A Social Ecology of Stress and Coping among Homeless Refugee Families

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Dedication

To my mother who taught me devotion.

Abstract

Refugee families undergo multiple challenges and hardships that tend to cause tremendous psychological distress in the migration and resettlement processes. This dissertation research was designed to explore refugee families' mental health in the social ecological contexts of displacement and homelessness and to investigate stressors and coping in relation to transition of resources including social capital of refugee families. With three theoretical frameworks, a social ecology theory, stress and coping theory, and social capital theory, the author developed a series of hypothetical statements as well as research questions to modify and refine hypotheses on stress and coping processes of refugee families. A modified analytic induction method was adopted for analysis of interview data from 26 Hmong and Somali families in Twin Cities area.

The findings of this study revealed that psychological distress was deeply associated with challenges and transition in resources at various levels. Rearrangement of resources (cultural resources in particular) occurred after resettlement, which tended to impede coping capacity of refugee families and cause acculturation stress. Social capital, both bonding and linking, functioned as a critical form of resource for refugee families to resettle and adjust to the host community by supplementing personal, family, and cultural resources that are often sparse in refugee communities. The results of the current study imply that it is a critical coping strategy for refugee families to build or increase social capital, which sometimes leads families' secondary migration in search of better bonding social capital. This study also demonstrated high levels of psychological distress among refugee families, ranging from traumatic experiences before migration to acute stress

after homelessness. Exposure to traumatic events before and during migration was salient in refugee families, while a lack of resources and frustrated coping strategies contributed to tremendous distress, which has been a chronic condition for the refugee families.

This dissertation underscores the importance of social work practice focusing on culturally responsive resettlement services considering various challenges and cultural coping of refugee families. Policy interventions promoting family and bonding social capital are also critical to improve resettlement outcomes as well as refugee mental health.

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Chapter 1. Introduction

Background of Study

Refugees are, as revealed in the definition, people who survived war, political violence, threats of persecution, and tremendous losses including families, home, property, social status, and normal life. After having fled from the home country, difficulties await and may include hardships and meager conditions in refugee camps, additional loss of family and friends, further trauma, deep sorrow, and uncertainty about the future. Challenges and distress continue after resettlement in a new country. What awaits refugees hoping for a better life are often low-wage jobs that are obtainable without the requisite skills and language ability necessary for higher paying work and frequently living in impoverished conditions. Practical needs among refugee families include but are not limited to transportation, language acquisition, legal support, employment, housing, access to health care and social services, and economic as well as social support. New life issues, along with imposed goals of social adjustment and self-sufficiency, emerge upon resettlement and may increase isolation and mental distress without appropriate intervention (Morris, et al., 2009).

Due to the tremendous hardships and traumatic experiences associated with forced migration, declines in mental health commonly arise through the resettlement process and may impede adjustment to the local community and host culture. The exposure to political violence and traumatic situations, for instance, can cause serious mental health problems and is known to interfere with adjustment to the host society (Silove, Steel, Bauman, Chey, & McFarlane, 2007; Ellis et al., 2008). Failure to provide appropriate

services and intervention may contribute to the challenges faced by refugees and thus deterioration of family structure, fiscal stability, housing security, and mental wellness. Other life challenges, combined with language barriers and lack of proper cultural orientation, may result in social, economic, and cultural marginalization.

On the brighter side, however, the resilience of refugees reveals great strength and this enables them not only to overcome adversities but also to navigate through new hardships. Efforts to restore daily lives and build a better life lead to the development of ethnic communities, local businesses, and civic participation and thus cultural, economic, and social contributions to the host society.

Due to the complex nature of refugee resettlement, many areas are in need of initial exploration or deeper investigation. Some subjects, such as post-traumatic stress disorder (PTSD) and health disparities, attract growing attention, while many other issues remain unidentified or poorly understood. Among the issues little touched are how refugees' mental health issues are affected by resettlement challenges and what coping strategies may or may not medicate psychological distress as well as resettlement stressors. In particular, in spite of growing concerns about housing issues in refugee communities, especially since the recent economic recession, little has been discussed about the impacts of housing insecurity and homelessness on refugee families in scholarly research. Homelessness or housing insecurity, in fact, may be one of the most immediate and primary concerns in refugee communities not only upon arrival but throughout the entire resettlement process. This study explored mental health experiences and coping strategies in refugee communities faced with housing concerns in the social ecological

contexts of forced migration and resettlement.

Current Status of Refugees Internationally

According to the 1951 Convention in relation to the Status of Refugees by the United Nations Higher Commissioners for Refugees (UNHCR), refugees are defined as those who flee their country of nationality due to a well-founded fear of persecution for reasons of their race, ethnicity, religion, political opinion, or membership of a certain social group, and are unable or unwilling to avail themselves of the protection of the native country (UNHCR, 1951). The World Refugee Survey in 2007 estimated that there are 14 million people who meet the definition of refugee, and 26 million in total are internally displaced (U.S. Committee for Refugees and Immigrants: USCRI, 2008).

Three durable solutions to refugee situations are suggested by UNHCR for refugee protection: repatriation, local integration and resettlement. The resettlement process, as outlined by UNHCR, involves selection and transfer of refugees from a country providing asylum to a third country providing permanent residence status (UNHCR, 2011). Resettlement countries have obligations for non-refoulement as well as provision of similar levels of access to civil, political, economic, social and cultural rights that nationals enjoy (UNHCR 1996). The United States resettles more refugees than any other country in 2008 with the second largest number of refugees resettled in Canada (10,804), followed by Australia (8,742) and Sweden (2,209) (USCRI, 2009). There are 25 countries that practice resettlement for refugees, which has increased from 14 countries in 2005. It is estimated, however, that about 800,000 refugees currently need resettlement and only around 80,000 are actually resettled a year worldwide (UNHCR, 2011).

C**urrent Status of Refugee Resettlement in the United States (U.S.)**

The U.S. receives a higher number of refugees than any other country. In 2009, 62,011 refugees resettled in the U.S. and this amounts to approximately 73% of total refugees (84,657) resettled in the world of the year (UNHCR, 2011). The total number of admitted refugees in the U.S. amounts to 2.6 million between 1975 and 2008. Each year, the U.S. government determines a maximum number of refugees that may be resettled in the country during that year. The number of resettled refugees were 48,281 in 2007 and 60,191 in 2008, whereas the ceiling numbers were 70,000 and 80,000 respectively, suggesting that the United States is falling far short of its capacity for refugee resettlement. Within the United States, California resettled the largest number (9,480) of refugees in 2008 followed by Texas (5,130) and Florida (3,723) (USCRI, 2009).

Overview of U.S. Refugee Policy

The U.S. has a long history of refugee policies. Following the Displaced Persons Act of 1948 and the Immigration and Nationality Act of 1952, the Refugee Act of 1980 was enacted, which is the most important and comprehensive refugee policy in the U.S. The main goals of the Refugee Act are to help refugees achieve economic self-sufficiency and social adjustment as soon as possible. The Refugee Act consists of six parts: dealing with general provisions; procedures; treatment of asylum seekers and refugees; revocation of declaration; accelerated procedures; and miscellaneous provisions. This policy also includes some revisions of previous policies regarding refugee resettlement. The Refugee Act follows the UNHCR's definition of refugee and designates comprehensive programs and services for refugees, distinct from those for immigrants,

including more incorporative and supportive assistance for refugee resettlement. The Office of Refugee Resettlement (ORR) provides detailed regulations for resettlement policy (UNHCR, 2007).

Because various interests are involved in the issues of forced migration and refugee protection, policies related to refugee issues are often affected by diplomatic and economic circumstances both at domestic and international levels. The history of refugee resettlement policy in the United States shows the impact of international and national situations and politics on the policy (Zucker, 1983; McBride, 1999). The anti-communist sentiment in the Cold War heavily affected early refugee policy in the U.S., which resulted in the establishment of the Cuban Refugee Program (CRP) in 1962. After the conclusion of the Vietnam War, the focus of U.S. refugee policy moved to Indochinese refugees. The United States passed the Migration and Refugee Assistance Act of 1975 and initiated the Indochinese Refugee Assistance Program (IRAP) in response to the temporary refugee relief and resettlement program (Zucker, 1983; McBride, 1999). The accommodation of the US refugee policy to the political circumstances illustrates how priorities for the admittance of refugees shift with the political leanings and international relations that predominate at a particular point of time. This, in turn, implies that these adaptations will be reflected in the services and programs to provide adequate assistance to refugees in an agile and realistic manner.

The resettlement process in the U.S. Refugee resettlement in the U.S. usually starts with UNHCR's referral of a refugee to the U.S. State Department, or with the

refugees' application for the Affidavit of Relationship (AOR)[1] or I-730, known as a free case, to the U.S. State Department. Upon approval, the International Office of Migration (IOM) arranges for travel to the U.S. with the cash flow for travel costs being provided by a loan program, wherein refugees are expected to pay back travel costs within three years after arrival.

Upon arrival, refugees are granted an initial resettlement grant through resettlement agencies, or voluntary agencies (VolAgs), at the local level to ensure that basic and immediate needs for food, housing, clothing, medical care, school, and other information are met. For the first 90 days, refugees receive cultural orientations and referral services for public assistance, health screening, employment, school, housing, language class, legal issues, and identification such as Social Security (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). Local agencies' services and programs may vary, but usually include language classes, employment education and counseling, food shelves, housing subsidies, case management for people with special needs (i.e. HIV), and community outreach and adult education (Grigoleit, 2006).

Refugee Resettlement in Minnesota

Minnesota has attracted many different refugee populations for the last few decades. Horst (2006) points to the economic structure and greater job opportunities in Minnesota as well as its more open and welcoming climate towards immigrants. According to the Minnesota Department of Health (2009), Minnesota received approximately 3,000 refugees per a year, on average, between 1979 and 2008. The numbers of resettled

[1] The process of AOR, or family reunification, is currently closed because of the concerns of fraud and questioning of the method of screening.

refugees, however, have been declining in the past few years because of a combination of domestic and international circumstances, including economic hardships. In 2005 and 2006, for instance, 5,320 and 5,356 refugees arrived in Minnesota, respectively, while 2,867 and 1,329 people resettled in Minnesota in 2007 and in 2008, respectively (Minnesota Department of Health, 2009). Traditionally, Southeast Asian refugees, including the Hmong, and Sub-Saharan Africans, such as Ethiopians and Somalis, have been the dominant refugee subgroups in Minnesota. Since the family reunification program was shut down, however, the number of refugees from Eastern Africa has slightly decreased, while the number of free cases is steady. Significant groups newly resettled in Minnesota since 2008 include Iraqi, Karen, and Bhutanese (Minnesota Department of Health, 2009). A total of six VolAgs provide refugee resettlement services in Minnesota, which include: Catholic Charities, International Institute of Minnesota, Jewish Family and Children's Service of Minneapolis – Immigrant and Refugee Services, Lutheran Social Services of Minnesota, Minnesota Council of Churches, and World Relief Minnesota.

Due to the relatively long history of resettlement, Hmong and Somali refugees have formed the two largest ethnic communities in Minnesota, particularly in Twin Cities area. In fact, Minnesota has the largest Somali community in the U.S. and Saint Paul is known to have the second largest Hmong populations in the U.S.

Somali refugees in the U.S. and Minnesota. For Somali refugees, unstable political and economic situations in Somalia led to civil wars in the late 20th century, which forced Somalis to flee to refugee camps, predominantly in neighboring Kenya and

Ethiopia, and then to other countries around the world. The immigration status of most of the Somalis who have entered the United States is refugee (CDC, 2009). The Department of Homeland Security (2009) indicates that 10,745 refugees whose country of birth is Somalia obtained legal permanent resident status in the U.S. during fiscal year 2008 and 3,372 among them settled in Minnesota.

