Misplaced/Displaced: Defining the 'Refugee' Category

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Introduction

Global conflict and growing inequality continue to displace increasing numbers of diverse populations. While the United Nations High Commissioner for Refugees (UNHCR) identified approximately 13 million refugees in 2015 (UNHCR, 2015), the highly complex geopolitical climate continues to complicate traditional notions of nationality and citizenship. As a result, the populations of concern to the UNHCR also include millions of individuals in equally tenuous, but far less delineated circumstances than officially designated refugees. As of the 2015 report, these individuals-- including asylum seekers, stateless persons, internally displaced persons, and populations vulnerable to exploitation-- numbered nearly 43 million people (UNHCR, 2015). This is comparable to every single person in the states of California and Oregon combined being forcibly removed from their homes in some way.

A refugee's journey, or *flow*, through the refugee-regime complex can be a matter of years or decades, and may or may not lead to resettlement (UNHCR, 2015). While human history has always included refugees (Gushalak, 2001), the global institutionalization of the category of 'refugee' took place following World War II, when countries officially collaborated to direct and project refugee movement through treatise and declarations. The 1951 Refugee Convention is the most "comprehensive codification of the rights of refugees at the international level" and has only been amended once in 1967 (UNHCR, 2010). This document has three key functions; to specifically define the term refugee, to prohibit discrimination barring refugee status on the basis of sex, age, disability, or sexuality, and to enforce the principle of *non-refoulement* (or prevention of forced return), acknowledging that by seeking asylum, refugees likely will have broken immigration rules (United Nations General Assembly, 1951).

The international community views repatriation as the most "durable solution", and negotiations over managing displacement can be protracted (UNHCR, 2015). Only 1% of the world's refugees are permanently resettled into a host country, and of those, approximately half are resettled into the United States (Resettlement Fact Sheet, 2014). In addition to the United States, the other most active resettlement countries include Canada, Australia and the family of Nordic European nations, while there are 27 official resettlement programs globally (Executive Committee of the High Commissioner's Programme, 2014). Every host country's resettlement system varies from others, and while the UNHCR offers guidance for resettlement best practices, the prevailing political and economic institutions in each nation guides each system.

Much has been written about the refugee regime complex and its structures and transnational flows (Betts, 2009), but comparatively little analysis of the domestic resettlement apparatus has been undertaken, nor has it been related to the measurement and characterization of psychosocial wellbeing for resettled refugees.[1] In addition to being a common programming focus, the literature concerning the mental and emotional health of refugees in the resettlement apparatus is primarily concerned with acute

[1]For example, in the last two years of publication for the leading Journal of Refugee Studies, eleven of 36 articles were concerned with resettlement, while the remaining 25 were concerned with transnational issues. Only one of 11 resettlement articles was set in the United States, and none were concerned with resettlement structures (Journal of Refugee Studies, 2014-2015).

distress, almost exclusively engaging with PTSD, anxiety, and depression.[2] While the symptomology of diagnoses like depression, anxiety, or PTSD are indeed critical for refugee populations that have often endured violent political and social upheaval as well as acute poverty, it is also important to keep two points in mind. First, the boundaries of these illness models have long been contested in the social and psychological sciences, from Kirmayer's analyses of cultural variation in psychiatry (Kirmayer, 2001), to Fassin and Rechtman who argue for a more nuanced conceptualization of psychological diagnoses— particularly depression and post-traumatic stress disorder (PTSD)— as Western social constructions of illness that are variously applicable in different contexts (Fassin and Rechtman, 2009). Secondly, while heightened incidence of these symptoms among resettled refugees overall is not contested, the actual incidence rate *is* contested, due both to the uncertainty around the boundaries of these diagnoses, and the unreliability of existing statistical analyses and survey methods.[3]

The Harvard Trauma Questionnaire (HTQ) and the Refugee Health Screener 15 (RHS-15) are both well respected and heavily utilized surveys that have been statistically verified and translated into multiple refugee languages. Both tools are also exclusively aimed at identifying emotional distress and psychopathology. In the United States, governmental entities, health care providers, academia, and non-governmental agencies *all* utilize these two tools to assess mental health in almost every kind of setting within resettlement. The heavily utilization of the HTQ and RHS-15 within and outside clinical contexts likely resulted from the intersections of asylum policies that have an emphasis on the verifiability of persecution, conventions of Western mental health, and the nature of how refugees are resettled, including the funding of those activities.

It should be noted here that this writing does not contest the validity of these tools, or the importance of their application in many clinical and/or early resettlement settings. However, these tools may often be contextually dissonant in practice *and* in research, and diverge from identity and acculturation pathways for resettled refugees. These tools may not allow for occupation of various states of acculturation beyond that of the "traumatized refugee," nor do they allow for acculturation and mental and emotional experience as a dynamic process.

Taking Stenner and Taylor's (2008) "transdisciplinary psychosocial approach," this paper proposes that refugees are 'created' as a homogenous, traumatized category as a result of international and domestic refugee resettlement policies. The statistical instruments that characterize refugee mental health further legitimize this category and are used too broadly in clinical, non-clinical, and scholarly contexts. According to my empirical evidence, a paradigm shift towards wellbeing and resilience would better align with self-characterizations of mental health by refugees and clinical and non-clinical

[2] In a Proquest search using "refugee" and "mental health" as the primary search terms, 82.3% of results were also associated with "depression" (34.3%), "anxiety" (32%), or "PTSD" (16%), whereas 17.7% were associated with "resilience" (11%) or "wellbeing" (6.7%). The Search was conducted most recently in July of 2015 using Proquest general database "advanced" search option. The total number of articles retrieved was 19797, and included articles from 2010 to 2015.

