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# Refugee Mental Health and Healing: Understanding the Impact of Policies of Rapid Economic Self-sufficiency and the Importance of Meaningful Work

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**Abstract**
Although refugees who are accepted for resettlement in a third country are guaranteed certain rights and experience safety from war and persecution, they face many mental health challenges. Using qualitative methods and constructivist grounded theory, we explored culturally specific perspectives on trauma and recovery among Burundian, Congolese, and Iraqi refugees resettled in the USA. Eighteen semi-structured interviews provided extensive data on the meaning of productivity and work, the ways in which they index normalcy and self-sufficiency, and how they create security that facilitates the healing process. Our inductive analyses revealed that participants emphasized the relationship between productivity and healing when they described recovery from trauma. Participants also discussed individual and structural facilitators and barriers to work. Finally, prominent themes emerged around gendered roles and expectations and the ways these function in refugee resettlement contexts that are shaped by policies that demand rapid economic self-sufficiency. Taken together, these findings suggest that policies that promote underemployment and foreclose opportunities for education and professional development may contribute negatively to refugee mental health, as well as keep refugees in poverty.

**Keywords** Healing · Health · Policy · Recovery · Refugees · Work

## Introduction

Refugees are a category of displaced people who are recognized in international law as "having a well-founded fear of persecution" that prevents them from returning to their country of origin (U.N. General Assembly 1951). In 2015, the United High

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Commissioner for Refugees determined that there were over 21.3 million refugees among the total displaced population of 65.3 million, the world's highest number of displaced people ever recorded (UNHCR 2016). The lived experience behind the phrase "well-founded fear" reflects the extreme situations that led to their flight. These include threats to life or bodily integrity, torture, loss of family, loss of employment, the dissolution of trust and social norms, discrimination, threats, and separation from family, friends, and all that is familiar. Although the concept of a refugee pre-dates recorded history, it was codified in international law in the wake of World War II, and has been a feature of scholarly research and national and international humanitarian intervention from the mid-twentieth century to the present.

In groundbreaking work that examined the scholarly treatment of refugees as "people out of place," Malkki (1992) revealed how, in a world of nation-states, refugees are treated as a problem. Biomedical approaches to refugees have focused primarily on trauma exposure and post-traumatic stress disorder (PTSD) (Summerfield 1999). Fassin and Rechtman (2009) wrote about the social history of PTSD, and trace its development to World War I and the recognition of the effects of combat on soldiers and veterans. They traced the late twentieth century expansion of PTSD to those who have experienced humanitarian disasters, and the increasing numbers of civilians affected by war.

As the concept of PTSD predominated in the Western biomedical literature, some questioned its relevance in non-Western contexts (e.g., Summerfield 1999). Marsella (2010) has argued that the biopsychosocial response to stressors appears to be universal, yet their meanings, appropriate treatment, and recovery are culturally specific. Droždek, Wilson, and Turkovic (2012) recommended that culturally informed understandings of trauma be developed using qualitative and ethnographic methods, and culturally specific measures of symptoms related to trauma exposure have been developed by several researchers (Miller et al. 2006; Terheggen et al. 2001; for a review see Wilson and Tang 2007).

Healing and recovery also have culturally specific meanings and dimensions, which are important to understand, especially when endeavoring to create interventions or policies that aim to improve health and quality of life. According to Kirmayer (2004), "Notions of healing are central to any system of medicine" (p. 33). Anthropologists and others have documented the wide array of healing practices and treatments around the world. Further, Kirmayer acknowledges that the concept of healing is grounded in metaphor and symbol, and he includes in his system the family, community, and society, which also are encoded and encode processes of healing and recovery.

Many scholars have noted that healing is processual (e.g., Herman 1992). Herman's three stages of recovery include safety, reconstruction, and reconnection. Gorman (2001) applied these to refugees, specifically in the context of torture. Mollica (2006) wrote about humiliation and degradation as part of the trauma experience, and discussed many aspects of healing, including the decision of survivors to live in a new world, the ability of people to self-heal, and social instruments of healing. Kleinman, Das, and Lock (1997) wrote that attention must be paid to collective, social aspects of recovery and healing.

Research specific to refugees has also found that their health and well-being is promoted when they engage in meaningful activities and roles, including work (Goodkind 2005, 2006; Goodkind et al. 2014; Miller 1999; Silove 1999). Meaningful

employment may be very empowering and beneficial to refugees through aiding in the process of adjustment, providing sufficient income to support their families, helping develop roots in their new country, developing language skills, and creating opportunities for social support (Yakushko et al. 2008).