The number of Somali refugees in the United States has dramatically increased since the 1990s (Putnam & Noor, 1999). According to the U.S. Office of Refugee Resettlement (2004), a total of 55,036 Somali refugees resettled in the United States between 1983 and 2004. The estimated number of people born in Somalia living in the U.S. in 2010 was 85,700 (U.S. Census Bureau, 2010). Due to the active flow of secondary migration within the U.S., it is hard to calculate the Somali population accurately, but it is projected that a total of 25,000 Somalis resided in Minnesota in 2004, and the number grew as high as 30,000 in 2006 (De Shaw, 2006). A significant number of Somali refugees settle in Minnesota due to several pull factors. The thriving ethnic community in Minnesota attracts those who resettled in other states with sparse cultural resources. Accordingly, organized social programs and community services have been developed and provided through the community-based organizations (CBOs) serving the Somali community, including the Confederation of Somali Communities in Minnesota, Somali Women's Association, and the Somali Health Project.

Hmong refugees in the U.S. and Minnesota. Hmong refugee resettlement started due to the Hmong alliance with the U.S. government during Vietnam War. The Hmong are originally a mountainous, isolated ethnic group who lived mostly in Laos and

Vietnam. Hmong migration began during the Vietnam War due to their cooperation with the CIA in performing the secret war in Laos, which left the Hmong in danger of persecution after the U.S. left the region. Most Hmong refugees exiled to Thailand and migrated between several refugee camps in Thailand. A total of 180,000 Hmong have been resettled in the United States between 1975 and mid-2005, when Wat Tham Krabok, the last Hmong refugee camp in Thailand, was closed. More than half (57.2%) of Hmong refugees arrived in the U.S. before 1990, while only 14.2% were newly resettled after 2000. According to the American Community Survey (2008), a total of 194,798 Hmong live in the U.S. and Minnesota is home to 48,668 Hmong, which ranks Minnesota second in number of Hmong, with the largest population next to California. Among them, 66,181 Hmong reside in the Minneapolis-St. Paul area of Minnesota (U.S. Census, 2010). Like the Somali community in Minnesota, the Hmong group has developed many community resources, including the Hmong American Partnership, the Hmong Cultural Center, the Center for Hmong Studies, and the Hmong American Mutual Assistance Association. These resources as well as the large ethnic community have attracted additional Hmong populations to Minnesota.

The number of refugee arrivals and the pattern of resettlement have fluctuated according to political and economic situations and thus have affected resettlement services at the state level. For example, after the U.S. government and Thailand agreed to close the final Hmong refugee camp and decided to resettle the 14,500 refugees in the camp in the U.S in December 2003, Minnesota had an influx of 4,972 Hmong refugees in March 2004. This caused serious disturbances to resettlement service agencies as well as

to the Hmong community due to lack of resources to support the large number of newcomers at once. Many newly arrived refugees ended up being homeless as a result, and one of the local homeless shelters, Mary's Place, was full with 221 Hmong families, while many others became homeless (Asian American Press, 2005). In another example, the close of family reunification cases impacted the Somali community significantly, which led to a decrease in the number of Somalis, as well as other Eastern African refugees, from 4,764 to 1,981 in 2006 and to 350 in 2008 (Minnesota Department of Health, 2009). This also influenced the resettlement agencies' service provision, adding more burdens of finding resources for free case refugees.

Identified Challenges in Refugee Resettlement

Refugee migration begins under forcible circumstances and thus is accompanied by tremendous challenges and hardships, while causing sudden losses of the valuable and the familiar (Djuretic, Crawford, & Weaver, 2007). Prior to arrival in the host country, most refugees have experienced a series of traumas caused by war, violence, or persecution in the home country and by the conditions in a refugee camp. A lack of proper mental health screening and treatment before and during resettlement obstructs successful adjustment and integration of refugees to the host society. In addition, migration and relocation are known to cause an additional stressor, known as resettlement trauma (Clinton-Davis & Fassil, 1992). Forced migration tends to lead to dislocation of families and privation of social connectedness and resources (Marsiglia, Miles, Dustman, & Sills, 2002). In addition, as most refugees leave their home country in urgent situations without preparation or anticipation, they tend to experience a greater amount of

psychological, economic and social loss than do immigrants who emigrate voluntarily, which in turn interferes with refugees' coping with new situations and acculturation to the new culture (Colic-Peisker & Walker, 2003).

Faced with a multitude of challenges, refugees are in need of special care and support from the host country as well as from local communities during the resettlement process. Well-identified resettlement challenges among refugees include language barriers, isolation, insecure employment, and financial difficulties, all of which undermine refugees' adjustment and integration to the host society as well as overall mental health (USCRI, 1999). Lack of cultural knowledge as well as language ability inhibits employment and forces refugees into the unstable, low-wage job market. Moreover, refugees' previous job skills and educational background tend to be devalued in the host country, which affects their employment, finances, housing prospects (Canadian Council for Refugees, 1998). Furthermore, the low rate of refugees' access to social services and health care tend to worsen these hardships (Uba, 1992; Chung & Lin, 1994). Refugees' lack of information about available services and proper transportation to access to the services can play as one of the biggest obstacles to accessing appropriate resources. These challenges are exacerbated by the paucity of policies and programs that are culturally appropriate and responsive to refugee populations (Ell & Castaneda, 1998). In fact, refugees' experiences of poor treatment or discrimination during service utilization in the early resettlement stage tend to discourage further access to social services, which can be an obstacle to social integration and adjustment in the long run (Peisker & Tilbury, 2004).

It is essential, therefore, to systematically understand the urgent needs of the refugee community and to develop adequate and timely services to refugee populations not only for successful resettlement of refugees but also for humanitarian protection of the populations (Hauff & Vaglum, 1995; Steel, Silove, Phan, & Bauman, 2002).

Statement of Problem

> *"Cha Vang, a Hmong refugee and adult student in English as Second Language (ESL) class, resettled with his wife and five young children, all under 10, in St. Paul, Minnesota in October, 2004. Since he was eight, he had lived in various refugee camps in Thailand. His relatives who had settled in the region helped him find a two-story house to rent in St. Paul, the rent of which costs $1,350 per month excluding utilities. The monthly income of his family, all from a MFIP grant, amounts exactly to $1,350 after Vang and his wife had another baby after arriving in the U.S. Vang has approximately $3,000in debt for the travel costs that he needs to pay back within this year. A few months later, Vang's mother and his brother joined the household and the total occupancy became twelve. No one in the house could find a job."*
>
> *"Chue Yang, a 40 year old father of six children, resettled in Atlanta in July 2004 and moved to Minnesota in January 2005, where many of his relatives reside. He had spent the prior 26 years living in Hmong refugee camps in Thailand. So, he has little work experience, has never driven a car, and is able to speak almost no English. After his family relocated to Minnesota, the eight-person family moved to a two-bedroom apartment in north Minneapolis for which they pay $665 a month for rent, plus utilities. With no one in the household working, and just a welfare check to support them, the bills quickly piled up in addition to $3,000 debt that he already owed his relatives for foods and shelter for his family. Yang and his family ended up with being homeless and moved to a family homeless shelter in north Minneapolis, like 221 other Hmong residents in the place, among whom 157 are children. Several months later, Yang got a job, working 30 hours a week as a janitor for $8 an hour. Yang is a better case than many others staying in the shelter and most of others who could not even get in the shelter."*
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> *City Pages, Jan. 2006*[2]

[2] These two stories of Cha Vang and Chue Yang were summarized based on the original news article.

Housing stability. Stable housing is a basic need as well as an indicator of successful resettlement. Housing, however, is one of the most challenging issues to deal with in the resettlement process. The majority of refugees in many cultural groups arrive in the U.S. neither with English proficiency nor with advanced job skills, which obstructs immediate or steady employment and thus secure, sustainable income. Relying on welfare subsidies and public assistance in the early stage of resettlement, many refugees start their new life in uncertain and vulnerable situations. Especially by settling in metropolitan areas, in spite of many benefits such as more job opportunities and better accessibility to services compared to rural areas, many refugees have difficulties finding affordable and adequate housing because of high costs of rent, small space and limited options for individuals with low incomes.

Considering resettlement challenges, housing insecurity and homelessness in refugee communities may indicate more than just economic hardship or unavailability of affordable housing. Rather, housing issues often occur as an outcome of a combination of insecure employment and failure of timely and/or appropriate service interventions to refugee families. As many empirical studies with native born citizens have revealed, homelessness is deemed a product of extreme poverty in addition to a result of such risk factors as individual health issues and lack of proper support, either formal or informal (Burt et al., 2001; Marpsat & Firdion, 2000; Harber & Toro, 2004).

Housing crises and homelessness among refugees imply even more complicated issues given the nature of refugee situations. A lack of a credit history and previous monetary transactions exposes refugees to discriminatory experiences in seeking housing,

along with prejudice and cultural insensitivity of some property owners. Also, a lack of adequate housing units accommodating large households, which are common among many cultural groups, adds another hurdle to refugees. Language and cultural barriers obstruct ease of communication and information acquisition and tend to lead to troubles in securing and managing proper housing. A lack of social support for the newly settled is likely to limit possible options for temporarily stays with relatives among refugee families, limiting options for coping with housing challenges. Thus, housing insecurity and homelessness among refugees may be an inevitable consequence of the shortfall of appropriate and timely interventions or resettlement services, a lack of social resources, inadequate affordable housing available, and failure in adjustment and integration to the new society.

Relationship between mental health and housing instability. One vital issue that requires consideration in addressing homelessness is mental health as both a contributor to and a consequence of resettlement challenges and housing difficulties. A strong correlation between mental disorders and homelessness has been found among the native-born American homeless population (Bassuk, Buckner, Perloff, & Bassuk, 1998). The prevalence of mental health issues among refugees may be a critical risk factor for housing instability. It is known that refugees tend to have more mental health issues such as PTSD, anxiety, and depression than their non-migrant counterparts and are vulnerable to additional mental distress because of pre- and post-migration stressors (Pumariega, Rothe, & Pumariega, 2005; Hermansson, Timkpa, & Thyberg, 2002; Fenta, Yman, & Noh, 2004). These mental health issues tend to get exacerbated by resettlement and

adjustment stress and lead to interruptions in coping in general. Given that previous studies have revealed that mental illness can affect coping and adjustment and have a bad influence across situations (Porter & Haslam, 2005), refugees' homelessness and housing crises may be understood in the contexts of all the challenges closely related to each other. In fact, poorly housed families are known to have more mental health issues (Bassuk et al., 1998) and that housing instability may serve to worsen the mental disorders they already have (Buckner, 2004). The mutual influence of housing and mental health may be one of the most apparent hardships that refugees go through during the resettlement process.

Need for current study. In spite of the importance of this issue, however, little has been investigated about what may lead to housing insecurity and homelessness among refugees and how these affect mental health and coping strategies that refugee families have. Even though previous studies have implied that homeless people from different ethnic groups may have different patterns in utilizing social services, and that this may lead to different results in housing crises and homelessness, there are few studies that directly explore homeless refugees (Julia & Hartnett, 1999).