[3] A meta-analysis by Fazel and colleagues (2005) highlights great heterogeneity and unreliability--both of study design and incidence rates of psychological disorders—within studies of resettled refugees. Furthermore, even if a sample population is an adequate size for statistical analysis, psychosocial survey tools that are statistically verified and have been reliably translated to one of many resettled refugee languages are few.

professionals working on the ground in resettlement. Importantly, it would also undermine the homogenous category of the "traumatized refugee."

Methods

This research was guided by Stenner and Taylor's (2008) "transdisciplinary psychosocial approach." Unlike interdisciplinary approaches that simply account for multiple epistemological sites, transdisciplinary approaches take a perspective from "spaces in between" epistemological sites where situated knowledge blends. The transdisciplinary approach also incorporates "non-specialist" knowledge and the social life (Latour, 1993) of the artifacts that are generated through on-the-ground experience.

This work also utilized Neuman's (2011) framing of critical social science and his recommendations for field-based research, with particular attention to the ecological validity of material that was generated through the researcher's presence in the community. In hopes of supporting the external consistency of the data, material from multiple field sites in Canada, Vermont, New Hampshire, and Middle Tennessee, as well as data from national organizations were compared and analyzed together.

My fieldwork was conducted with refugees, agency employees, health professionals, and government officials, for the most part between 2013 and 2015. A formal focus group was held, and researchers engaged in observation and participant observation in various settings such as homes, communal garden spaces, community meeting spaces, and workplaces. Refugee respondents included 19 Bhutanese refugee participants in a two and a half hour focus group in 2014, short conversations with approximately 26 Bhutanese and 28 Burmese refugees living in Tennessee in 2015 over the course of the 2015 growing season, as well as three extended conversations with one Bhutanese refugee community leader and one extended conversation with a Somali refugee community leader living in Tennessee between 2013 and 2015. Agency informants cited in this writing include electronic correspondence with one programming director in Vermont between 2012 and 2013, as well as a two hour formal interview with a New Hampshire program director. Weekly one to two hour meetings were held with one programming director, and quarterly meetings with one public health professional working with refugees, both in Tennessee between 2013 and 2015. Participant observation was also conducted through regular attendance at refugee agricultural sites, monthly Refugee Task Force meetings, and Quarterly Resettlement Consultations in Tennessee between 2013 and 2015. Government respondents included the former director of the Refugee Agricultural Partnership Program (RAPP) (two hour extended interview) and the Director of Wilson-Fish Programs (at an official question and answer session during community consultation), both under the federal Office of Refugee Resettlement (ORR) and in 2014. Finally, a psychiatrist specializing in forced displacement that is based at a busy urban trauma and torture survivor center in Ontario, Canada, was also formally interviewed for one and a half hours after a previous informal meeting and electronic correspondence.

Respondents were engaged either through direct request for interviews and/or word-of-mouth referral in the case of government and agency officials and refugee community leaders. Other refugee community members were accessed through their participation in a concurrent quantitative study, either through a refugee agricultural

program or at their homes. These individuals were recruited to the quantitative study (during which qualitative interviews that informed this writing were also conducted), either as a result of their involvement in a refugee agricultural program, or were invited through their resettlement caseworker to participate in a quasi-control group if they were not involved in the agricultural program. Data was collected directly and solely by the author, except in the case of the focus group and quantitative study participants in Middle Tennessee, in which case data was collected with the assistance of bilingual research assistants and/or translators in refugee's primary languages.

The university institutional review board (IRB) approved all of the research conducted in Tennessee, and all respondents in that region were formally consented according to the rules and regulations of the IRB. All respondents in Vermont, New Hampshire, and Ontario are quoted anonymously and only with their permission, and all participants in this research were informed of the goals of the research to learn more about psychosocial wellbeing and the way it is addressed, managed, and perceived by refugees, individuals involved in refugee resettlement, and communities outside of resettlement. The study was funded in part by the Meharry-Vanderbilt Community Engaged Research Core Graduate Community Engaged Scholar Award and the Vanderbilt Institute of Global Health Anne Potter Wilson Award.

"More Than a Head Count:" Entering the 'Refugee' Category Through International Refugee Flows

The "refugee regime complex" is an intricate network of international entities and laws that work to protect innocent citizens from violence (Betts, 2009), and from the outset internationally organized refugee relief efforts struggled with categorical uncertainties. In the waning years of World War II and before the formation of the UNHCR, the United Nations Relief and Rehabilitation Administration (UNRRA) sought solutions to "surplus population," wherein migration routes in central Europe were cut off by war damage, causing over-crowding in some countries and labor shortages in others (Elie, 2010). The formation of the International Refugee Organization (IRO, and later IOM) was the result of strategizing a way to categorize groups in order to justify and enable their resettlement. The ironically named PICMME program (the Provisional Intergovernmental Committee for the Movement of Migrants from Europe) was the first time groups applied to be selected for categorical resettlement on a large scale (many headed to North America), and the 'refugee' category was claimed as part of that process (Elie, 2010).