Given the recent increase in refugees worldwide, there is an urgent need to develop viable mechanisms for ensuring refugees' well-being and to encourage countries to accept more refugees for resettlement. Thus, it is particularly important to understand and demonstrate how refugees can be meaningfully integrated into resettlement countries, how they can contribute economically to their host countries, and how their health and mental health problems can be reduced. Unfortunately, there are gaps in the literature and in our understanding of how best to address these issues and promote healing and recovery among refugees; this article focuses on several of these important areas.

Using a qualitative approach, we asked recently arrived refugees who identified as Burundian, Congolese, or Iraqi to explore stress, distress, healing, and recovery from their perspectives. In this article, we report the findings of this preliminary research, in particular the data related to healing and recovery, which suggested that refugees see processes of recovery as embedded in sociocultural constructs that are rapidly changing and influenced by structural opportunities and constraints associated with resettlement in a new country. Refugees in this study identified productivity as key to the process of healing and recovery. Productivity is not only a marker of recovery; it is essential to the process of recovery. Preconditions for work (English, skills) are an integrated part of productivity and cannot be separated from it. Productivity itself includes work, but also other aspects of not isolating oneself (going out of the house, interacting, caring for others). It is important for policies and programs to recognize this and support ways in which refugees can engage in productivity in order to facilitate individual and collective healing. Our research fills numerous gaps: (1) it provides an emic perspective on what recovery looks like from a refugee perspective; (2) it enriches and extends previous research on the importance of work by examining emic understandings of productivity from both an individual and collective point of view that includes family, ethnic and religious affiliations, and the multiple communities and experiences that refugee perspectives reflect; and (3) it examines how facilitators and barriers to productivity relate to current resettlement policy in the USA, which is organized around policies promoting rapid economic self-sufficiency.

## Methods

### Developing Culturally Specific Measures of Distress

As part of a larger study to test the effectiveness of a community-based advocacy and learning intervention to reduce mental health disparities among refugee adults in Albuquerque, New Mexico, we conducted qualitative interviews with 18 refugee adults from Burundi, Democratic Republic of Congo, and Iraq to develop culturally specific measures of psychological distress. The final author (principal investigator) conceived of the study and its design (Goodkind et al. 2017). The first author, in consultation with the research team, developed the interview questions. The first, third, fourth, fifth, and sixth

authors conducted the interviews and analyzed the data. For the measurement development, we applied a model developed by Miller et al. (2006) to elicit idioms of culturally specific stress and distress in Afghanistan to the two populations we anticipated including in our study: Africans from the Great Lakes region (in this instance, Burundi and the Democratic Republic of Congo, but hereafter referred to as Great Lakes Africans) and Iraqis.

We developed a series of 20 open-ended questions based on Miller's model. We asked participants to think of two people from their country of origin whom they were close to who had experienced difficult things in the past, one of whom had seemingly recovered and one of whom appeared to have not, and then to answer 10 similar questions about each person. We began by asking participants to describe their relationship with each person and continued by asking: what happened to each person, and how he or she was affected by these experiences. Participants described similar traumas for both those who had recovered and those who were still having difficulties. For Africans, these included being impacted by war (including avoiding recruitment by militias, being forced to recruit for militias, fleeing home, destruction of home by fire), the poverty of refugee camps, fear for girl children threatened with rape while carrying out basic tasks including getting water in refugee camps, being attacked in refugee camps, the death of family members, and losing their social safety net. Iraqis similarly described war, associated sectarian conflict, kidnapping or threats of kidnapping, imprisonment, torture, and loss of family and home.

We then asked about the current challenges/stressors and everyday functioning of the person they were describing, the difficulties that keep him or her from doing well or better on a day-to-day basis, how the interviewee knew if he or she is doing well or not well, what things help this person, and what makes the symptoms worse. For the person who had experienced significant recovery or healing, the final three questions were modified: How do you think this person got better? How does this person address/face/cope with challenges he or she faces? Is there anything else we should know about this person?

Our aim was to elicit culturally specific idioms of distress and healing and some culturally specific themes emerge. For example, comparing predominant themes in the Congolese and Burundian sample with those in the Iraqi data, we found that for the Great Lakes Africans, religion and spirituality were very important (see Table 2). Additionally, talking and sharing about one's problems was a predominant theme among the Africans but was not discussed at all by Iraqis. Further, for Iraqis, the motivation to get better and move on was prominently discussed while not discussed by any African respondents. However, the importance of agency, or the "ability to act" was discussed by African participants, which may reflect a particular sense of disempowerment that is associated with refugee camps (versus urban refugee environments, which were more typical of the Iraqi experience). These culturally specific concepts and behaviors did recur in the data when participants from these groups described healing processes.