This may be related to the closed circuit of helping and support systems in many refugee communities. Refugee groups may have developed spontaneous and situational, but unique adaptive coping strategies, such as relying on expanded family support and the same ethnic community by living in doubled-up housing situations. In fact, Wong, Culhane, & Kuhn (1997), for example, revealed that Latin American immigrants use shelters less frequently than other groups, although they experience longer periods of

homelessness after seeking help. Baker (1994) and Belcher (1992) also argued that Latin American groups in the U.S. are underrepresented in shelters. As many empirical studies with immigrants and cultural minorities have revealed, refugees' preference for informal help-seeking (from family, friends, or people from the same cultural background) over formal help-seeking (from social agencies and people or organizations from the host culture) may influence their coping strategies for housing (Kaniasty & Norris, 2000; Fung & Wong, 2007).

This pattern of problem solving in refugee communities may be even more the case when it comes to mental health issues. In fact, mental health is often associated with stigma and even taboo to disclose in many cultures and thus mental disorders are seldom discussed in public and easily disregarded or regarded as "invisible." Only family members or internal people who are considered "safe" are allowed to find out these sensitive issues in many cultural groups. The coping strategies bound to the cultural community are not only precarious, but may also put families and the community in danger of worse situations by overburdening the community. In this respect, even if some refugee families can avoid "literal homelessness," it does not necessarily mean that the families are not facing a housing crisis, unless they have eradicated risk factors for housing insecurity. This paper investigates the use of social capital within one's ethnic community as a means of coping with housing instability.

Refugee homelessness may be easily overlooked partly because it is not "obvious" and mostly "out of the system" (Access Alliance Multicultural Community Health Centre, 2003). This gap in knowledge, consequentially, impedes improvement in providing and

delivering appropriate services and interventions. Thus, refugee homelessness remains hidden homelessness and the vicious cycle of housing instability and mental health may continue until they are revealed. As this is the case, the present study will address an important gap in the current understanding of refugee resettlement, but calling attention to the ecological context in which housing instability may occur and what refugee communities do to cope.

Significance of Study

Many areas of refugee experiences await further or initial inquiries. Among many challenging and urgent issues in refugee communities, the most representative concerns of social and psychological hardships include housing and mental health. Mental health issues are known to be the most challenging issues to approach in some cultural groups due to high stigma attached to the issue as well as culturally different constructs of psychological distress. In the meantime, housing is among the least studied subject among resettlement challenges in refugee communities partially because the housing crisis is hidden. For example, separation of family members or double-up with relatives or neighbors for the sake of temporary stability in housing may be common among refugee families not only because it is a strategy that is working but also because it may be the only working strategy when failing to access other resources and information.

It would be hard to provide systematic services that are culturally competent and responsive to refugee populations and resolve problematic issues of concern without a profound understanding of the issues in ecological systems. Not only because housing issues are complex, but also because refugees are in unique situations where various risk

factors are involved, a comprehensive approach considering contextual environments is essential to probe refugees' housing insecurity and psychological experiences. Because housing insecurity in the resettlement process is intertwined with mental health issues and possibly vice versa, this dissertation proposes to identify the interplay between housing and mental health and to explore how these two interwoven issues interact with the systems surrounding refugee families in the resettlement process.

This study attempts to suggest policy and practice implications for resettlement agencies and social service organizations as well as for refugee communities facing this common issue. The results of this study will contribute to the current state of knowledge on this topic, and will help social service providers design services that are culturally relevant and targeted to the specific needs and desires of refugee families. In particular, knowledge about the interplay between housing insecurity and mental health among refugees will be useful in designing services that are aimed at proactively addressing both psychological and social challenges in resettlement, while new information about cultural constructions of acculturation and social capital as coping strategies will provide insights into how social service providers may best reach refugee populations to provide assistance before difficulties reach the crisis stage.

Chapter 2. Literature Review

This section will discuss the current status of the literature regarding mental health issues and housing concerns among refugees to illuminate the interplay between psychological distress throughout migration and housing situations (particularly, homelessness). I will also present the theoretical and conceptual frameworks that were used to explore these topics. Finally, this section will outline the main research questions and hypotheses for this study, which arose out of the current base of knowledge from the literature.

Mental Health in Refugees

Mental health issues are prevalent in refugee populations. Many empirical studies have shown that refugees demonstrate higher incidence rates of mental illness such as PTSD, major depressive disorder (MDD), and dissociation than native populations in the host country (Porter & Haslam, 2005; Carlson & Rosser-Hogan, 1991; Steel, Silove, Phan, & Bauman, 2002; Kinzie et al., 1990). A meta-analysis of 20 surveys with 6,743 adult refugees revealed that 9% of total respondents were diagnosed with PTSD, while 5% were thought to have MDD (Frazel, Wheeler, & Danesh, 2005). According to another review study, however, 4% to 86% of refugees had PTSD and 5% to 31% refugees met criteria of depression symptoms (Hollifield et al., 2002). Ellis and her colleagues (2008) also indicated that a high proportion of refugee children and adolescents have PTSD, ranging from 11.5% to 65% of the samples in studies with Bosnian children (Goldstein, Wampler, & Wise, 1997; Weine et al., 1995), Cambodian children and adolescents (Sack, Him, & Dickason, 1999; Hubbard, Realmuto, Northwood, & Masten, 1995), and refugee

youth from Tibet (Servan-Schreiber, Lin, & Birmaher, 1998). A substantial number of refugee children report MDD in other studies, ranging between 11% and 47% of the samples studied (Servan-Schreiber et al., 1998; Weine et al., 1995; Heptinstall, Sethna, & Taylor, 2004). In spite of such variation, recent literature provides convincing evidence that refugees experience tremendous difficulties, social, physical and psychological, and are thus exposed to high risks of mental distress (Lustig et al., 2004; De Jong, Scholte, Koeter, & Harte, 2000; Pumariega, Rothe, & Pumariega, 2005).

As shown above, the wide variation found across the studies reflects the challenges in studying mental health issues among refugees. In spite of the high correlation between traumatic experiences that refugees have gone through and the incidence of mental health issues, a lack of adequate mental health assessment and referrals obstructs accurate estimation of the mental health status of this population. The Office of Refugee Resettlement (ORR) has provided rudimentary guidelines for refugee mental health screening and there remains wide variability in screening practices throughout the United States with most states relying on informal interviews only (Shannon, et al., manuscript). In addition, it is especially challenging for health professionals in mainstream services to diagnose refugees' mental health status since mental health disorders are highly stigmatized in many cultural groups and the concepts and expression of psychological distress and its symptoms are often shaped in way different than that of mainstream American culture (Peter, 2009; Gong-Guy, Cravens, & Patterson, 1991). Some scholars criticize certain psychological disorders and mental health concerns, including PTSD, saying that there are derived from Western culture and are not appropriate to explain

refugees' grief and psychological suffering, nor their resilience (Wilson & Drozdek, 2004; Einsenhruch, 1991). In fact, culture is one of the most critical aspects to consider in addressing mental health issues and has been in the center of discourse about refugee mental health.

Cultural considerations to investigate refugee mental health. A majority of the studies on refugee mental health have focused on mental health symptoms based on a medical or pathology model. Research based on this model has mainly explored mental symptoms and pathological conditions of refugees and thus has focused on diagnosis, pharmacological treatment, and therapeutic interventions (Ryan, Dooley, & Benson, 2008). In spite of many benefits, this approach has been criticized, as it dismisses various forms responses to trauma and resilience from traumatic stress (Ryan, et al., 2008; Miller & Rasco, 2004). In addition, Hoshmand (2007) and Miller (1999) have criticized the medical model as culturally unresponsive since it tends to ignore or exclude the ecological environment, which is a main source of both emotional suffering and resilience.

Culture, among other environmental factors, affects mental health several ways, including: (a) conceptualization of psychological distress and well-being, (b) meanings of psychological experiences, (c) health communication, and (d) service seeking and utilization. For instance, refugees are likely to have different help-seeking patterns and beliefs about treatment of mental health (Gaines 1998; Butcher 199), as well as pervasive stigma and taboos around mental health both within and outside the ethnic community (Jaranson, 1990; Alvidrez, 1999). Cultural minorities are often underrepresented in

accessing and utilizing mental health care services for such reasons (Alvidrez, 1999; Leong & Lau, 2001). The traditional patterns of help-seeking and stigma, however, may be swayed by the extent of adjustment and acculturation to the host society. In fact, empirical studies have revealed that a high level of acculturation is related to decreased stigma associated with mental health distress and increased intention to seek professional help for mental health services (Zhang & Dixon, 2003).

Another cultural aspect of mental health issues regards culturally appropriate concepts and meanings of psychological distress and emotional suffering. Eisenhruch (1991), for instance, conceptualized cultural bereavement to provide an alternative explanation about the distress of Southeastern Asian refugees who did not present typical PTSD symptoms shown in the DSM-IV. This implies that cultural distress, although seemingly similar to PTSD, may be functional after such tribulations and emphasizes the importance of culturally embedded contexts surrounding mental health (Porter & Haslam, 2005; Hodes, 2005). This emphasizes the utility of an ecological view of mental health instead of a pathological model or medicalization of the psychological experiences of refugees.

Cultural contexts of migration are also considerable in determining the mental health of refugees. A study assessing psychological well-being of Southeast Asian refugees (Rumbaut, 1991) showed that Hmong reported the lowest level of life satisfaction compared to Khmer, Vietnamese, and Chinese-Vietnamese populations. Depending on the position of marginalization and the social power of the subgroup, mental health status may differ (Rumbaut, 1991; Goodkind, Hang, & Yang, 2004). In

addition, the characteristics and types of trauma (e.g.: gender-based violence, torture, child soldiers) require specific consideration.

Refugee mental health in migration and resettlement processes. Authors of systematic reviews of empirical studies on refugee mental health assert that it is useful to divide refugee experiences into three chronological phases to understand specific mental health issues and distinctive stressors prevalent and relevant to each stage of migration (Lustig et al., 2004; Crowley, 2009; Berman, 2001; Fazel & Stein, 2002; Pumariega, et al., 2005; Davidson, Murray, & Schweitzer, 2008). The three stages consist of pre-migration, migration, and post-migration, or resettlement.

Pre-migration, referring to the time period before fleeing the native country, is characterized by social upheaval and chaos, which often calls for prioritizing safety (Davidson et al., 2008). This stage involves exposure to traumatic events such as political and sexual violence, war, rupture of social resources, threat to life, and loss of family and/or social networks. Risk is often increased during this stage for suicidal ideation, substance abuse, depression, anxiety, and war injuries (Lustig et al., 2004). Empirical studies with the Somali community, for instance, reported that pre-migration trauma is the sole risk factor for anxiety and depression, although it is not necessarily related to psychoses (Bhui, Abdi, & Abdi, 2003). It is estimated that 35% to 50% of refugee populations have experienced torture in their home country (Chester, 1990) and between 200,000 and 400,000 refugees who resettled in the U.S. are deemed to be torture survivors (Gorman, 2001). A review study reported that torture experience accounted for high inter-study variance of PTSD (23.6%) and depression (11.4%) (Steel, et al., 2009).

Numerous empirical studies reveal impacts of exposure to war trauma on mental health in various refugee groups (Birman & Tran, 2008), including PTSD and depression in Vietnamese refugees (Mollica et al., 1998; Silove, et al., 2007; Hinton, Tiet, Tran, & Chesney, 1997), Sudanese (Karunakara, et al., 2004; Tempany, 2009), Somali (Kroll, Yusuf, & Fujiwara, 2010), Oromo (Jaranson, et al., 2004), Hmong (Mollica et al., 1990), Cambodian (Carlson et al., 1991), and Iraqi (Gorst-Unsworth, 1998).