In 1951 when the Refugee Convention was instituted, the refugee regime was for the most part a pyramidal apparatus with the UNHCR at the highest point of authority. Over the past half-century the apparatus has become more decentralized with the proliferation and contracting of non-governmental organizations (Betts, 2009), as well as a growing political uncertainty around who may access the category of 'refugee' as they emerge from mixed migratory flows.[4] For a Eurozone struggling with the burgeoning

[4] To illustrate these categorical uncertainties, an anecdotal analysis of media reports on Syrians and Libyans escaping conflict in their regions demonstrated that news outlets such as the New York Times portrayed these individuals as both refugees *and* migrants in crisis, depending on their mode of transportation and their destination (Cummings-Bruce, 2014; Yardley and Pianigiani, 2013)

decision of whether and/or how to contribute to global resettlement efforts, these categorical negotiations continue to vex the refugee regime complex more than 75 after the PICMME program.

Despite ongoing shifts in institutional power structures however, the UNHCR remains central to this network insomuch that it reserves the final authority over inclusion and exclusion into the 'refugee category', and presides over the negotiations of resettlement or repatriation between countries. Once a refugee has fled their country of origin and reached a potential asylum site, such as a camp, border crossing, or embassy, that person must apply for registration with the UNHCR. Host states are responsible for the actual registration process (this will often also be executed by a contracted NGO, say for instance at a camp), with the assistance of the UNHCR and their proGres refugee database (UNHCR, 2015). Registration is the first physical site of categorization and serves two functions; to determine the amount of assistance that is needed, and to be sure individuals meet the definition of 'refugee.' Once registration is completed, refugees are then entitled to receive security, food and water, and shelter from the supporting agencies, which may or may not directly include the United Nations.

If an individual has been given official 'refugee' status at a secondary site, they may qualify for referral to a resettlement admissions program in a third host country. The admissions program for the United States (USRAP) is administered by the Department of State, where a regional officer will create a case file and consider resettlement requests according to interview material that is gathered in cooperation with the Department of Homeland Security's Citizenship and Immigration Service (DHS/USCIS). Alternately, individuals will apply directly for asylum within countries they have reached on their own, which is more common in large urban port cities or in countries with smaller refugee programs, like Canada. If a resettlement or asylum application is approved for security clearance, applicants are required to submit to medical examination and cultural orientation (Bridging Refugee Youth and Children Services (BRYCS), 2013) before receiving their status as a permanent resident; a "green card" in the United States (U.S. Citizenship and Immigration Services (USCIS), 2011), or "PR Card" in Canada (Government of Canada, 2014).

As previously mentioned, the United States accepts the majority of the world's resettled refugees, and has done so since World War II.[5] In 2013, the United States accepted 50,000 out of almost 75,000 resettled refugees worldwide, with the second biggest resettlement site, Australia, accepting 9900 (Resettlement Fact Sheet, 2014). In 2014, the United States alone accepted nearly 70,000 refugees for resettlement or asylum, only 13 individuals shy of the president's binding yearly resettlement "cap" (Fiscal Year 2014 Arrivals, 2014). Despite the fact that obtaining permanent residency is an entry-point into a new nation and a continuation of ongoing processes of acculturation, governments and agencies conceptualize refugee flows as ending with resettlement. For example, a "journey" chart distributed through local resettlement agencies such as the Tennessee Office for Refugees or Arlington Refugee Services depicts a refugee's flow as beginning with fleeing their home nation and ending with arrival in a resettlement city (Journey of a Refugee, 2013). Helping refugees establish new identities and

[5] Following WWII but before the institution of the UNHCR, over 400,000 European refugees by the end of World War II (Refugee Council USA, 2004).

independence in host countries through the operations of resettlement however, is very much a continuation of refugee sorting and categorization.

The End is the Beginning: Resettlement Flows

There is a growing interest in conducting research with and on refugees, yet comparatively little has been written about the fragmented apparatus by which refugees flow through resettlement in host countries. As noted by Darrow (2015), national resettlement programs—and in the United States in particular—are by nature in a near-constant state of "flux" and development. Federal, state and private organizations are rarely aligned beyond the basic resettlement requirements of the Office of Refugee Resettlement (ORR), and their divergences are driven by top-down uncertainties surrounding funding and sustainability. Trajectories for refugees re-entering citizenship are often fraught with uncertainty, impacted by the variable level of organization and available resources at each resettlement site. The near constant development of resettlement policy and practice plays a large part in the experience of refugees themselves, as well as how the public perceives them. At some point, the framing of what it meant to be a 'refugee' in the American media or political debates took a marked turn from the depiction of European refugees from WWII, giving a new focus to mental health status and acculturation.

Even though the U.S. had been resettling refugees on a large scale for thirty years, the Refugee Act of 1980 was the first official legislation addressing refugee flow as a political concern, directing the resettlement apparatus to channel refugees both in terms of health and employability. Following their initial medical exams and cultural briefings, the Department of State's Bureau of Population, Refugees and Migration (PRM) will negotiate with one of nine Placement Program Affiliate Sites to accept them into an American host city (Bureau of Population, Refugees and Migration, 2013). Once refugees arrive in their destination community, local agencies will arrange housing, health insurance, Refugee Cash Assistance (RCA), and Temporary Assistance for Needy Families (TANF) funds as authorized by the Social Security Act. In many cases, this connection to the general welfare system, a lack of knowledge about refugees, and a lack of communication between service providers and community stakeholders often foster resentment and misunderstanding of refugee communities, as cited by the Government Accountability Office (Brown, 2012). During these initial months caseworkers will also help to secure employment, arrange language and other classes if needed, and navigate other services such as public schools and public transportation. At the end of the RCA program (usually a year or less), refugees are generally expected to have either secured their own reliable source of income, or have joined the household of an 'anchor' who has agreed to support them. Some scholars have noted as early as 1983 that the trend of refugees being funneled into the unskilled labor force, regardless of individual skill levels or aptitudes, recapitulates negative public and self perceptions of refugees as well (Lanphier, 1983, or Nawyn, 2010).