While our original goal was to explore culturally specific aspects of healing and recovery, what was striking in our data was the overlap and similarity across national origin groups on emic experiences and important elements in the process of healing. Thus, in this article, we present results with the goal of contributing to the literature about healing from refugees' perspectives, not necessarily as prescriptive for Iraqis and

Great Lakes Africans, but as experiences that may give us insight in how to better support resettled refugees of many different non-Western groups. Thus, the goal of this article is to present how people who are refugees from Iraq and the Great Lakes region of Africa report on the process of healing and recovery and how structures and policies around work affect these processes.

## Data Collection

Participants were recruited by research team members who were also refugees from the same national origin group as the participants. We interviewed 10 Iraqis (5 men, 5 women) and 8 people from the Great Lakes region of Africa (3 men, 5 women; see Table 1). The study team recognized the linguistic, religious, cultural, and socioeconomic diversity that exists in the Great Lakes region. However, given input from research team members from the Great Lakes region, and given that all of our participants were Kirundi/Kinyarwanda speakers, we decided that grouping together participants into one Great Lakes category for the purpose of analysis was warranted. Thus, we decided to present the results together, noting differences at national and regional levels when appropriate. The average time participants had spent in the USA was 5.06 years with the range being 1 to 7 years. The first author conducted interviews with female participants and the sixth author conducted

**Table 1** Participant demographics

| Nationality | Age range[1] | Gender | Gender of example 1 (person not recovered) | Gender of example 2 (person who has recovered) |
|---|---|---|---|---|
| Burundian | 20–29 | F | F | F |
| Burundian | 30–39 | F | M | M |
| Burundian | 30–39 | M | M | M |
| Burundian | 40–49 | M | M | M |
| Burundian | 40–49 | M | M | M |
| Congolese | 30–39 | F | M | M |
| Congolese | 40–49 | F | F (child) | F |
| Congolese | 60+ | F | M | F |
| Iraqi | 20–29 | F | M | M |
| Iraqi | 30–39 | F | M | M |
| Iraqi | 30–39 | M | M | F |
| Iraqi | 40–49 | F | F | M |
| Iraqi | 40–49 | F | F | M |
| Iraqi | 40–49 | M | F | M |
| Iraqi | 40–49 | M | F | F |
| Iraqi | 40–49 | M | M | M |
| Iraqi | 50–59 | M | F (child) | M |
| Iraqi | 60+ | F | M | M |

[1] Exact age of each participant is not provided in order to avoid including identifying information. Mean age = 42.56 years (SD = 10.73)

interviews with male participants. All participants provided written informed consent and all interviews were conducted jointly with bilingual, bicultural interpreters fluent in Arabic or Kinyarwanda and Kirundi (third, fourth, and fifth authors). Interpreters identified culturally specific terms and expressions during the interview, drawing attention to them during the interview when translating to English, re-stating them in the participant's language and then discussing nuances of the concept in English. Interviews were audio recorded with the permission of the participants. The study was approved by the university institutional review board. Participants were provided with $20 gift cards to compensate them for their time.

## Data Analysis

The English-speaking portions of the interviews were transcribed by a professional transcription service. The first author cleaned, anonymized, and imported the transcripts into NVivo 10, a qualitative data analysis software package. For our analysis, we used a constructivist grounded theory approach, which builds on classic grounded theory, but incorporates the recognition that analysis is an interpretive process and uses both researcher and participant perspectives to co-construct theory (Charmaz 2014). Data analysis was conducted in three stages. First, the structured nature of the interview guide allowed us to easily compare participant responses to each of the ten questions. Second, we conducted thematic coding in two main thematic clusters: experiences/symptoms of trauma and healing/recovery. These were done separately for the African and Iraqi participants. At the end of this process, the first author met with the third author to discuss the Iraqi symptoms, explicate meanings of these concepts in English, and cluster or group them in ethno-semantic groupings that reflected Arabic-language and Iraqi understandings and meanings of the term. The same process was conducted for the Great Lakes African data with the fourth and fifth authors.

Coding was inductive: if people described a process or theme related to healing and recovery, we created a node to capture that idea. We did not start with any predetermined categories. Themes were analyzed by team members who spoke the native language the interview was conducted in and by the first author, and semantic categories were clustered or differentiated based on semantic meanings for participants (as understood by our team members). All text was coded with as many themes as were applicable.