The migration stage, between exile and resettlement, involves displacement, physical deprivation, poor experiences in refugee camps, and uncertainty about the future. Refugees in this phase are often exposed to extreme trauma during migration, such as witnessing murders, family loss, and life-threatening crises (Frazel, Wheeler, & Danesh, 2005). Hardships and abysmal conditions during migration tend to leave refugee children in particularly vulnerable situations because of parents' or guardians' lowered sensitivity to their physical and emotional needs, particularly during the migration stage. Psychological distress resulting from family loss or separation is commonly associated with this stage (Pumariega et al., 2005; Crowley, 2009; Lustig et al., 2004). Meager conditions and continuous insecurity in refugee camps are known to exacerbate or precipitate the development of mental health issues (Mollica, et al., 1993; De Jong, et al., 2000; Pumariega, et al., 2005). Migration itself is also regarded as a condition of risk for mental health problems (Beiser, 1990; Roizblatt & Pilowsky, 1996).

Mental health issues of the post-migration or resettlement stage, in the meantime, encompass a different set of psychosocial stressors and distress in addition to the issues permeating the previous two stages. While the mental health issues that started before and

during exile persist, new stressors emerge upon resettlement, which pertain to livelihood challenges and adjustment to a new culture. Resettlement stressors become of primary concern and entail a series of adaptation stresses, as well as experiences of deep grief and cultural bereavement over major losses, such as losses of family, social support and status, culture, and home country (Eisenbruch, 1991; Lustig et al., 2004). The stress of adaptation relates to language barriers, unemployment issues, role changes in gender and generation, family discord, discrimination and racism, and social isolation (Beiser, 1990; Nichholson, 1999; Potocky-Tripodi, 2002). Adaptation stress, in particular, is represented as acculturation stress or assimilation stress, which refers to a particular set of distress occurring during acculturation and may accompany "lowered mental health status (specifically confusion, anxiety, and depression), feelings of marginality and alienation, heightened psychosomatic symptom level, and identity confusion" (Berry, Kim, Minde, & Mok, 1987, p. 493). Identified risk factors related to resettlement and adaptation distress include job insecurity, poor housing, social discrimination, and isolation associated with high anxiety and depression (Pernice & Brook, 1996). Other inquiries reported demographic information, such as social and economic status (SES) (Markovic et al., 2002), gender and age (Plante, Simicic, Andersen, & Manuel, 2002) as significant predictors of poor mental health status. Also, many other scholars found that parents' severe financial hardship is associated with high depression scores in their children, while pre-migration trauma was related to high PTSD scores in children (Heptinstall, et al., 2004; Steel, Silove, Bird, McGorry, & Mohan, 1999; Mohan, 1999; Sundquist, Bayard-Burfield, Johansson, & Johansson, 2000).

Considering the accumulative nature of distress throughout the migration and resettlement stages, it is necessary to understand mental health issues as caused by multiple incidents in multilayered contexts (Porter & Haslam, 2005). According to Nicholson (1999), although it is resettlement stressors that are directly associated with adjustment and acculturation distress, pre-migration and migration experiences primarily influence refugees' coping with the stressors and thus affect mental health outcomes in an indirect but significant way. In particular, historical factors and pre-migration and migration experiences such as exposure to traumatic events in the past, loss of family, and age at the time of resettlement can all have major impacts on mental health (Heptinstall et al, 2004; Ellis et al., 2008). Each migration stage, therefore, has a cumulative effect on mental health.

Homelessness and Mental Health in Refugees

Mental health disorders and psychological wellness in refugee communities are of growing importance due to their influence on resettlement and adaptation process, including: social adjustment (Yeh, 2003; Almqvist & Broberg, 1999), community engagement (Lindstrom, 2005), acculturation and cultural development (Miller et al., 2006; Knipscheer & Kleber, 2007), subjective well-being (Yoon, Lee, & Goh, 2008), employment and economic self-sufficiency (Pernice, Trlin, Henderson, North, & Skinner, 2009), and thus successful resettlement (Lindencrona, Ekblad & Hauff, 2008). One of the domains that is tightly linked to mental health in the resettlement process is how refugees' housing situations impact mental health or vice versa.

Even though homelessness in the U.S. has been a visible problem, few studies with

refugees have been conducted to probe housing issues in the U.S. The previous studies conducted in different countries, however, may inform distinctive issues in refugee communities and imply housing patterns different from those of native citizens. Refugees experience urgent demand for housing as one of the immediate and fundamental needs soon after resettlement. Research in Canada and the United Kingdom identified barriers to affordable housing that are unique to the refugee community. They include family size, lack of knowledge of the housing system as well as legal rights and responsibilities, language/accent, and disability (Phillips, 2006; Papadopoulos, et al., 2004; Murdie, 2008; Wayland, 2007). Social circumstances at a macro level also contributed to housing insecurity and homelessness in refugees. These range from the structure of housing markets (ex. housing prices and availability of adequate housing), to state policies on housing, and to social structure such as cultural discrimination (Wayland, 2007; Zetter, 1999). Some of these challenges may overlap with those of the U.S. born homeless, while many others are unique or more relevant to refugee populations. This will be addressed in a later part of this paper.

Homelessness and housing instability among refugees. Homelessness is defined roughly as two categories in previous studies with the general population: the "literal homeless" and the "at-risk homeless" (Rossi & Wright, 1987). According to the federal definition of homelessness, a homeless individual or homeless person is:

1. An individual who lacks a fixed, regular, and adequate nighttime residence; and
2. An individual who has a primary nighttime residence that is -

a. a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);

b. an institution that provides a temporary residence for individuals intended to be institutionalized; or

c. a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. (HUD, 2011).

As shown above, the literal homeless are those who do not have a permanent residence during night time, while the at-risk homeless mean those who stay only in tenuous or temporary housing, including hospitalization and incarceration (Burt, 2004; Peroff, 1987; Rossi, 1989; VanGeest, 1998). Defining homelessness by the concept of "literal homelessness" has some benefit, such as making it clearer for researchers to identify the population. However, it has been often criticized because it tends to include an overly narrow scope of homeless people and it is practically and ethically difficult for researchers to access the population. Furthermore, many homeless people tend to experience homelessness on multiple occasions, and research focusing on the literal homeless may overrepresent long-term and chronic homeless people and miss other types of homeless people in need (Bachrach, 1984; Roth & Bean 1986). Thus, there is a need to include both the literal homeless and the at-risk homeless in the study of homelessness.

Although the definition of homelessness may be applied to general populations, culturally unique issues need careful attention in investigating refugee homelessness. For instance, the meaning of homelessness and the degree of stability of housing may differ

according to the resettlement status and adjustment stage (i.e. where they are situated in the resettlement process) as well as cultural background and beliefs about residence (i.e. how they perceive permanent residential arrangements). In addition, previous studies have implied that homelessness among different ethnic groups may have a different etiology due to variant coping strategies and social service utilization (Acevedo, 2004; Julia & Hartnett, 1999; Gamst et al., 2006). Among Hispanic homeless populations, for instance, cultural values and norms tend to increase the sense of ethnic community and promote social networks with in-group members. These patterns are presented as allocentrism (i.e. collectivistic identity) and familism (family-centered orientation), which may prevent Hispanics from seeking formal help and perhaps ameliorating difficult situations (Acevedo, 2004).

Even though homelessness in the U.S. has been a visible problem, few studies with refugees have been conducted to probe housing issues in the U.S. The previous studies conducted in different countries, however, may inform distinctive issues in refugee communities and imply housing patterns different from those of native citizens. Refugees experience urgent demand for housing as one of the immediate and fundamental needs soon after resettlement. Research in Canada and the United Kingdom identified barriers to affordable housing that are unique to the refugee community. They include larger family size than is typical of native born families, lack of knowledge of the housing system including legal rights and responsibilities of tenants, language/accent, and disability (Phillips, 2006; Papadopoulos, et al., 2004; Murdie, 2008; Wayland, 2007). Social circumstances at a macro level also contributed to housing insecurity and

homelessness in refugees. These range from the structure of housing markets (e.g. housing prices and availability of adequate housing), to state policies on housing, and to social structure such as cultural discrimination (Wayland, 2007; Zetter, 1999). Some of these challenges may overlap with those of the U.S. born homeless, while many others are unique or more relevant to refugee populations. This will be addressed in a later part of this paper.

Interplay between mental health and housing. Homelessness or housing crisis is a form of trauma (Goodman, Saxe, & Harvey, 1991). Like other traumas, homelessness impedes social bonds and adjustment, and develops or exacerbates psychological distress. A substantial number of empirical studies with U.S.-born Americans have indicated a close, positive relationship between mental health and housing insecurity or homelessness.

Comprehensive studies have revealed that more than half of the homeless have either mental illness or substance dependence problems (Burt, 1992). In fact, mental illness is regarded as the most salient cause of homelessness in addition to poverty. According to one of the most comprehensive studies on homeless epidemiology by Bassuk and her colleagues (1998), two-thirds of both homeless single mothers and poorly-housed women have experienced a psychiatric condition and the majority of them are likely to have MDD, PTSD, and/or alcohol or substance addiction. The proportion of the homeless having mental disorders is significantly higher than the general population. For instance, 45% of homeless mothers have MDD and 10% experienced depression in the past month, while 20% and 6% of women in the general population experienced

MDD and recent depression, respectively. Also, 36% suffered from PTSD and 17% lived alone for the past month, which amounts to triple the rates of their counterparts of the same residential area (Bassuk et al., 1998).

Even though a close relationship between mental health and housing insecurity seems obvious, the links between the two are still unclear. Three models can help explain the links, which include a causal model, an epidemiological model, and a reciprocal effects model. Both the causation model and the epidemiological model imply that a mental disorder is either a cause of or a risk factor for homelessness. A small number of studies demonstrate that there is evidence of the impact of housing insecurity on mental and physical health (Easterlow, Smith & Maliinson, 2000; Robinson, 1998; Easterlow et al., 2003). Conversely, many more empirical studies have indicated that mental illness is one of the most critical risk factors for housing insecurity, especially homelessness (Burridge & Ormandy, 1993; Smith, 1989; Smith, Easterlow, Munro, & Turner, 2003; Ineichen, 1993). Homeless individuals with mental disorders tend to stay homeless for a longer time period and to have more problems with employment, physical health, and legal issues than those without mental health issues as a result of chronic homelessness (National Coalition for the Homeless 2006).

Between the causal model and the epidemiological model, scholars claim that the latter is more relevant and appropriate to explain homelessness, particularly those in families. Buckner (2004) argues that "[t]o better understand the nuances, it is useful to separate the question of who is most at risk to experience homelessness from the issue of why homelessness exists as a major social problem in the first place" (p. 1).

The reasons for homelessness are not singularly within personal problems but are also related to and under the broader influence of social and societal structures. This association with socioeconomic structures is even stronger when it comes to family homelessness. As Acevedo (2004) pointed out, economic pressures and family dysfunction are main causes of homelessness among families, while mental health issues and substance abuse as well as collapse of social support are critical issues that lead singles to homelessness. In other words, it is hard to conclude that mental health and substance abuse disorders are fundamental reasons for homelessness and that homelessness is a cause of severe mental disorders. Rather, it is important to distinguish "who vs. why" in the epidemiology of homelessness and to identify who are at risk for homelessness rather than addressing etiology exclusively (Buckner, 2004).