The debates surrounding the 1980 legislation and the resulting resettlement practices speak to a long history of immigration policy that has sometimes tended toward xenophobia, and developing views of migrancy in a post-war context (see for example Barnett, 2006, or Kerwin, 2012). The United States sought to balance competing desires

to be exclusionary towards immigrants of any category versus the desire to fulfill a humanistic and altruistic mission that began with the PICMME program. The tension created by these competing desires likely acted upon the decentralized way refugee program funding was instituted, which has had reverberating effects upon the defining of the 'refugee' category.

Refugee resettlements following the Vietnam War in the late 1970s played a large part in informing the 1980 legislation and could be argued as the point in which the refugee category first took a major shift towards being defined through mental health status and acculturation. This resettlement was complicated by U.S. involvement in conflict with the country of origin, which unlike WWII, was a very unpopular and controversial war. As analyzed by Espiritu (2006), Vietnamese refugees were subjects of a pervasive "traumatized refugee" paradigm constructed politically and by the media. These refugees were characterized as helpless, uneducated and traumatized-- not as result of a legacy of violence, but as a result of their own identities and lack of acculturation-- and Americans as best suited to teach and rehabilitate them. Successful integration of Vietnamese refugees into U.S. society was the result specifically of "care" provided by the United States in addressing their "victimhood" (Espiritu, 2006). This viewpoint is infused with nationalism, history, and hegemony, and one that continues to evolve (Barnett, 2006). Whether the production of a "traumatized" refugee originates with the government, media, or the resettlement apparatus is unclear, but it does seem to contribute to the sorting of refugees and migrants and have implications for how refugees themselves acculturate within a host country.

Acculturation and Identity in Resettlement

Refugees of multiple ethnicities bound for resettlement from such disparate locations as Bhutan, Myanmar, Somalia, and Iraq, are consolidated and reconsolidated under the refugee label as they are displaced and resettled. Because of the layers of movement that accumulate as groups shift, disperse, and sometimes reunite, new layers of identity and mental and emotional experience are formed that are transitory, erasing, and multiplicative. Refugee identities simultaneously occupy various states of *non*-affiliation and *many*-identity that are shaped by acculturation experiences and practices of self-governance. That is to say, what would otherwise be a mundane experience of occupying one's identity variously according to the context (for example, one's "professional self" versus who they are with their family), is heightened through forced departure that might have been violent and/or unwilling, and forced entry into a new 'refugee' identity that may or may not be individually identified with. This could result in not just occupying identity in various ways, but experiencing erasure altogether of some aspects of yourself, while other aspects get exaggerated or mischaracterized.

Marta Zabaleta, a refugee from political persecution in Chile and Argentina was granted asylum in England in 1976 (European Institute for Gender Equality, 2013). In her 2003 piece "Exile," Zabaleta describes how she experienced a traumatic and pointed sensation of "erasure," both of her personal and professional identities that often made her feel outside of herself as well as "incompatibility between anticipated and actual identities." Zabaleta concurs that the category of 'refugee' is reductionist, explaining how her occupation of the 'refugee' category "made" her variously "illiterate, deaf and mute,

and poor-but-good mother" until she had "earned" a new success in the context of her resettlement destination. She further discusses how she experienced displacement in positive and negative ways. She describes forming and re-forming her identity as an ongoing process, as things like language skills altered her access to resources and the host culture she was acculturating to.

Acculturation as a process could be viewed as a form of self-governance. Berry (1974, 1997, 2005) has long proposed that everyone possesses "acculturation attitudes" which express the conscious choices people make in the incorporation and rejection of components of the cultures they live in contact with. Originally these "orientations" of acculturation were delineated with the understanding that each person's experience was the accumulation of intersections between discreet cultural categories. More recently, Berry and colleagues have suggested that a new, confounding "global/pan-human" culture is increasingly relevant as a third "culture" that individuals can occupy, adding a third dimension to this intersectionality that may be salient for resettled refugees. In this sense, besides just framing one's identity in terms of the mostly-discreet cultures we interact with, those who experience a great deal of displacement have more access to a non-discreet global 'culture' that is enabled by increasing technological advances in telecommunication.

Berry and colleagues also suggest that even the act of measuring attitude (ie. asking someone how they feel/what they think about their own acculturation status) can have an impact on personal wellbeing (Berry and Sabatier 2011). In other words, not only does the experience of negotiating multiple cultures influence the decisions you make about what to internalize, the *way* you are asked about those choices, *what* you are asked about those choices, and in what *context*, can also influence acculturation attitudes. Being consistently asked about negative psychological states using mental health screening tools, even in the context of programs that should have a positive effect (ie. language classes, employment coaching, or health modules, etc) for instance, might negatively color one's acculturation attitude within resettlement.