For the third phase of analysis, a member of the analysis team conducted focused coding (Charmaz 2014) on all text coded at each of the predominant themes (see Table 2). Looking across the data, he or she categorized the text according to the focused coding that he or she saw in the data and wrote a summary memo comparing data across the participants, looking for patterns and anomalies. A second team member looked at the data separately, using focused coding techniques, and then wrote an addendum to the original memo if he/she found additional categories, or had different interpretations of the data. Finally, for the themes that were predominant for both Great Lakes Africans and Iraqis, a team member wrote a memo comparing the similarities and differences in the theme across the two groups.

**Table 2** Predominant recovery themes from interviews with Great Lakes African and Iraqi participants

| Great Lakes African recovery themes | No. of interviews with theme (*n*) | Total no. of references across interviews (*n*) | Iraqi recovery themes | No. of interviews with theme (*n*) | Total no. of references across interviews (*n*) |
|---|---|---|---|---|---|
| Work | 7 | 28 | Work | 9 | 42 |
| Memories | 6 | 15 | Access to resources, benefits | 9 | 14 |
| Family support | 6 | 19 | Language | 6 | 22 |
| Religion, spirituality, prayer | 6 | 14 | Motivation to get better, to move on | 6 | 11 |
| Barriers to recovery | 5 | 13 | Responsibility to support family | 5 | 24 |
| Socializing, social life | 5 | 13 | Family support | 5 | 17 |
| Talking about self, own problems | 5 | 9 | Caregiving, helping others | 5 | 17 |
| Education, schooling | 5 | 9 | Social life | 5 | 10 |
| Access to resources | 5 | 8 | Social support, belonging | 5 | 10 |
| Treatment physical or psychological | 4 | 9 | Treatment, physical or psychological | 5 | 9 |
| Responsibility to support family | 4 | 6 | Finances | 4 | 11 |
| Future orientation | 4 | 5 | Physical health | 4 | 8 |
| Children | 4 | 4 | Independence | 4 | 7 |
| Learning English | 3 | 5 | Happy | 4 | 6 |
| Independence | 3 | 5 | Gender expectations, roles | 3 | 6 |
| Change | 3 | 4 | Cultural differences | 3 | 4 |
| Ability to act | 3 | 4 | Future orientation | 3 | 4 |
| Eating, food | 3 | 3 | Memories | 3 | 4 |
| Help-seeking | 3 | 3 | | | |
| Finances | 3 | 3 | | | |

## Results

Our findings fall into three general categories. First, we explore the meaning of work, or more broadly, productivity, for refugees who participated in our study. Notably, productivity as a theme is interrelated with many other aspects of recovery, including access to resources, family support, language acquisition, and socializing with others. The results below, although oriented towards work, show how many of the other aspects of recovery are inseparable from productivity. Second, we explore barriers and facilitators for work that consist of an interrelated set of factors: (1) knowledge and

skills (e.g., English language fluency and transferable professional skills); (2) health and well-being; and (3) gender roles and expectations around work, education, caregiving, and productivity. Third, we present data on the meanings of not working. Finally, we note that the economic and policy context, although it did not feature prominently in the discussions of our participants, functions as the underlying framework that shapes experiences and perspectives on work.

### The Meanings of Productivity for Great Lakes African and Iraqi Study Participants

Both Great Lakes Africans and Iraqis mentioned work more than any other theme in relation to recovery (see Table 2). Work is often considered to be participation in the labor force; however, in light of how our study participants discussed the concept, we apply a more expansive version of productivity, including accessing resources, language acquisition, caregiving, and education, which encompass cultural and gendered expectations around work and productivity. Taken together, these themes were prominent across both groups and make up a large proportion of the predominant themes in our analysis.

For Great Lakes African participants, work was a stand-in for productivity, normalcy, and well-being.

> Interviewer: What are the things that do stress him out or do challenge him?
>
> Participant: I don't think he's stressed at all. Every time I talk to him, he tells me that he works. His wife works. They both work. They pay all their bills. They are safe. They don't have any problem.

Notably, this participant mentioned safety, which has long been recognized as a primary condition that promotes healing from trauma to occur (Herman 1992). In post-resettlement contexts, safety is often conceptualized as the absence of war and everyday threats of violence. Participants in our study discussed safety this way, but also described safety as a sense of security around meeting basic needs. A closely related idea was the alleviation of extreme poverty post-US resettlement. Participants often referred to access to the most basic resources—food, shelter, and clothing—as being more easily met in the USA, and thus as a step in recovery and healing. This is not to minimize the problem of poverty for refugees in the USA (see Dawood 2011), but for Great Lakes Africans especially, comparing present circumstances to their previous life revealed a marked distinction. For example, an interviewee related how his friend was affected by the stress of poverty in DRC:

> All the time living in poverty just lack of resources, that was making him think a lot and . . . lack of sleep. Since they came here, right now they're living much better. He's working. They living better. His wife living, too. That means they're joining their friends, their income so they can support each other. Now they're living much better.