In the meantime, the third model, a reciprocal effects model of mental health and housing stability, posits that there are mutual effects of mental health and housing stability. Mental illness influences housing instability and housing situations, in turn, affect mental health status of the occupants. According to Easterlow and her colleagues (2003), housing and health are not in an opposed or exclusive relationship. "Rather, they represent two snapshots [at any point in time] of what is, in practice, a dynamic interplay, unfolding over time, between housing careers and health trajectories" (p. 502). The reciprocal model, especially the one suggested by Easterlow et al. (2003), is comparatively new, but it enables demonstration of continuous interactions between the two from an ecological perspective by introducing a concept of health capital whereby people tend to reduce potential health risks, increasing resilience, and improving

emotional well-being (Smith, Easterlow, Munro, & Turner, 2003).

It is notable that determination of which model provides the better explanatory framework for the links between mental health and housing can differ according to research questions. An epidemiological model seems appropriate to identify subpopulations at risk (i.e. those with mental disorders) for homelessness, while a reciprocal effects model may be a better fit for considering complex interactions between two variables in broader contexts.

The reciprocal effects model is fit for exploring refugees' experiences of housing and mental health issues in that they occur sequentially and the model allows for capturing a bigger picture of risk and preventive factors throughout the migration stages and the layers of social systems where mental health and housing give mutual influences in a series. Loss of home and other resources due to war and threat to life, for instance, causes psychological distress, which is likely to impede adjustment to the host community and thus to additional psychological distress. Given that refugees go through various challenges in each migration phase, it is important to identify critical factors that are relevant to refugee situations and that affect the interplay of housing insecurity and mental health in the contexts of resettlement.

Accumulated literatures have demonstrated that various and diverse variables can be associated with housing insecurity and have a direct effect on mental health. They range from demographic factors including education, gender, age and employment, to cultural and social resources, such as English fluency, family support and resettlement services (Gaines 1998; Butcher 1993; Jaranson, 1990; Alvidrez, 1999). According to

Acevedo (2004), risk/preventive factors regarding homelessness occur at three different levels: individual attributes, such as mental illness; structural influences, including economic hardships, housing markets, available housing resources, and residential segregation; and middle-range factors such as social networks and support. These three domains function as combined risk and preventive factors for homelessness and its psychological outcomes.

Refugee populations are situated in especially vulnerable positions in migrant and resettlement countries, considering not only socio-demographic characteristics or the individual level of resources but also social circumstances and support from the broader community. A lack of social support, pervasive among refugees, tends to exacerbate resources for affordable housing, and such housing insecurity in return contributes to the decrease in proper support from the community, which causes a vicious circle of lacking resources (Hawkins & Abrams, 2007). Loss of social support as well as personal resources is also known to be one of the major risk factors for psychological distress. Within limited social networks, refugees may have to develop limited options of coping strategies, such as tighter bonding with family members or people from the same ethnic community to manage housing concerns and to meet psychosocial needs (Marsiglia, Miles, Dustman, & Sills, 2002). This pattern of help-seeking may add additional dynamics to attaining resources and thus in managing stressful situations. Furthermore, compared to their counterparts in the host community, refugees are likely to have insufficient social services, which endanger refugees with no buffer to negative economic impacts, such as an unstable job market and lack of affordable housing. For refugees,

living in a different culture is a great challenge and turns out to be an additional risk factor. All the aforementioned risk factors, or preventive factors when reversed, may mutually influence the interplay of housing and mental health and exhibit complex and complicated interactions in the resettlement process over time.

Theoretical Frameworks

Three theoretical frameworks guided this study: (a) a social ecological theory; (b) stress and coping theory and (c) social capital theory. These theories, combined and individually, framed the construction of the research hypotheses and accordingly the design of the study, and yielded theoretical concepts to explore.

A social ecology theory. Refugee resettlement is a long-term process in which psychological, social, and cultural complexes interact actively in contextual systems (Aroian, 1990; Ager & Strang, 2008; Gonslaves, 1992). It is essential not only to understand environmental ecology and the contexts of migration and resettlement experiences, but also to consider the interactions between social actors and their environments and the changing systems around them. In fact, the challenges and resilience that refugees experience are extended in multiple contexts. For instance, exposure to war violence and family loss may influence family members' mental health and consequentially their coping and adjustment to the host society. The coping results then have an impact on employment and housing security and possibly community participation that shape ecological systems as well as family functioning and dynamics.

Ecological perspectives attract growing attention from many disciplines in social and human sciences. They originally evolved from the concept of ecology originating in

natural sciences (Pickett & Cadenasso, 2002; MaLaren & Hawe, 2004). Brunswick and Barker (1968 & 1978) suggested psychological ecology in behavioral settings, derived and evolved from the field theory of Kurt Lewin. Moos (1980, 1991) proposed a social ecological model of human adaptation, revealing how human beings cope with environmental stresses and interact with social resources in human and environmental systems. This popularity was possible due to its comprehensiveness and the contextualization of life events and social phenomena. In community psychology, for example, social ecological models have attracted increasing attention for community development, collective actions and cultural competence, Cultural ecological models were also adopted to investigate trauma in cultural systems (Hoshmand, 2007). Public health pays more attention to ecological systems to address health behaviors and health outcomes in broader environmental systems (Lounsbury & Mitchell, 2009). Ecological models have been applied to such subjects as youth violence (Tolan and Guerra, 1994; Umemoto et al., 2009), trauma and coping (Wong, 1993; Hobfoll, 1998), collective trauma (Wicke & Silver, 2009), parenting and parent-child relationships (Murry, Brown, Brody, Cutrona, & Simons, 2001), and disaster research (Green, 1996).

Ecological perspectives have also been proliferating in social work practice and research. Social work's ethical mission emphasizes helping individuals and families and addressing their needs while identifying available resources in social systems and environments (Woody, 2006). A person-in-environment perspective is aligned particularly well with the focus of social work on human needs within the resources available from multiple agents ranging from individuals to families, to communities, to

broader society and system.

One of the most frequently used and well-known ecological approaches in social work is Bronfenbrenner's family ecology model. Bronfenbrenner (1979) viewed human beings in the context of larger environments, which include personal, interpersonal, intergroup relations and dynamics with and within larger ecological settings. The levels of systems that Bronfenbrenner discussed include microsystem, mesosystem, exosystem, and macrosystem. Microsystems include individuals' interactions with the immediate environment such as interpersonal relationships and interactions, and physical settings and mesosystems refer to the relationships between microsystems such as family, school, work, and neighborhood. Exosystems mean environmental contexts of human development that include social and political agencies, neighborhoods, and economic structure, while macrosystems indicate broad social and institutional patterns of society and culture (Bronfenbrenner, 1979). Exosystems and macrosystems are somewhat overlapped, so three systems of micro-, meso-, and macro-systems are commonly used in social work (Hepworth, et al., 2010).

Although there is variation between different ecological models and theories, the fundamental assumptions and approaches to human behavior and social phenomena are common: ecological approaches focus on both individual and contextual aspects and the interplay between two (McLarsen & Hawe, 2004; Umemoto et al., 2009). Ecological frameworks enable one to delve into the dynamic interaction and organic relationships between individuals, groups, communities and broader societies. The person-in-context orientation of ecological models also allows for exploring multilayered social systems

and multilevel interactions between them. Especially when cultural factors should be considered, ecological approaches are optimally useful (Hoshmand, 2007). According to Sasao and Sue (1993), cultural complexity indicates the degree that a cultural group is defined within the environmental ecology and this process occurs at both individual and collective levels. An ecological perspective is a "conceptual vehicle" conveying culture and environments as well as a more contextual approach to acculturation (Trickett, 1996).

A social ecological model explicitly focuses on social, institutional, and cultural contexts in which social relations and interactions occur within and between systems as well as structures and processes (Lounsbury & Mitchell, 2009). Thus, this model allows exploring not only individual coping and adaptation but also social and communal strategies in a group or community that shares common cultural norms and beliefs. Also, this model is fit for dealing with complex situations occurring in multiple dimensions at multiple levels (McLaren & Hawe, 2005; Stokols, 1996). For instance, complex issues such as the accumulative effect of traumatic events over time can be investigated at individual, community, and societal levels, while considering different dimensions including personal attributes, neighborhood environments, and social services. In addition, a social ecological model emphasizes the mutual influences of systems and reciprocity of transactions such as bidirectional relations between individuals and the environment (Moos, 1991). Thus, the congruence and fit between individuals and the environment are regarded as the important predictor of human well-being in social ecological models (McLaren & Hawe, 2005).

Because of these strengths, a social ecological theory is advantageous to explore the

interwoven issues of housing and mental health in the resettlement process. The interplay between mental health and housing issues are an organic system. Mental health is embedded in housing contexts, while mental health plays as an important precedent and contingency of housing insecurity. The mutual influences of housing insecurity and mental disorders imply dynamic transactions in both individual and social contexts. Dynamic cycles of housing and mental health interactions are situated in larger systems and environments as well as situational contexts of resettlement and adjustment to a new culture. Accessibility or availability of social service systems and community resources will also influence housing management and mental wellness of refugee families and this also feeds into community development and wellness, which eventually leads to cultural assets for other members in the community and society as a whole.

Adaptation and resilience are other reasons for the relevance of the social ecological perspective to this research topic. Refugees are in the middle of transitions at psychological, cultural, economic, and social levels (Weine, 2001). Mental health and housing are understood within the dynamic course of adjustment and acculturation processes. In other words, to identify risk and preventive factors in the context of resettlement and acculturation it is useful to explore how a series of acculturating processes, both psychological and social, generate contexts and interact within spatial and situational systems. Resilience is a key concept to understand refugees' strengths and adjustment to the host society, and plays a critical role in understanding the cycles of changes and adaptive capacity (Gunderson and Holling, 2002). An ecological model is also useful for revealing coping with cultural assets and strengths in cultural minorities

(Hoshmand, 2007; Theokas & Lerner, 2006).

To understand the social ecology of housing and mental health among refugees, possible systems and potential dimensions need to be identified. The majority of inquiries adopting an ecological perspective focus on stratified levels of systems, such as macro, meso and micro, whereas not many studies pay attention to the time dimension of systems. Also, only a few studies include both time and space in the ecological system framework. Not only social systems but also time dimensions are essential in understanding the whole process of refugee migration and resettlement, since refugees' experiences that preceded migration and resettlement impact and shape their coping and adjustment in the host country. As one of few examples of adopting time levels in ecological systems, Farrell and Camou (2006) developed a grid that consists of four dimensions of different intervention domains in their study on youth violence prevention. These include ecological systems, developmental stages, level of risk, and goals of intervention program. The present study similarly uses an ecological framework with both time and social systems under consideration.

A few theoretical studies have attempted to conceptualize migration stages and culture shock models of immigrants and refugees. Williams (2009), for instance, developed a four-stage model of refugee parenting from an ecological perspective, which includes the social systems surrounding parenting according to four linear processes in: a) country of origin; b) pre-flight contexts; c) flight and forced migration; and d) resettlement. Among models focusing on refugees after resettlement, Gonsalves (1992) follows the four stage model of cultural sojourners' adjustment to the host society by

Grove & Torbiorn (1985), which consists of: a) early arrival; b) destabilization; c) experimentation and stabilization; and d) return to normal life. More recently, Markovizky and Samid (2008) established a U-curve three-stage social adjustment model, which is comprised of deterioration stage, low well-being stage, and recovery stage, to identify the specific timeline aligned with each stage of social adjustment to a new society. These stage models tend to focus on adaptive and maladaptive issues of each stage and how they impact human well-being. They are useful in understanding the process in a comprehensive frame and exploring cumulative impacts of previous experiences over time and in providing implications for policy interventions and service implementation. However, stage models may entail limitations by generalizing the adjustment and acculturation process to all refugees. In fact, the stage models assume common direction and goals of development which may not include the marginalized cases that hardly attain integration to the society. Stage models may be helpful in identifying experiences, such as pre-migration, migration and resettlement according to milestone events. However, they may not be able to explain multidirectional process such as adjustment and acculturation after resettlement, which occur at psychological, relational, and social levels.