In the course of my empirical research, refugee respondents expressed a dislike of surveys that asked them how they felt at one instance in time. One refugee respondent noted that "human beings change every day, so I don't like being asked to think about this day only versus my cumulative experience of day to day life." In a focus group of refugees involved in an agricultural program, respondents concurred that in terms of mental health, they liked to think of their individual experiences in terms of improvement over time, for instance, "never being bored, feeling really socialized and busy," or feeling "more energized, more focus, [and] less tension." If researchers, clinicians, and non-clinical resettlement workers increasingly utilize surveys that only pertain to the acculturation process a "traumatized refugee" would have, especially in non-clinical settings, do refugees create and recreate multiple versions of self that begin to incorporate psychopathology? Are refugee perceptions, uses and experiences of Western biomedicine mediated by this multiplicity of roles that are simultaneously occupied? Is there a role to occupy in the eyes of Western resettlement that *isn't* tied to PTSD, anxiety, or depression?

Many workers on the ground in resettlement are very self-conscious of these questions as they face many challenges in providing high quality services to refugees that are accessible and understandable, especially early in resettlement. Refugees are an

extremely ethnically diverse group, and even refugees who may share a country of origin may not share ethnic backgrounds, religion, or even language. One can easily imagine the challenge of providing job training, health services, and mental health services to refugees from Myanmar-Burma[6] by themselves, let alone the other refugees in resettlement from South Asia, Africa, the Middle East, and so on. Particularly in smaller communities, multi-lingual resources that are specialized to their uses are at a premium, especially tools that have been statistically verified to be reliable.

For instance, refugees who make up the variously displaced ethnic groups from the politically tumultuous region of Myanmar-Burma represent one of the most diverse regions in the world, with eight distinct cultural groups and over 100 further divergent sub-groups. All of these different cultural groups are often characterized overall as lowland occupying majority groups such as the Burmans (at the expense of including myriad highland occupying sub-groups), but they have distinct linguistic and cultural practices, which is further complicated by the conversion of many previously animistic cultures to Western Christianity (Myint-U, 2008).

Also, in comparison to Bhutanese refugees who were for the most part wholly resettled out of camps in Nepal as part of one unified process, the Burmese resettlement and asylum history is varied and protracted, with Burmese families and clans dispersed across many countries, variously labeled as refugees, migrants, and illegal immigrants, and with a very high level of secondary migration. For example, every Bhutanese informant included in this research was resettled directly from a refugee camp in Nepal to the United States. Comparatively, informants from Myanmar-Burma were resettled into the United States from camps in Malaysia and Thailand, and experiences at each camp were very unique and specific to that location. Informants from Myanmar-Burma also resettled through individual asylum applications, and prior to their application submissions lived in places like Hong Kong, Japan, France, or Canada.

Even just the example of refugees from Myanmar-Burma alone demonstrates just how challenging the task of administering and assessing resettlement programming can be. Many programs cannot be evaluated against each other and often not even evaluated individually in an effective way, as program administrators who are already operating with limited funding do not have the time and resources to perform quality control measures. Moreover, there is great uncertainty even when quality control is addressed, what outcomes exactly should even be measured. This uncertainty, coupled with a public health focus on risk, and the pervasiveness of the "traumatized refugee" category sets the stage for the overuse of mental health screening tools across many disparate settings.

Screening for 'Health?' Refugee Mental Health Screening Tools

Of the many refugee mental health screening tools, the two most commonly used are the Harvard Trauma Questionnaire (HTQ) and the Refugee Health Screener 15 (RHS-15). Both surveys are well respected and heavily utilized screening tools that have been statistically verified and translated into multiple refugee languages. In the United States, governmental entities, health care providers, scholars and researchers, and non-

[6] I am choosing to utilize a hyphen here in acknowledgement that refugees from this region who were interviewed for this research variously identified from 'Burma' and/or 'Myanmar'.

governmental agencies all utilize these two tools to assess mental health in almost every kind of setting within resettlement.

Both tools are aimed at identifying emotional distress and psychopathology. The HTQ gauges PTSD and depression levels for individuals who have been severely traumatized by torture or other extreme experiences ("HPRT Questionnaire"), and the RHS-15 gauges anxiety, depression and PTSD not only in terms of trauma, but also personal and family history, reactivity and coping (Hollifield et al, 2013). The developer of the RHS-15, Pathways to Wellness, describes the survey's goal as being "an efficient and effective [tool] to sensitively detect the range of emotional distress common across refugee groups (Pathways to Wellness, 2011)." It also cites that "best evidence" report a "large minority" of refugees suffer deleterious mental health-related symptoms, and identifies a need for a streamlined survey to help funnel refugees into services early. Other common surveys in use include the Vietnamese Depression Scale (VDS), the New Mexico Refugee Symptom Checklist-121 (NMRSC-121) and the Hopkins Symptoms Checklist (HSCL-25), all of which variously screen for anxiety, depression, and/or PTSD.

It should be noted here that this writing does not contest the validity of these tools, or the potential usefulness of their application in some clinical and/or early resettlement settings. However, these tools may often be contextually dissonant in practice *and* in research, and diverge from identity and acculturation pathways for resettled refugees. These tools may not allow for occupation of various states of acculturation beyond that of the "traumatized refugee," nor do they allow for acculturation and mental and emotional experience as a dynamic process.