Participants discussed work as it relates to being able to take care of one's basic needs. Thus, self-sufficiency was understood as part of health and well-being. One participant explained, "I think it's the fact that she's working and she gets her paycheck. She

knows, 'I can buy this, and this for myself. I don't have to ask for anything.' I think that's what makes her going day-by-day."

Work, or being productive, also served an important function of providing relief from always thinking about traumatic memories and even a way of actively avoiding them. For one participant, working helped the woman she is speaking of "fight" against losing her mind. Work also served the function of getting people out of the house and in contact with other people. "She is working and she is—well, she can't forget her family that she lost. Of course, nobody can ever forget [traumatic events in the past], but because she's busy working doing this and that, she moved on."

Similarly, Iraqis discussed work as an essential part of their lives. For Iraqis, work helped people to manage stress and the demands of everyday life. Work provided more safety and stability for the family and improved emotional health. Similar to the Great Lakes Africans in our sample, and as the literature has repeatedly shown for all people, safety is often mentioned as paramount:

> Things start to change when he find out that there's financial assistance here. There's food stamp[s], other government assistance, good schools. He start to feel safe. He start to feel that he's secure. Now, he is working in Wal-Mart. He does not even think to leave the country.

Thus, beyond being in a safe environment, access to resources is an important aspect of security that seemed to facilitate employment. Further, increased safety and security precludes thoughts of secondary migration or of return to previous countries of refuge or home countries, and is also indicative of the stabilizing effects of work.

Moreover, participant responses were striking in how clearly they linked work to recovery, particularly when they felt employers valued their work. For example, discussing someone they had classified as recovered, one Iraqi participant answered the question, "What are the factors that help him do well on a day-to-day basis?"

> Since he is a pharmacist already, and he has a degree at being a pharmacist, but he's working as a pharmacy assistant [working towards recertification to work as a pharmacist in the United States]. Everyone else working with him, they are only pharmacy assistant, so he have more knowledge than them. When he works he knows more. His supervisor, she is very happy about him. She always appreciate that he knows more. She always evaluated that as a good thing. That makes him really feel proud, and makes him feel happy.

Iraqi respondents described a productive dynamic between work, well-being, and a positive sense of self: "The fact that he learned the language, and found a job, that made him feel better about who he is." The theme repeats in the following exchange:

> Interviewer: What do you think are the factors that helped him to—or that help him on a day-to-day basis to be well?

> Participant: Then, how he's already overcome all those issue. He's very active. He's very socialized. Because again this job, he's given a lot of experience and skills to help him in the future. . . . Like when they get invitation like for wedding

> or for anything, he's joining. That's because . . . he's now the man or the [head of] household for this house. Then, he's doing very well in his community.

Thus, work was a sign of normalcy: understood to be an essential act that signals productivity, role fulfillment in the household, socialization, and facilitates participation in community. In addition, participants described work as fundamental to well-being and dignity of the person. Beyond individual well-being, Great Lakes Africans and Iraqis saw work as part of the wider socio-ecological context in that family, community, and society contributed to their ability or inability to work.

### Not Working and Its Meanings

Work was also discussed in relation to those who have not recovered. First, not working was seen as a sign of not doing well, and stopping work was seen as a sign of decline. For those who were not able to work because of poor health, friends and family members mentioned the ways in which work might help: by decreasing social isolation, getting out of the house, and relieving a person of just "thinking and thinking" which makes a person "worse." Iraqi interviewees described those who were unable to work as more stressed and as not feeling useful, but being freer than those in the work force to help raise children.

### Facilitators and Barriers for Refugee Work and Productivity

Our analysis of study data revealed three interrelated factors that facilitate and/or constrain refugee ability to engage in work or other productive activities: (1) knowledge and skills, primarily English language fluency and transferable professional skills; (2) health and well-being; and (3) gender roles and expectations around work, education, caregiving, and productivity.