To develop a hypothetical statement of the social ecology surrounding the issue of housing and mental health, this study included both the dimensions of social space and time to structure the complex contexts and transactions between systems. For a systematic approach to identify a structured conceptual frame as well as important dimensions among refugees, this study will adopt two main theoretical concepts, social

capital and acculturation, and propose an explanatory model revealing the multilayered social interactions and adjustment process of refugees in a social ecological web.

Stress and coping theory. Stress and coping is another theoretical heuristic that guided this study. Stress and coping theory has been proliferating in social sciences for the last three decades. The most prominent work on this comprehensive approach to probe stress and coping was proposed in the article "Stress, appraisal, and coping" by Lazarus and Folkman (1984). This model of stress and coping allows exploration of how stressful situations impact individuals, and especially focuses on mental health outcomes and how stressed individuals handle situations to reduce negative psychological impact (Lazarus & Folkman, 1984; Hobfall, 1989).

Although stress and coping are defined in various ways, many inquiries refer to the work of Lazarus and Folkman to address stress, especially psychological. Lazarus and Folkman (1984) defined stress as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p.19). Stressors, as a cause or source of psychological distress, refer to the issues and events that individuals in the situation perceive to actually or potentially threaten normal functioning and resources (Schneiderman, Ironson, & Siegel, 2005).

Stressful situations are to be managed through a coping process. Coping is broadly defined as cognitive or behavioral process to react to the stressors to avoid the stressful situation or reduce stress (Folkman & Moskowitz, 2004; Lazarus & Folkman, 1991; Thoits, 1995). Lazarus and Folkman (1984) especially emphasized the role of appraisal in

coping, which is a process of actively evaluating stressful demand (primary appraisal) and one's own ability to manage the situation using resources (secondary appraisal).

Resource is another critical concept in stress and coping theory. Resources are defined as "objects, personal characteristics, conditions, or energies that are valued by the individual, or that serve as a means for attainment of these objects, personal characteristics, conditions, or energies" (Hobfoll, 1989, p. 516). Resources are not only limited to one's personal domain, such as personal traits and properties, but also include social, environmental and cultural assets that are available for the person within the systems. Various coping resources range from self-esteem, personal coping skills, social status and material property to social support, services and policy, cultural norms, and community assets. Resources are known to moderate negative impacts of stressors and bolster coping (Banyard & Graham-Bermann, 1993). Both stress and coping are heavily influenced by resources that individuals possess (Hobfall, 1989; Hobfoll, Shcwarzer, & Chon, 1998).

Stress and coping theory provides an optimal set of concepts and a model to explain how precedents and consequences of refugee experiences affect mental health within the contexts of multiple challenges in both home and host countries. First, from a mental health perspective, stress and coping theory offers insight about how trauma may be construed as an extremely stressful event that affects refugees' mental health and their psychological well-being afterwards. Trauma, characterized as uncontrollable, unpredictable and life-threatening events, leads to challenges to coping, occurring at physical, emotional, cognitive, behavioral, and social levels (Schneiderman, et al., 2005).

Psychological symptoms of mental distress, such as depression and anxiety, have, in turn, been regarded as negative psychological outcomes of the traumatic stressors and unmatched coping strategies (DeNelsky & Boat, 1986).

Second, stress and coping theory can be embedded in ecological systems, which allows the researcher to explore refugees' stress and coping process interwoven with dynamics of environmental transition and change in resources. This makes stress and coping theory quite useful to the current investigation. Coping appraisal and behavioral strategies depend on stressors and resources within the contexts where refugees are situated (Folkman & Lazarus, 1986; Lazarus, 1999). Thus, stress and coping can be investigated not as an isolated process but as a product of dynamic interactions between social systems and the agent (Banyard, 1995).

The critical role of resources in stress and coping theory is another aspect that fits well for refugees' migration and resettlement experiences. When stressors are accumulated, they tend to lead to exhaustion of resources that a person possesses or can utilize, which eventually drives the person to a situation that is more vulnerable to psychological distress as a failure of coping (Lazarus & Folkman, 1984; Thoits, 1995). This also allows overcoming a medical model of mental health, while still addressing psychological outcomes of stressors and coping (Ager, 1997; Ryan, Dooley, & Benson, 2007; Watters, 2001).

Stressors. Scholars have conceptualized and verified various types and contexts of stressors, resources, and coping to articulate the mechanism and process of stress and coping. For stressors, one of the most cited classifications was proposed by Hobfoll

(1989), which is based on his Conservation of Resource (COR) theory. He categorized stressors into three conditions, which include: (a) the threat to resources; (b) the loss of resources; and (c) failure to gain resources after investment. Both perceived or estimated loss and actual loss of resources can cause stress. These categories, however, have been criticized as they dismiss or devalue psychological trauma, which is not necessarily involved with resources (Ryan, et al., 2008). Lazarus and Folkman (1984), therefore, included life-threatening events or security issues as high level stress-provokers.

Acculturative stress. One of the particular types of stressors applicable to the refugee population is acculturation stress. Numerous studies have applied stress and coping theory to immigrants' strategies for cross-cultural transition and social adjustment. Acculturation is defined as a dynamic process of psychological and behavioral adjustment and adaptation to a new culture (Sam & Berry, 1995). Conceptually, Berry's acculturation model, one of the most frequently adopted acculturation models, is construed of acculturative attitudes, changes in behaviors and stress caused by acculturation (Navas et al., 2005). Acculturative stress has attracted great attention in studies on health disparities among immigrants (Hunt, Schneider, & Comer, 2004; Salant & Lauderdale, 2003). Many studies have claimed that acculturation is significantly associated with the psychological well-being of ethnic minorities (Abu-Rayya, 2006; Gailly, 1996; Khan & Waheed, 2006; Berry, 2005). Even though it is not a direct effect, some inquiries revealed that acculturation positively affects psychological well-being by increasing self-efficacy which functions as psychological buffers to stressors (Wright, Johnston, & Weinman, 1995; Sohng, Sohng, & Yeam, 2002; Torres & Solberg, 2001).

Migration and demand for adaptation, however, are more likely to increase psychological distress, including anxiety, depression and other somatic symptoms (Berry, 1990; Berry & Kim, 1988; Ritsner, Modai, & Ponizovsky, 2000; Rotenberg, Kutsay, & Venger, 2000; Shuval, 1993).

Discrepancies between results about the impact of acculturation on mental health are suspected to result from conceptual confusion (Cabassa, 2003). Based on a bilinear model, Berry (2005) suggested two dimensions of acculturation: maintenance of cultural tradition and contact and adoption of the culture of the host society. These two dimensions yield four different strategic outcomes: integration (acceptance of both cultures), assimilation (participation in host culture without maintenance of traditional culture), separation (maintenance of traditional culture without participation in host culture) and marginalization (withdrawal from both cultures). Each type of acculturation tends to generate different mental health outcomes. For instance, integration tends to increase psychological well-being and reduce acculturation stress, while marginalization correlates with high levels of psychological distress (Berry, 2005). Assimilation is perceived as a source of stress, while segregation is associated with positive health status (Knipscheer & Kleber, 2007).

In spite of its adequacy and applicability to studies on refugees, the acculturation processes of refugees have been less discussed, either combined or separately with/from immigrants' acculturation. In spite of the contextual and situational differences surrounding emigration and settlement studies of acculturation have focused on cultural adjustment and adaptation. According to Berry (1997), it is important to consider how

people enter the acculturation process, based on three conditions of voluntary, mobility and permanence. For refugees, for example, the acculturation process starts with forced migration, and the purpose of resettlement tends to be for permanent or long-term settlement to the host country. Mental health research has posited that the effect of acculturation on mental health may have different results between immigrants and refugees because of high rates of pre-existing distress and PTSD that refugees tend to have (Carlson & Rosser-Hogan, 1993; Salant & Lauderdale, 2003). Aversive situations after resettlement are likely to aggravate mental health conditions, adding additional acculturation stress due to lack of emotional and material support (Berry, 1997; Sue & Sue, 2003). Aggregated distress tends to deteriorate mental health issues developed through migration and resettlement processes and thus tends impede coping ability to handle new challenges and adjustment to the new culture (Chung & Bemak, 2002; Weine, et al., 2004).

As Cabassa (2003) postulated, acculturation as well as stress driven from acculturation should be considered within the contexts where it occurs (Berry, 1997; Ryder, Alden, & Paulhus, 2000). Since many health researchers focus heavily on intra-psychic model of acculturative stress, and thus on the psychometrics of acculturation, psychological scales have received criticism for simplifying acculturation process and removing situational contexts (Salant & Lauderdale, 2003; Hunt, Schneider, & Comer, 2004). Cabassa (2003) also suggests that consideration of the prior immigration context is necessary in terms of the political, economic, and social situations of the home country as well as attributes of individuals at the social and psychological level. As cultural

adaptation occurs at multi-dimensional levels, time and environmental contexts are critical to understand the acculturation process.

Resources. Resource can be sorted according to their source in social systems, ranging from personal to family, social, cultural, and environmental resources. Personal resources refer to personal ability to cope with stressors, consisting of financial or material (eg.: savings and property), educational (eg.: school diploma or degree, literacy), health (eg.: disease in negative direction), and psychological resources (eg.: self-esteem, self-efficacy) (Kwai-sang Yau & Li-Tsang, 1999). Each component of personal resources has been identified as a risk factor for developing psychological distress in many studies, in cases in which the resource is lacking (Wilkinson, 1996). Overemphasis on personal resources, also known as trait-based resources, has been criticized as its conclusion often leads to development of personal coping skills rather than understanding contextual influences and acknowledging the social facets of the coping process (Ryan et al., 2007).

At a family level, resources are what family members can draw from each other for coping. They include socio-economic (e.g.: social status, employment and family income), psychological (e.g.: emotional support), and physical (e.g.: human capital in household and family health) resources (Burr et al., 1994). Family resources differ depending on family structure and dynamics and can fluctuate as family structure changes. Two-parent and single-parent families, for instance, are likely to develop different characteristics of family resources, which impact not only their coping strategies and outcomes but also potential stressors that the family can encounter. Gender roles of parents and parental coalition have been the focus of family stress and coping theory in

this regard (Davies, 1997).

Social resources are "beneficial aspects of personal relationships" (Ryan, et al., 2007, p.7). Although they have not been conceptualized through social capital theory in the previous studies, the definition of social resources is highly matched with the meaning and function of social capital. These include any form of assets derived from social relationships and networks, such as emotional support, informal and formal help, access to information, and sense of belonging and integration. The notion of social capital is covered in greater depth in the following section.

The concept of cultural resources was proposed by Ryan and his colleagues (2007) to explain adaptation process where resources are shaped by cultural contexts. "Cultural resources can be seen as a 'toolkit' that is provided by one's culture" and "includes linguistic skills, literacy, education, computer skills and occupational skills" (p.8). Cultural resources also can be expanded to cultural knowledge such as "familiarity with various services and system in a particular cultural environment, such as public transport systems and banks," and "knowledge of physical surroundings and climate" (p.8). Although conceptually overlapped with other types of resources, a set of cultural resources functions uniquely in the process of adaptation in a new culture and thus the author adopted this separate category and applied it to refugee situation.