Ashkiro,[7] a Somali refugee in the United States, was interviewed for this research and asked to characterize her "mental and emotional life" in the context of giving feedback for a wellbeing survey for refugees. She replied that she felt it was a "positive thing in general, visualizing how you feel in life, because human beings change every day, so I don't like being asked to think about this day only versus my [cumulative] experience of day-to-day life." She went on to say that she thinks refugees

> "Often feel overwhelmed by the independent nature of U.S. society, and may start to think about yourself versus community instead of yourself inside community. It is important to think of yourself included in community part and parcel. Sometimes I think about some things more than other things (stiff or sore one day, sad or happy another day), [but] it's good to balance them all together. I really like visualizing my mind and brain and then scaling all together with my feelings."

As many program directors, mental health professionals, and refugees themselves rightly observe, none of the aforementioned tools quantify *improvement* in wellbeing, nor do they measure emotional experience in terms of one's location within their communities, as Ashkiro notes. These individuals identify wellbeing as a concept that holds centrality in their work and lives, though they may name it or quantify it differently between them. One refugee respondent from Bhutan noted, "my experience is not the

[7]Ashkiro is a pseudonymn, the identity of this informant is confidential.

ideal or the exemplary one [among all other people's experiences], and so how can my [experience] be meaningful [in a survey]?" Other refugee respondents, when discussing their impressions of refugee surveys either in their homes or at agricultural sites, often expressed a desire to describe and/or quantify "meaning of variety," or "how to express wanting to do many different kinds of things, and being able or not able to do them." Overall, this theme of "meaningfulness" and daily life reappeared often when respondents were asked about how they thought about their mental health or psychological state, and no study respondents expressed themselves using the constructs of depression, anxiety and PTSD utilized by all of the refugee mental health screening tools.

In an interview with a public health professional that works closely with refugees, the individual noted their displeasure with an ongoing focus on "bad mental health." They feared that their refugee clients and friends were internalizing their community's perceived mental illness, even abandoning ethnic expressions of psychosocial states for the term "mental health" itself. They went on to wonder aloud about the source of the term "mental health" for refugees, that in their experience was not initially part of a repertoire used to express emotional and mental states. They also expressed a frustration with the "trauma training" they had received through the Global Mental Health Trauma and Recovery Certificate Training Program (http://hprt-cambridge.org/), which they felt had too little emphasis on resilience and whole-person integration.

> "I was under the impression it was going to be an interdisciplinary training that took into account all of the factors that played into psychosocial wellbeing for refugees, like economics. But then when I got there it was mostly psychologists, and not one economist. Everyone there seemed to be of the same mind about how psychosocial wellbeing is so central to [our] work with refugees, so it was great for meeting other people, but not so much for learning good strategies to use [in working with refugees]."

Netis[8] is a psychiatrist that specializes in refugee youth and asylum cases at a busy trauma and torture survivor center in Ontario, and was prompted to talk about how she felt about the way that refugee mental health was characterized both in general and in her practice.

> "In 2007, I attended that Harvard program in Italy [the Global Mental Health Trauma and Recovery Certificate Training Program] and came back armed with the Harvard Questionnaires [HTQ]. I never actually used them though for multiple reasons; I thought they were pathologizing, that it was a clunky tool, and that it had no engagement with client experience. It just felt very distancing—tend to break connections instead of build them. I have found in my practice that PTSD is so culturally specific—some symptoms very universal but PTSD [is the] expectation of a trajectory. There are real symptoms from experiencing real horror—a biological cascade that is likely universal, but symptoms are experienced universally. Back then I had a gut feeling it wasn't the right thing to do."

[8] Netis is a pseudonymn, the identity of this informant is confidential

She went on to say that in reality her practice was almost entirely framed around notions of resilience, but that in order to support asylum applications and help refugees access resources, "they" [the clinicians in her practice] officially used the language of PTSD, anxiety, and depression as described in the Diagnostic Statistical Manual (DSM-V).

> "Catharis is a culturally specific way of dealing with suffering, and my colleagues agree. There is value in communicating similar symptoms, but are we really measuring the same things?... Trainees learn the psychiatric interview [and] are expected to memorize the DSM criteria, [but the interview] should be artful and seamless, a process of building rapport and alliance, ideal to make someone feel understood, not drilled with questions… I focus on strength, interpersonal support, social support, and resourcefulness. I ask clients what they think would be helpful, what they think they need."

She expressed a frustration with the "catch-22" of not wanting to engage in perpetuating "victimhood stereotypes" of refugees by using DSM language in official documents, but believed it was "that kind of language" that would help refugees access resources. When asked if she met any clients who "didn't have anything wrong with them," she replied

> "Clinically I do a lot of advocacy so I do use a floating checklist of the DSM in my mind to say whether a client meets criteria and if that would support [an asylum] application…Maybe some people have some symptoms, but they wouldn't be any where a psychiatrist if they weren't refugees. I have a client from the Rwandan genocide who is a Canadian citizen, and she described the time she spent caring for her siblings as a happy and hopeful time. I don't think everyone who is a refugee has problems. Definitely not."

Nikolas Rose has suggested that "biological citizenship can thus embody a demand for particular protections, for the enactment or cessation of particular policies or actions, or… access to special resources based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it (Rose, 2007)." In the pre-WWII history of immigration, your biological citizenship within a disease category (for instance, tuberculosis) would *exclude* you from citizenship (Dara et al, 2013). Comparatively, in the case of resettled refugees, biological citizenship within a psychological disease category (like PTSD or depression) can potentially help to *include* you in citizenship, sometimes in the most literal sense via the asylum process. The asylum application is built upon the premise that one must prove they are 'real' refugees among other categories, like migrants. By extension, if the Western medical and psychological practice has established mental illnesses like PTSD as 'real,' they can be utilized to prove the suffering of refugees is 'real,' whereas a normal reaction (or a resilient reaction) to what Netis termed "real horror" is not as easily verifiable within a judicial system or in public opinion.