Participants cited individual knowledge that facilitated working: English skills and education or work skills acquired pre-resettlement. For example, an Iraqi participant spoke of how language facilitates getting a job:

> That person, when they first moved here, they didn't know English at all, not even the alphabet, and they didn't know anything, language or culture life. After a while, he started learning the language, and he got a really nice job and he got promoted. He's like a part of the management of that place that he works at, a restaurant, so he's doing really, really well. He's very successful.

Another Iraqi described poor English as a disability:

> He's tired because he feels crippled. Since he's unable to speak the language—the English language here, he cannot depend on himself. He cannot do his work. He cannot go to work. He cannot communicate. He cannot read a letter and respond to it. He cannot pick up a phone and make an appointment. You live here and you need the language. He depends on his daughter with everything. Sometimes she feels that he get embarrassed so much when he asks his daughter to do things for him. He feels really disabled concerning language barrier.

Other barriers participants mentioned included lack of legal status, and poor health, which manifested as sleep problems, physical injuries, anxiety, fear of new situations, and PTSD symptoms. Participants also spoke of attitudinal factors like the motivation to get better and move on. For example, Iraqis spoke of the importance of motivation and helping oneself get over past events and face the hard times post-resettlement. Great Lakes Africans did not explicitly talk about motivation to get better, but they emphasized thinking about the future: "We most of the time look forwards. Not good to look on past. Should look on future."

Moreover, a basic level of physical and mental health is required for working. Both Great Lakes African and Iraqi participants discussed people with severe mental and physical health conditions that curtailed participant expectations of the possibility of work and productivity. For example, one Iraqi participant described someone with short-term memory problems due to traumatic brain injury who as a result was not able to learn English. A Burundian participant described a woman whose mental health condition may have predated her flight from her home, but was certainly exacerbated by the trauma she experienced. In the USA, she was living in a group home facility. However, for the vast majority of people, even those who suffered a great deal prior to resettlement, the notion that work and productivity promotes healing was a prominent and repeated theme.

In addition, participants articulated the role of gendered expectations as facilitators or barriers to work. Because cultural values and expectations are often understood to be common sense, they are often unvoiced; however, participants readily identified gendered expectations and roles as conducive to or a barrier to work. For men, the responsibility and pressure of providing for one's family can drive them to work. For many women, responsibilities for caregiving of children, parents, or those with disabilities are often prioritized over formal employment. However, living in the USA, different social expectations, and economic pressures may serve as an impetus for women to enter the workforce. Thus, policy and economic necessity can trump cultural expectations in relation to work and also provide individual women and men with a way around or out of roles and expectations shaped by their experiences in their home country.

For men, the ability to work and provide for one's family is key to fulfilling gender roles around family support, thus serving as a facilitator for working in a job that may have negative health effects.

> Interviewer: Okay. Is he happy with his work?
>
> Participant: . . . [H]e's kind of comfortable, but it's still hard on him. It's tiring work, especially after what he faced from torturing him, from hanging him. He was not that healthy anymore. Even when he has pain, he has to work and he will do his best because he feels that this is the support. This is the secure thing for his family, who he really loves a lot. He cannot sacrifice his job because he wants to afford them everything they need. She used another term we use in Iraq, she said, "as if he is carrying a lot on his back." He will not say anything because that's the way . . . he [creates security for] his family.

Thus, for many men, there is pressure to work even if the job may be detrimental to their health. Yet providing for one's family reinforces expectations around men's gender roles related to dignity and self-worth.

Caregiving in the home is often considered to be primarily women's responsibility. Although there are differences across class and educational levels, many participants described women prioritizing caring for young children over formal employment. For example, one Iraqi participant described one woman's current situation: "Life in America is very hard. Since her husband is working, she has to stay home. If she was able to work and succeed and be able to provide things for her family, she might be gone more, but she didn't succeed to be able to go out the home and work." On the other hand, for many women, developing or furthering a career in the USA was a welcome opportunity that was forestalled in their home countries or countries of refuge by societal norms and war and occupation. In addition, work is often seen as a financial necessity given economic considerations in the USA. However, even given the economic and social climate that promotes the participation of women's labor in the workforce, the pressures of raising children and working were challenging to participants in light of gendered expectations around caregiving. Participants viewed combining work and caregiving in the USA as stressful. These activities contribute to refugees' stress and ability to cope with the pressures of everyday life, as illustrated by one participant:

> Interviewer: Can you tell me about this person's current situation? What are her current stressors or challenges?
>
> Participant: She say that life in America is not easy; it's very hard. One of the challenges that she face[s], besides that, she has her kids. She has a lot of responsibilities and she has her school to go and her work, now. Being able to control all of these things is really a big challenge to her.

