The four qualities of home illustrated above were perceived to affect mental health. For study participants, positive mental health meant having emotional support and fulfilling the social expectations of caring for family members in Canada and Sudan, which speaks of reciprocity and mutual respect. As one explained:

> If I'm healthy, I have good plans to work hard and support my family here and support my family back home. (Male participant in Calgary)

Mental health was associated with social support available at home, whereas mental distress was associated with social deprivation in Canada. As one participant said:

> Back home I didn't have much to eat, but I had much to get from my people. You feel stable, except for the war. Your mind is so fresh and relieved. But here [in Canada], you are so loaded with a lot of things to think of. (Male participant in Toronto)

Not having a sense of home, and its associated social support and shared experiences, made coping with resettlement stresses a lonely experience, deterred formal support-seeking, and magnified mental distress. As one refugee said:

> With no family here, sometimes you don't want to share your problems with people you don't know ... And the problems are even bigger than the ones back home. (Female participant in Toronto)

Home life in Canada was perceived to be a source of mental distress, because conflict was seen to increase when social support and other personal resources decreased. As some said:

> A healthy family means – not people who are always [having] problems – fighting makes people sick at home. But if there is nothing like that, if your wife respects you, you respect her, your kids respect you . . . then I am healthy. (Male participant in Brooks)

> Most sickness comes from trouble at home. If you don't have enough money, a good job, if you don't have car, what's your wife going to say? What are your kids going to say? . . . you don't have a good job to make them happy . . . then slowly you get depressed. (Male participant in Brooks)

One participant suggested that family conflict and lack of conflict resolution had long term consequences linked to diminishing hopes:

> If [conflict] happens it could be resolved at home in a good way, but here it's like you are tearing the family apart. We keep hoping for the best and the hope seems to be fading away. I think that is the frustration. (Female participant in Toronto)

Another participant suggested that, while refugees must adapt to life in Canada, the society also should make opportunities available in order for them to feel at home. He said:

> When people come here, it's already a 'home' . . . They have to feel that it's like their home and there should be nothing that should hinder them if they want to achieve. (Male participant in Toronto)

When facing difficulties, Sudanese refugees rely on one another; however, informal family and community supports alone cannot meet all their settlement and health needs. Nevertheless, Sudanese feel that they retain a culture of mutual aid related to the home culture. As one participant said:

> We work together. We support each other. That's one thing from back home that is in us. We support each other very, very well, but sometime our support is limited. Then we cannot go further. That's one good thing I think is still alive in us. (Female participant in Calgary)

Discussion

The 'myth of return' discussed in refugee studies assumes that refugees' desires to return to the homeland impede adaptation to the resettlement society; however, retaining some social and cultural attributes of the past – in this case, ideas about home – is an important part of the transition and adaptation process (Zetter 1999). What Sudanese refugees say about home reveals not only what social supports are missing from their daily lives in Canada and but also how it affects their mental well-being. These missing qualities are worth highlighting because they may contribute to positive refugee mental health and resettlement outcomes. Granted, ideal visions of 'home' are part of any culture, and these ideals may become a source of nostalgia in the diaspora, no matter the individual reality experienced or remembered. Assuming that ideas about 'back home' are born of simple nostalgia, however, would be superficial. Papadopoulos (2002) refers to 'nostalgic disorientation' as a psychologically painful and unique predicament of refugees. The evidence from our studies with Sudanese refugees shows that multidimensional, protective functional, and psychological factors associated with 'home' – emotional support, fulfilling social expectations, problem solving, and dignity – can restore and protect refugee mental

health, and points to critical gaps in psychological and social experiences during refugee resettlement that should be filled.