Rose continues that "making up biological citizens also involves the creation of persons with a certain kind of relation to themselves" (Rose, 2007), and has also written extensively in regards to how the occupation of psychiatric diagnoses situates an

individual uniquely in terms of biological, societal, and epidemiological risk (for example Rose, 2005, 2001). What are the effects upon acculturation and identity if one way to access asylum is through a risk-oriented illness category? Would reframing refugee mental health in terms of positive emotional experience as opposed to psychological diagnoses undermine the already tenuous asylum process?

Global institutions like the United Nations created the category "refugee" in the first place to identify a particular set of circumstances and to direct access to resources for people experiencing those circumstances. Treating the group of 'refugees' uniformly in this way is also often seen as encouraging integration, particularly in resettlement, and in a practical sense, aids in providing assistance as quickly and effectively as possible. The institutions that govern allocation of resources are dependent on the construction of categories of recipients, as a way to be sure that the intended amounts flow to the intended populations. In this way, the 'refugee' category is protective and alienating; protective in that it is a privileged migration category entitling individuals to asylum and/or resettlement, and alienating in that it imposes a "traumatized refugee" identity. It is possible to preserve the integrity of the protective aspects of this category while subverting the "traumatized refugee?"

Reframing 'Refugee:' Resilience and Wellbeing

The conceptualization of health as more than the absence of illness was institutionalized by the Alma Ata Declaration in 1978 (World Health Organization, 2005), and a great deal of research has demonstrated a relationship between positive psychosocial states and high levels of social inclusion, financial independence, personal successes, and physical health (See for example Björklund, 1985; Kawachi et al, 2001; Prince et al, 2007). Notably, much of the debate centers on the method and unit of measurement for wellbeing, as demonstrated by an ongoing fascination with the topic of wellbeing in health, economics, and psychology since the beginning of the 20th century (Salvador-Carulla et al, 2014). Despite best efforts to uniformly define wellbeing, there remains uncertainty as to what wellbeing outcomes actually *are* and how they can be measured. What is more, some scholars argue that framing mental health around notions of resilience simply recapitulates the notion that individuals are solely responsible for their own emotional state, absolving institutions of any culpability for damaging structural inequalities (for example see Harper and Speed, 2012, or Fraser, 2000).

There are other problems with measuring psychological and emotional experience in refugee communities as well. Established survey methods are often inaccessible to populations with limited literacy and/or numeracy, which is exacerbated by shifting cultural contexts and multi-dimensional acculturation processes. Furthermore, wellbeing defined as an ongoing process cannot be fully characterized at a single point in time, but measured longitudinally. Nonetheless, clinicians and scholars alike are increasingly acknowledging that despite these uncertainties, wellbeing is a productive way to frame psychosocial states; since "well" and "sick" people alike all possess some kind of wellbeing, that wellbeing accounts for resilience and coping processes, and that it appears to not only be related to psychological recovery outcomes, but physical-neurological health as well (for example, Davidson, 2000; Fredrickson et al, 2003; Juster, 2011).

Refugee programming directors also often share these views regarding wellbeing

and resilience, and are interested in finding appropriate ways to evaluate program quality in terms of these concepts. Lauren Bailey is the director of an agricultural program that serves refugees in Middle Tennessee, who expressed a desire to find a new way to gauge the "emotional" benefits, or "mental impact" of her program to its participants. She had administered a "health inventory" in the first phase of the program but not a "mental health screener."

> "It seemed like it was taking time away from the program in an unproductive way, and many people could not write in order to respond anyway… I was really interested in the social benefits [of the program] over time, particularly isolation."

As a result of her interests in learning more about the psychosocial effects (if any) that were a result of her program in order to try and continually improve it, Lauren reached out for a research partnership. Following her involvement in the partnership, other program directors at her organization expressed to her that they were interested in similar themes as they pertained to their diverse cohorts, which were divided not by ethnicity, but by age (ie, a youth program, an employment program, or an elders program).

The experiential histories of refugees will continue to diversify, and so will the level at which different refugee populations are able to engage with American conventions of mental health. Depending on age, education, gender, and social background, individuals have wildly divergent command of their own written native language, the English language, American customs, and cultural conventions. Survey tools that have been validated for their translation does not mean the measure is validated in meaningfulness or significance to different cultural groups. Agreement on the dimensions to conceptualize wellbeing meaningfully across "experiential" (for instance, meaningfulness of daily activities), and "evaluative" measures (Haro et al, 2014) (for instance, gauging of intra-community support) has the potential to address the inconsistencies of wellbeing measurement associated with transcultural application.

An increasing amount of ethnographic literature focusing on refugee groups has demonstrated that refugee enclaves already manage emotional experience in collective, sophisticated ways that have little to do with Western therapeutic models of catharsis. Refugee enclaves often have innately high levels of intra-community social support, as well as semi-acculturated group coping mechanisms that integrate existing ethnic practices and beliefs with the new cultural and structural contexts of resettlement. Chase's ethnography with 600 Bhutanese refugees in Vermont is one such ethnography that is exemplary of a resettled community capitalizing on site-specific resources to support the emotional health of the group overall. This community endeavored to create unique "initiatives," such as knitting circles and agricultural programs, that provide psychosocial support in a way that resonates with their ethnic practices and beliefs surrounding mental and emotional experience, but also incorporate their host community's resources, interests, and culture (Chase, 2012).