Thus, while English language skills and a basic level of health and well-being are important as baseline factors in readying people for work or productivity, gendered expectations, such as having a family to support, serve as motivation for not only for men but also for women, who may want to develop professional opportunities and/or contribute economically to the household. Still, gendered expectations for women around caregiving may serve as barriers to formal employment.

Great Lakes Africans mentioned three barriers to working: not knowing English, the fear that religious beliefs would be infringed upon by work demands (e.g., for a Christian working on Sunday), and not being able to work because of illness, either physical or mental. Participants also described the effect on people's quality of life and health (both mental and physical) of doing jobs that they were not happy with. For example, one Burundian man described work and how it was affecting his life:

> As I told you, the most thing is the language barrier. He's working now [as] a chicken butcher. He still say that "I have to do this. It's too cold. If I know English I could get a job which is better than this one. Seem that I have to do this job, even though it's affecting my life. I don't have another choice."

Thus, for all of our participants, barriers and facilitators to work involved multiple, interrelated domains that include individual considerations such as knowledge and skills; health; sociocultural factors including continually shifting values around gender

roles and expectations; and structural conditions created by the broader economic context and policies that influence refugees' requirements and supports for work.

## Discussion

Using qualitative methods that privileged participant perspectives on recovery, this study highlighted Great Lakes African and Iraqi refugee perceptions of productivity as essential to recovery from past trauma. Although the intent of the research was to gather data on culturally specific responses to distress and healing, we were struck by the predominance of the necessity of productivity for healing for all participants and the many similarities across the groups with respect to barriers and facilitators for productivity. Thus, we suggest that this research offers potentially important insights into healing and recovery for recently resettled refugees from diverse national origin groups and sociocultural backgrounds. Participants indicated that a full life included work or other forms of productivity such as pursuing educational goals or caregiving which entailed being out in the world, being engaged with others, and contributing to self-efficacy and familial and societal well-being, all of which are reflected in the predominant themes recorded for each group. Moreover, productivity was not only an outcome of recovery from trauma, it was essential to the process of healing.

Much of the social science and health literature on refugees that focuses on refugees as people out of place and frames mental health almost exclusively in relation to trauma and PTSD is being challenged. Further, recent theoretical framing often follows Agamben's notion of refugees being relegated to "bare life," or "humans and animals in nature without political freedom" (Agamben 1998). Although Agamben is referring to refugees in camps, as Owens (2009) argues, Agamben has become a primary "legitimator" for those in refugee studies (p. 567), and we agree that Agamben's work joined with others "[does] not provide sufficient analytical and normative understanding of the real and symbolic violence administered to refugees, including liberal democracies" (p. 568), and that this view forecloses opportunities to see refugees as people with agency, resiliency, and with the capacity to heal. By focusing on emic perspectives of healing, our goal is to underscore what refugees see as critical to their healing processes.

Refugee perspectives on work and healing, although discussed by participants largely in terms that can be understood as individual and sociocultural, are situated in larger social forces—global, national, and local—that constrain and enable choices. Most notable in the US resettlement context are policies that require rapid economic self-sufficiency. Racism and discrimination are also salient at the structural level, which has been discussed relative to this study elsewhere (Hess et al. 2014). US policy towards recently resettled refugees has changed dramatically over the decades. The Refugee Act of 1980 originally contained an exemption that enabled refugees to refrain from working the first 60 days after arrival. The exemption was removed in 1982. The program's focus quickly became early employment and self-sufficiency, and other priorities, including learning English and employment training programs, were de-emphasized (Brown and Scribner 2014). The 1980 Act also provided 36 months of financial and medical assistance. Haines (2010) chronicled how this assistance came to be seen as fostering dependence and assistance was reduced to 8 months. Between

1985 and 1989, assistance provided by the Department of Health and Human Services to refugees declined 48% (Brown and Scribner 2014). A 2010 US Committee on Foreign Relations stated, "Resettlement efforts in many U.S. cities are underfunded, overstretched, and failing to meet the basic needs of the refugee populations" (U.S. Senate Committee on Foreign Relations 2010). ORR's performance measures encourage service providers to focus on short-term outcomes and do not currently measure refugee integration (U.S. Government Accountability Office 2012). Without sufficient monitoring and evaluation systems for US resettlement programs, policy makers are unlikely to understand the implications of existing policies or promising practices that are not yet evidence-based.