Environmental resources refer to conditions that are advantageous to coping. Both Hobfoll and Lazarus and Folkman (1984) acknowledged the importance of the environment and mentioned environmental resources. This type of resource has not been clearly defined as a separate resource in previous literatures. Rather, it has been treated as

a constraint or a stressor that impedes coping as a form of environmental influence. The author included environmental resources as a distinctive form of resource as it helps explain the shift of what resources are available or unavailable depending on the physical environment where refugees migrate and resettle. For example, sanitized water and foods are commonly-found environment resources in the resettlement country, while access to them is very challenging in many refugee camps. Social structure and public assets, such as hospitals, schools, and service programs, are also included in environmental resources. The availability and accessibility of environmental resources is heavily dependent on both social and natural environments surrounding a person.

All five types of resources, personal, family, social, cultural, and environmental, are considered in this study to explore how these resources, individually and combined, facilitate or constrain refugees' coping with multiple stressors.

Coping. Depending on its focus and direction, coping is divided into two categories: problem-focused coping and emotion-focused coping. Problem-focused coping refers to coping strategies aimed at solving problems or attempting to change the source of stress, while emotion-focused coping refers to efforts to reduce psychological distress caused by stressors (Carver & Scheier, 1994; Moos & Schaefer, 1993; Lazarus & Folkman, 1984). Problem-focused coping is associated with appraisal of the situation as a controllable stressor and thus is likely to link to positive psychological outcomes, while emotion-focused coping is related to perceiving stressors as uncontrollable events, which leads to more psychological distress and mental health symptoms, such as depression and anxiety (Pakenham &Rinaldis, 2001; Williams, Hagerty, Yousha, Hoyle, & Oe, 2002).

Another type of coping is avoidance, which is opposed to what is called approach coping, such as problem-focused and emotion-focused coping. Avoidance refers to cognitive and/or behavioral efforts to stay away from a stressful event and situation by ignoring or repressing the stressor (Compas, Connor, Saltzman, Thomsen, & Wadsworth, 1999; Bernard, Cohen, McClellan, & MacLaren, 2004). Avoidant coping has adaptive functions in the short term, although it may be problematic in the long run (Van Der Kolk & McFarlane, 1996). As Herman (1992) pointed out, avoidance, including suppression and distraction, is one of the major psychological coping strategies responding to traumatic events. This may work for survival of extreme trauma but this pattern of coping may also result in "atrophy in the psychological capacities that have been suppressed" and is thus maladaptive in solving further stressors (Herman, 1992, p.87).

Opposed to avoidance, proactive coping, proposed by Aspinwall and Taylor (1997), indicates a coping process through which people predict and estimate potential harms, loss, threat, and challenges that tend to cause distress and prepare for them by taking action in advance (Ouwehand, de Ridder, & Bensing, 2008). This notion helps explain human needs in the life course and the role of planning and expectation for incoming challenges and management. Proactive coping is related to the types of potential stressors and threat, such as natural disaster and war. Social support is one of the factors that is highly associated with proactive coping in that social support tends to inform potential challenges and help anticipate incoming stressors (Greenglass & Fiksenbaum, 2009; Thoits, 1995).

Depending on the method and source of coping resources and references, family

coping (Burr et al., 1994) and religious and/or spiritual coping (Folkman & Moskowitz, 2004) have been identified as major types of coping.

Social capital theory. Social capital has been defined in various ways. Social capital often refers to the social and organizational ties that individuals can draw upon for assistance (Stanton-Salazar, 1997) and thus the resources available through social relationships and networks (Kawachi & Berkman, 2000). Putnam (1993) defined social capital as a social structure including the network of interpersonal and intergroup relationships within and between family and community, which facilitate actions in the structure where a person lives. Coleman (1988) conceptualized social capital both inside and outside of the family. The former type of social capital regards to cooperative relationships among family members as well as the time and attention each member pays the others. Outside of the family, social capital encompasses the social relationships that exist among individuals, families, and institutions that create opportunities for consistent positive expectations and experiences. Although variant, two common components of social capital in these definitions are teh centrality of relationships and resources embedded in the relationships (Burt, 1992; McFadyen & Cannella; 2004).

Social capital consists of three types, bonding, bridging, and linking social capital. Bonding social capital refers to exclusive social ties based on homogeneity, while bridging social capital means social association across diverse social groups (Putnam, 1993). Linking social capital refers to interactions with structures of the State. This level of social relations and resources may be aligned with upper macrosystems as conceptual pairs. This distinction enables discerning different levels of connectedness and support

system and helps to reveal dynamic linkage and mutual relations of individuals, family, community, and society. For instance, an empirical study revealed that most newly-settled immigrants and refugees rely more on bonding social capital, while bridging social capital helps minority group members to connect better to the broader community (Nannestad, Svendsen & Svendsen, 2008). Ager and Strang (2008) also found that refugees' bonding capital (involvement with the same ethnic group members) is related to the reported quality of life, regardless of the level of bridging social capital (involvement with cultural other communities). This categorization is especially useful to explore immigrant and refugee populations whose cultural or ethnic background is different from those in the host society.

Social capital contains acculturative implications when applied to immigrant or refugee populations. Two types of social capital, bonding and bridging, are particularly theoretically aligned with two dimensions of acculturation, cultural maintenance (i.e. following traditional values and norms) and participation in/contact with host culture (i.e. acceptance of American culture). For instance, bonding social capital implies more interactions within the homogenous community and this may be closely related to acculturation strategies of cultural maintenance. In the meanwhile, bridging social capital is theoretically aligned with the other dimension of acculturation process, active participation in the host society and acceptance of new culture. Thus, the amount and the quality of bridging social capital may imply a refugee's status of acculturation level. Even though the links between social capital and acculturation may not be as simple and direct as mentioned above, the interactive effects of the components of bonding and

bridging social capital may enable more precise understanding of the relationships between social networks and ecological systems of refugees and their coping strategies for adjustment.

Social capital theory is well aligned with both a social ecological perspective and stress and coping theory due to its multidimensional and interactive features of social relationships and resources depending on the types and levels of social capital (Hoshmand, 2007). Lochner, Kawachi, and Kennedy (1999), for example, address social capital by adopting and integrating ecological concepts of collective efficacy, sense of community, neighborhood cohesion, and community competence. Black, Cook, Murry, and Cutrona (2005) applied an ecological theory to find roles of different social support levels in African American women's health functioning. Embedding social capital in a social ecological model will help in exploring interactive social transactions between agencies and systems in the current study.

Social capital theory is also useful in explaining how refugees cope with stressors as it suggests the level and the quality of resources available for a person in the surrounding socio-ecological systems. Previous studies have revealed that certain resources are available or accessible based on group membership (Hero, 2007; Muhkerjee, 2007). Therefore, the types of prominent social capital matter in explaining what coping resources a person or a group can utilize especially when the person or group belongs to a low-resource community (Hawkins & Maurer, 2010; Lin, 2001). As Hawkins and Maurer (2011) articulated, social capital is a unique concept to provide a means to "assess the value of the resources garnered via a network or to fully understand how a network

functions to help or hinder positive outcomes" (p.4).

Social capital theory has a few characteristics and benefits distinctive from other theories that it was derived from, such as theories of social support, social exchange, and social networks. While social networks indicate social links and relationships between individuals and groups that individuals possess, social support refers to "provision and receipt of assistance to and from individuals" (Hawkins & Maurer, 2011, p. 3). Social capital, in the meantime, implies social systems that include extensive perspectives not only on interaction but also on values and cohesion between individuals, groups, communities, and broader societies. Many studies on homelessness and mental health have adopted social support and social network theories to explain the process of homelessness and the successful factors to escape homelessness (Tischler, 2006; Bassuk, 1997; Killworth, McCarty, & Bernard, 1998). Although significant associations have been found between social support or networks and the variables of interest, only social capital theory can consider dynamic circumstances where refugees are situated and focus on interactions with multilayered parties of individuals and society.

Application of social capital to current study. Social capital theory has been applied to various social issues and phenomena, including homelessness and mental health as well as service access among cultural minority groups. Several empirical studies have uncovered the important role of social capital in homelessness and related risk factors. For instance, social capital, sometimes along with human capital, turned out to be more important than disability or economic capital in predicting homelessness (Shinn, Gottlieb, Wett, & Bahl, 2007). Social capital also mediates negative psychological

symptoms, such as suicidal ideation, for homeless adults (Fitzpatrick, Irwin, Lagory, & Ritchey, 2007). Many empirical studies have indicated that social capital itself may not function directly in recovering from homelessness due to high costs associated with re-housing, but it can play an important role in preventing people from becoming homeless and mitigate psychological distress (Lin, 2001; Shinn et al., 2007).

The effect of social capital on mental health has been also widely supported. Previous studies in public health have confirmed that social capital promotes mental health (Dalgard & Tambs, 1997; Thomas, Weaver, Bell, & Lewis, 2007; Arayaa et al., 2006; Ross, 2000). Some show that particular geographical areas that consist of high social capital are associated with mental health (Skapinakis et al., 2005), while residential instability and poor neighborhood environments are linked to depression (Ross, 2000). Others demonstrate the relationship between environmental characteristics and psychiatric symptoms (Dalgard & Tambs, 1997; Sampson, 2003; Weich et al., 2002).

As McKenzie and his colleagues (2002) pointed out, however, the links between social capital and mental health are rather complex. Poor social environments are associated with social disadvantage and thus with exposure to more psychosocial stressors, which tend to lead to the onset of psychological distress and symptoms (Bebbington et al. 1993; Cullen &Whiteford, 2001).When psychological and social resources are abundant, they play a role as preventive factors against the psychosocial stressors (Marsella 1995; Muntaner & Eaton 1998). According to Cullen & Whiteford (2001), the social factors contributing to depression, such as financial difficulties, low social status and unstable jobs are under the direct or indirect influence of social capital.

According to McKenzie et al. (2002), in spite of its complexity, social capital can provide a comprehensive framework to understand long-debated issues such as the composition or context of mental health disparities by including ecological, geographical and socioeconomic structures and fabrics.

Another important aspect of the meaning of social capital is related to help-seeking behavior and the use of social services, particularly those among cultural minority groups. When there remain few resources for the homeless, seeking help outside of family or friends depends on accessibility to the public systems and broader community. Cultural minority populations, including refugees, tend to have limited purview of social networks even before starting resettlement and thus start with limited social support in the host country. This often leads them to rely more heavily on family resources than other groups (Shinn, Knickman, & Weitzman, 1991). Immigrants and refugees tend to have different patterns in seeking formal and informal help and in utilizing social resources, which is associated with patterns of social capital as well (Shor, 2007; May, 1992). Family bonds are one of the most important types of social capital that immigrants have (Sander & Nee, 1996), which is aligned with the fact that seeking help mainly from family members is characteristic among Latino, as well as Asian immigrants (Cabassa, 2007). Thus, social capital allows estimating potential resources at both individual and community levels based on dynamics of social networks and ties as well as trust between individuals, families, groups, and communities.

As outlined above, the three theories in this study, social ecology theory, stress and coping theory, and social capital theory offer an array of unique theoretical concepts and

frames to explain dynamic relationships between the concepts of mental health and homelessness, both individually and combined. Based on these theoretical frameworks, the author developed the research questions and hypotheses of the current study.

Research Questions and Hypotheses

Adopting an ecological perspective, this exploratory inquiry identifies the problems of housing insecurity and psychological distress among refugee families and situates these issues in ecological contexts encompassing multilayered social systems as well as migration stages. The phenomena of focus in the current study propose a unique combination of research questions and hypotheses, due to both the knowledge gap in empirical evidence and the correspondence of previous theories with the subject matter of the study.