Larry Laverentz was the director of the Refugee Agricultural Partnership Program at ORR from 2004 until 2014. He stated that "refugees that tend to go into the agricultural [program] are the least educated and the most illiterate, and a lot of older refugees are participating in the RAPP program, but we never tracked it, demographic-wise." He went on to explain that he felt the RAPP program was a strong alternative to

unskilled labor jobs that RAPP participants would have otherwise filled. "ORR is looking for how many people are farming, are they marketing, are they making supplemental income, what is the impact on the community, what are their selling venues." He said the "other values grantees anecdotally report, like physical and mental health and community attitudes towards refugees" were also always very important to him, but that he never saw a program that was able to reflect those values in a meaningful way.

Much like the assessment of psychopathological symptoms, wellbeing should be assessed in a way that is contextually appropriate. Checklists, especially in transcultural contexts, are not ideal tools for the simultaneous assessment of status and delivery of care in clinical settings, and are likely contextually inappropriate for non-clinical programming as well. At the same time, non-clinical programming directors are obligated to assess their programming for efficacy, and bemoan the lack of practical tools available to help demonstrate whether their work has positive effects. There is a need for tools that help to quantify *improvement* in wellbeing, and wellbeing as a *process* and not a state, but most importantly, are built through an *iterative process in which the community defines the parameters of wellbeing* they are most concerned about, not the program director, clinician, or researcher. A tool that reliably gauges wellbeing in this way would be invaluable to the agencies that serve refugees in evaluating the efficacy of their programming and policies. Importantly though, refraining from assuming a psychopathological state to begin with would undermine the "traumatized refugee" category.

In the course of this research, refugees repeatedly discussed issues surround the variety and meaningfulness of their daily activities, how important their friends and family were to them, and their physical health. It was also shown that the weighting of these themes were highly variable from person to person and group to group. In the course of a series of home visits with the control group for the quantitative study, Bhutanese respondents who were older adults actually expressed more interest in addressing their physical health issues than mental health issues, despite the fact that the topic of the interviews were described to participants as being about "wellbeing for refugees." Among five older adult Bhutanese men, four respondents noted physical health issues that were limiting their activity, including sharing extensive details of their prescriptions and treatment histories. All respondents noted they felt well supported by family and friends in their lives, but did not feel they had access to the medical care that they needed, or guidance on how to find that access for themselves.

Another control group respondent was a Burmese mother caring for her daughter, who had a high level of developmental and physical challenges. This respondent expressed that the daily accumulation of stress from being a caregiver for her daughter was weighing on her emotional and mental states:

> "I am so very interested in participating [in the research] because I want to talk to someone about mental health and my community since I am often feeling many things about my family and my daughter, but also other health problems that I have."

Though she noted that she felt well supported and accepted by her entire community, she was trying to find "someone to talk to about the different pressures that were

accumulating." She said even though her community was kind and she knew they cared about her family, she felt like she wanted to have a chance to talk to other families who knew what their experience was like.

Meanwhile, among most of the respondents who were interviewed through the agricultural program, the theme of meaningfulness and variety of activity seemed to resonate the most. These individuals were mostly concerned about being sure they were not "sitting on the sofa more," "taking time to be with friends," and having alternative ways to contribute to their families that were not their primary employment. They were looking for involvement in activities they could learn new things about, whether they were older refugees who had extensive personal histories with agriculture, or younger refugees who had never encountered agriculture before.

Overall, my empirical evidence underscores a dissonance between the beliefs and practices held by refugees and resettlement professionals and the tools they use. On the one hand, there is near consensus surrounding themes of wellbeing and resilience, while on the other the refugee mental health screening tools only measure depression, anxiety and PTSD. Wellbeing and resilience are justifiable metrics that can be used and measured with appropriate contingencies, potentially unseating the HTQ and RHS-15 from non-clinical and tangential research contexts. Framing refugee mental health in terms of resilience does not seek to absolve institutional responsibility for structural inequalities or devalue the 'refugee' category in terms of asylum and/or resettlement. Resilience and wellbeing do however, have the potential to undermine perpetuation of the "traumatized refugee" category.

Conclusion

Refugee resettlement since WWII has been marked by the categorization of 'refugees' among other transitory groups in order to protect people from harm. As time has progressed and resettlement becomes more decentralized, the 'refugee' category has been increasingly homogenized into a "traumatized refugee" category, most recently through the over-application of statistical instruments like the HTQ and the RHS-15. Both clinical encounters and refugee programming are aimed at producing positive outcomes in health, social, and economic dimensions by capitalizing on resilience in practice. Yet the tools the clinical and non-clinical resettlement apparatus uses to assess their (quite often good) work only measures negative outcomes like depression, anxiety, and PTSD. Continuing to over-apply these tools in practice and research likely will continue to recapitulate the homogenization of the "traumatized refugee" category, having deleterious effects for refugee acculturation processes and health, social, and economic outcomes. A paradigm shift would involve the discontinuation of using statistical instruments like the HTQ or the RHS-15 in inappropriate contexts, and the development of a new set of 'tools' that are indicative of a wellbeing process. It would also help clinicians more closely align their involvement in asylum applications with their actual practices, which are built upon notions of resilience and resourcefulness. Importantly, it would undermine the proliferation of the "traumatized refugee" category.

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