In a refugee resettlement context, several challenges regarding obtaining employment arise. First, as a group, refugees have experienced high levels of violence exposure and trauma that impact mental and physical well-being. Participants gave numerous examples of people whose precarious mental and physical health status made it very difficult, if not impossible, for them to work, citing the effects of PTSD, depression, and traumatic brain injury. Refugees who are unable to work also have a right to feel a sense of safety and security in the USA in order to enhance their well-being. Our results affirm the work of many scholars (e.g., Herman 1992) who emphasize the importance of establishing a feeling of safety before healing can occur. Our study adds to the literature by revealing some of the ways in which other forms of productivity should be valued as "work" in resettlement policies to contribute to establishing a sense of safety for refugees.

Second, challenges refugees face related to English-language proficiency, professional recertification, and economic barriers to pursuing education limit their ability to obtain work that provides economic security to their families, and may contribute to high levels of poverty and health disparities among refugees (Dawood 2011). Third, although it is clear that there is a relationship between cultural expectations and roles around gender and work for refugees, we underscore the complexity of this relationship and argue that it is not reducible to sociocultural attitudes or practices around gender. The relationship between work and gender is clearly influenced by culture; however, it is important to recognize the way sociocultural factors interact with economic and social policies.

US refugee resettlement policies that provide limited support for refugees have direct impacts on refugees and their choices around work. Based on our results, refugees agree that engaging in work is important for overall mental health. Also, even though almost all refugees have experienced trauma in some form, our results echo others who have shown that refugees demonstrate remarkable resiliency and that their presence in a third country underscores their motivation and drive to build a new, fulfilling life. However, if the USA resettles refugees who have lived through extreme violence and instability, there must be support for those who continue to be impacted by these events in the form of economic, educational, and health care provisions. While the majority of refugees desire employment and self-sufficiency for their families, compelling people to work for low wages and limiting their opportunity to develop language proficiency and other relevant skills and to address health challenges may have long-term negative impacts on overall poverty, health, and well-being.

Our findings have several implications for policy change. First, we suggest increasing the length of economic support from the current 4–8 months, to a year or more, making it easier for refugees to pursue education. Educational services should include

English-as-a-Second-Language instruction at all levels, ranging from a focus on those who are illiterate, up to those who speak English well but need specific instruction in advanced English that will facilitate employment. Further, resettlement efforts should focus on professional development for those without transferable skills, or those who desire new employment opportunities, and recertification for those who wish to pursue their previous profession. For example, scholarships could be awarded to refugees in training programs so they can focus on their studies while still being able to support their families. Another area that can be explored is skill-based hiring which identifies worker job qualifications based on their skills rather than educational achievement and then matches them with employers. In addition, more flexible part-time employment arrangements would make it possible for people to combine work, education, and caregiving in culturally appropriate ways and increase women's participation in the workforce. These policies would benefit not only refugees, but also other immigrants and the US workforce, in general.

Large-scale refugee movement figures prominently around the world. Europe is struggling to define policies and practices to facilitate the integration of millions of recent arrivals from Syria, Afghanistan, Iraq, and various African countries. Our findings suggest that it is possible to create policies that will benefit refugee-receiving countries by facilitating the integration of productive refugees and at the same time promote the best interests of refugees who endorse the benefits of productivity and its role in recovery from the violence and trauma of the past.

### Study Limitations and Future Research

Study limitations include the data collection methodology that asked participants to describe the experience of someone they were close to. Although this was done out of consideration of the traumatic histories of many refugees, who may be triggered when asked to recount past events, it may be more informative to ask people about their own experience.

Given that our sample consisted of recently arrived refugees, future research should examine views on employment, healing, and well-being in a sample of refugees who have been resettled for longer periods of time. Multinational studies that compare policies of rapid self-sufficiency versus more extensive economic and educational support and the effects on economic well-being over time are also of interest. Issues of rapid and long-term employment for refugees, their health and well-being, and the impact on host nations are particularly relevant at this time given the influx of refugees fleeing to Europe from Syria and other war-torn countries. It is imperative that these issues are addressed in thoughtful ways that consider the impact on all stakeholders.

## Conclusion

When refugee participants were asked in our study what factors promoted healing, almost all mentioned the benefits of being employed and productive. Work was a sign of normalcy, well-being, and safety. Being employed allowed refugees to be self-sufficient, take care of their basic needs, and fulfill familial and community roles. In addition, participants reported that employment promoted emotional health by providing relief from focusing on past trauma and worrying about making ends meet

financially. However, refugees face many structural and individual barriers to finding and maintaining meaningful employment, which improved policies and practices could address. These findings are particularly important and provide the potential for significant impact given the current unprecedented numbers of refugees worldwide and the urgency for many countries to reimagine and improve their resettlement policies.

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