Theoretical and practice implications of these findings are two-fold. First, the dominant discourse in refugee mental health, which views trauma associated with pre-migration events as inevitable, tends to pathologize refugees and downplays psychological and social sources of resiliency. It also ignores systemic complexities such as the psychosocial significance of family separation for refugee families and communities, which can have significant mental health impacts (Rousseau *et al.* 2001). Enlarging the perspective on refugee mental health to examine qualitative meanings of home reveals non-pathological psychosocial dimensions of refugees' lives that promote positive mental health. Second, mental health professionals who care for refugees may therefore be able to reorient their practice toward refugees' personal and social sources of resiliency, such as social support within their families. At the same time they can explore the limitations of these resources and discuss how to recreate healthy conditions of 'home' during resettlement.

One might assume that refugee resettlement situations would compare more favorably with pre-migration situations than our data demonstrate, but resettlement is challenging, and for Sudanese refugees making social comparisons is one way of coping (Schweitzer *et al.* 2007). It also may be that the *process* of comparing and reevaluating is helpful as a way of reconciling the past and present. The tendency to compare what is perceived as negative about the country of resettlement to what is perceived as positive 'back home' also occurs among non-refugee immigrants, but for refugees the decision to migrate is less in their control. Thus, the sense of loss is stronger and the sense of relative deprivation enhanced. A sense of feeling at home in a country of resettlement may develop in time, but the immediacy and depth of their needs for resources that would normally have been available, but that are no longer available in the manner expected, intensifies pining for what was good about 'back home.' In the process, mental health may be undermined.

While refugees' perceptions of home and family may be changing and contested, the process of cultural adjustment and negotiation is not necessarily problematic; rather it is potentially enriching, empowering, and adaptive. There is general agreement between Sudanese women and men with respect to meanings of home, but cultural values are not static. For example, Sudanese women in Canada voiced dissatisfaction with customary gender roles, but men also recognized that adaptive changes in marital roles are needed. Furthermore, negative changes in refugee family relations cannot be attributed only to lack of social support after migration, because tensions due to war, changing social roles, and increasing poverty affected Sudanese families even before migration (Hutchinson and Jok 2002). Some findings reflect community concerns with increased marital conflict and domestic violence, which tend to occur in post-conflict migrant populations that suffer from high rates of trauma and depression (Mason and Hyman 2008). This implies not only the presence of conflict, but also lack of conflict resolution strategies, partly a result of resettlement practices that delay family reunification and impede social support. Traditional coping strategies and social networks that provide customary support may not be simply transplanted in the resettlement society and must be viewed critically if they perpetuate gender inequities or exert social controls at odds with the law. Nevertheless, healthcare providers may be able to optimize positive, culturally grounded supports, and strategies to strengthen resiliency factors.

A limitation of research focused on single-nationality refugee populations (although Sudanese comprise diverse ethnic groups) is the difficulty of generalizing findings to other populations. Sudanese values, such as the high esteem accorded to elders, may be culturally specific. However, the significance of home to refugee populations is fairly clear. Conceptualizations of home and its associated functions are likely important for mental health in all refugee populations, because social support is a well-established predictor of mental health. The high value placed on interdependence of extended family members is culturally normative in many populations, in contrast with the individualistic western cultural norms that influence mental health care.

In conclusion, service providers need to take into account the presence or absence of family members to help refugees resettle and maintain mental health. This evidence suggests the possible benefits of providing culturally appropriate counseling and alternative means of conflict resolution, which entails consulting with knowledgeable community members and caring not just for a client, but for a family as a whole. Family values, structure, rules, and roles affect mental health and problem definition, expectations and decisions about help seeking. These factors can be explored as part of an initial client assessment (Leininger 2002, Debs-Ivall 2007). Peer group interventions promoting strong families also may help especially in the early years after migration, when the sense of loss of home is greatest. Implementing such strategies may help refugees to recover the sense of mental well-being, dignity, and belonging that comes from being functionally and psychologically ‘at home.’

Key messages

- Refugee mental health research should explore understudied social dimensions of refugee mental health, such as conceptualizations of home and family that emerge from refugee adaptation experiences, to develop a more nuanced understanding of resources for refugee mental health.
- Refugees’ conceptualizations of home point to specific areas of informal social support, extended family responsibilities, and family conflict resolution that deserve more culturally appropriate attention in mental health practice, social services, and refugee resettlement.

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