The author developed several research questions along with hypotheses that were extracted from the three theoretical frameworks described above. As this study attempted to both test and build a theory, the author started with tentative hypotheses that were open to additional concepts that could emerge from actual data collected for this study. When relationships between concepts are clear or well supported by the previous studies, these were established as a hypothesis, while if there was a knowledge gap in certain concepts and links, they were developed as research questions. Four theoretical concepts based on stress and coping theory provided the main frames of the questions and hypotheses. A social ecology theory provided overall heuristics to approach the research questions and hypotheses, while social capital theory offered specific concepts key to the questions and hypotheses, particularly coping and resources in the stress and coping mechanism.

Following are the research questions and hypotheses to be examined and tested in this study.

A. **Stressors** (Research Questions/Hypotheses: R/H)

   a. **R1. What stressors do refugee families experience before migration, during migration, and after migration (resettlement)?**

   b. **H1. It is likely that refugee families have been exposed to multiple stressors, types of which vary ranging from threat to resources, harm/loss of resources, challenges, and security.**

Considering refugee conditions of forced migration and cultural challenges after relocation, it is estimated that refugee families experience multiple events and situations that cause psychological distress. Given the multilayered life challenges in the environments and circumstances where refugees are situated, it is not realistic to assume a single incidence of a stressful event comprises a source of psychological distress and mental health issues, even if one of the stressors is a major stressful event and others are less influential or secondary.

Different types of stressors are expected to be found in refugee experiences. Although Hobfoll (1998) argued that stressors are associated heavily with resources (i.e. threat to resources, loss of resources, or failure to gain resources after investment of resources), the author believes that refugees are likely to have undergone different types of stressors not necessarily related to resources, such as violation of human rights, broken community ethics, war, and political and/or sexual violence. In this regard, the first hypothesis is formulated not only to confirm that refugees experience various stressors

but also to explore types of stressors in refugee migration and resettlement processes.

c. **H2. It is likely that refugee families have gone through new kinds of stressors that are unique to each migration stage: pre-migration, migration and post-migration.**

Along with the first hypothesis, the author postulated that refugee families may have faced various types of challenges in different phases of migration. Before having fled from the home country, refugees are exposed to life-threatening events and thus threat to life and security issues are of major concern, which may continue even during exile due to the fear of repatriation and/or an attack from insurgents or government soldiers, for instance. While located in a migrant country, usually while living in refugee camps, lack of resources (such as foods, clothes, medical care, and family separation or loss) may be the most obvious source of stress. Upon resettlement, additional challenges emerge, such as acculturation stress including language barriers, lack of transportation, and social isolation. Even though each family has a unique experience in the migration and resettlement phases, common themes are expected to be found in each phase.

a. **H3. Homelessness is not an isolated issue, but is associated with other multiple stressors.**

The author assumed that refugee homelessness resulted from aggregated challenges and difficulties upon resettlement. Thus, lack of stable housing comes along with other stressors and housing issues are an anticipated result of such challenges as unemployment, lack of social support, language barriers, and/or family loss. In this regard, housing issues may not be seen as a sole stressor. Rather, housing concerns are associated with other

stressors, such as stressors regarding the resources for solving housing issues.

B. Resources and Coping

a. R2. How have resources available for refugee families been changed?

b. R3. How do refugee families cope with stressors and psychological distress?

c. H4. The stressors that refugees experience are likely to significantly threaten or deteriorate resources at all levels.

The author hypothesized that multiple stressors stretch coping resources that refugee families possess and stressors demand different types of resources for coping at varied points of time. Multiple stressors continuously play against resources not only that refugees have but also that families can attain. Depending on migration phases, types of resources at risk may also differ. Threat to and actual loss of personal and family resources as well as environmental loss, for instance, may be common stressors in the home country. Forced migration and relocation tend to nullify some resources that refugees took for granted, such as language/communication ability, mobility, regional familiarity, and cultural practice and values. These devalued resources may turn into burdens or become another stressor when living in a different culture.

d. H5. Failure to (re)build social capital may critically impede adjustment to a new environment.

Social capital may be especially vulnerable to certain types of stressors. Considering the common trauma and hardships refugees go through, broken social capital is a predictable consequence of stressors. Stressors not only destroy or break social

capital, but lead to rearranging of the relational structure of social systems which reshapes social capital. As social capital is a structure of social relationship as well, it gets loose or even broken after multiple stressors. Loss of family and community, for instance, are directly linked to broken bonding social capital, while exile from the home country implies loss of linking social capital. Displacement and relocation tend to lead refugees to exposure to heterogeneous environments, sometimes exclusively. Such diversified settings may not have been an active part of social systems to many refugees beforehand. These dynamic changes and transition of all levels of social capital will result in change in coping options and strategies.

a. **H6. Refugee families tend to adopt coping strategies to increase social capital.**
b. **H7. Refugee families are more likely to develop problem-focused coping strategies than emotion-focused ones.**

The author hypothesized that the coping strategies used by refugee families are focused on problems and seek for direct solutions. Considering that mental health issues are less discussed in non-Western culture, including the refugee community, it is likely that refugee families have narrow options of management of emotional suffering and psychological distress. Mental health issues are highly stigmatized and thus expression of psychological stress is often perceived as a sign of weakens in refugee communities.

C. Psychological outcomes

a. **R4. What psychological distress do refugee families experience?**
b. **R5. How does homelessness or lack of stable housing affect refugee**

families' psychological well-being?

c. **H8. As a result of imbalance between stressors and resources and failed coping, refugee families are likely to experience tremendous psychological distress.**

Psychological distress, according to stress and coping theory, is a consequence of lacking resources to deal with stressors. The author included failed coping as another main source of psychological distress since certain stressors, such as acculturation stress, break down the coping mechanism that used to function well. The frustrated coping strategies and impeded coping capacity will lead refugees to psychologically vulnerable situations and thus cause great psychological distress.

d. **H9. Absence of emotion-focused coping strategies as well as limited bonding social capital tends to exacerbate mental health issues.**

Along with the hypothesis H8, the author assumed that psychological outcomes will be different depending on how effective the coping was and what type of coping was adequately used. Based on the assumption that emotional coping strategies may directly correspond with psychological distress, it is expected that refugee families using emotion-focused coping may develop less psychological distress, while preventing deterioration.

Also, aligned with the findings from the previous studies, social capital, particularly boding social capital, is anticipated to be positively associated with mental health outcome. That is, the more bonding social capital a refugee family owns, the less psychological distress compared to those without bonding social capital.

Chapter 3. Methods

This chapter will discuss why a qualitative research design, and the analytic induction method in particular, is adopted in the current study, explaining the characteristics of the design and benefits for the research question of this dissertation. The author will also describe how this research sampled, collected, and analyzed qualitative data to investigate refugee mental health experiences and coping with distress and housing issues in the contexts of migration and resettlement. Ethics and reflexivity of the research will be discussed followed by the limitations of the research design.

Qualitative Research Design

This study aimed to explore the accumulated stressors and coping strategies among refugee families who are situated in an adverse and intractable circumstance: homelessness. In particular, the author aimed to understand refugee families' experience of stressors through the migration and resettlement processes and their coping strategies utilizing resources in the surrounding social ecological systems. Previous research using stress and coping theories to inquire about similar, if not identical, topics has been of great use and has contributed to the field by filling knowledge gaps and providing implications for further studies in the area. They, however, have rarely been applied to refugee populations and the contexts of forced migration. Thus, the author intended to apply the stress and coping theory, along with social ecology and social capital theories, to mental health and housing in refugee families in order to develop, test, and modify an adequate model to explain multiple stressors and coping resources from refugee families' perspectives in social ecological contexts.

To investigate the abovementioned areas, this study adopted a qualitative research design for several reasons. First, qualitative research methods are used to explore realities and meanings that can be viewed from multiple perspectives by a subject (Bogdan & Biklen, 2003; Patton, 2002). Qualitative methods are beneficial to inquire about less-known phenomenon that can be understood from an inductive approach (Padgett, 1998). It, therefore, allows an emic or native approach to the subject matter, which is advantageous to understand culturally diverse issues, meanings, and themes (Schreiber, 2001; Kuzel, 2000). As little is known about the dynamics among accumulated challenges including housing insecurity (stressors), mental health (psychological outcome), and social capital (coping resources) in refugee populations, the investigator determined that an exploratory research procedure of a qualitative research design would be suitable to uncover these obscure subjects.

Second, use of a qualitative method enables the researcher to investigate family experiences and coping strategies, considering dynamics in and of families. Since migration and resettlement difficulties, as well as coping with these challenges, occur at family level, rather than as an individual unit, it is necessary to apply more flexible and adjustable means of inquiring about this topic. The stressors and resources, for example, will be better understood by asking about the meaning and perceived experiences of families according to time and situation, as the questions need to tailor to the unique experiences of the family instead of assumptions for general populations. Rosenblatt & Fischer (1993) claimed that qualitative methods are especially valuable in investigating

family systems and dynamics by allowing "sensitive exploration of the multiple viewpoints of family members" (p.173).

Third, qualitative methods are useful in investigating sensitive and complex topics. Qualitative strategies are especially advantageous in revealing time-sensitive issues or situational subject matter, including issues involved in complicated feelings, meanings, values, and beliefs (Rosenblatt & Fischer, 1993). Considering the complexity and time-sensitivity of the subject of the current study, qualitative methods are beneficial.

Fourth, due to its inductive nature, a qualitative research method allows a hypothesis or a theory to be derived from observation by discovering patterns from the data (Pope & Mays, 1995). According to Glaser and Strauss (1967), qualitative research is powerful not only in building a theory but also in testing a theory, due to the richness of data and the creative transition between inductive and deductive processes of analyses. This unique strength of qualitative methods will allow the author to both build and test a set of hypothetical speculations according to emerging evidence from rich qualitative data.

Modified Analytic Induction

Analytic induction is known as "a non-experimental qualitative sociological method that employs an exhaustive examination of cases in order to prove universal, causal generalizations" (Manning, 1982, p. 280). It was developed by Znaniecki (1934) to reveal causality by developing hypotheses drawn from data and comparing the hypotheses with emerging incidences (Ratcliff, 1994). Although analytic induction has the same roots as does grounded theory, analytic induction has remained devalued due to

the positivistic view of the people utilizing this method, which is not necessarily within its principles (Gilgun, 1994 & 2001). As Gilgun (1992 & 2001) and Ratcliff (1994) pointed out, analytic induction is not for the purpose of testing causality only. Rather, analytic induction is to identify, elaborate, and modify hypotheses on concepts and relationships based on qualitative data and emerging findings (Gilgun, 2001; Bogdan & Biklen, 1992). To distinguish between the positivist use of analytic induction and the application of analytic induction to testing concepts and relationships, the latter is has been called modified analytic induction (Bogdan & Biklen, 1992). It is this modified analytic induction approach that was utilized in the completion of this study.

Modified analytic induction has advantages for the current study. First, analytic induction allows testing a theory while embracing themes and concepts emerging from qualitative data. While grounded theory is to discover or build a theory from emerging themes and categories grounded to the data, modified analytic induction allows the researcher to both test hypotheses and develop a theory (Strauss & Corbin, 1990; Gilgun, 2001). In fact, analytic induction is one of the few qualitative methods that allows for investigators' pre-held theoretical perspectives (Rettig et al., 1996). In other words, the current researcher can apply and test her theoretical frameworks to the topic with empirical cases and thus amend and improve the theories through the modified analytic induction approach.

Inductive analysis in analytic induction, which is often missing in quantitative research, also has a great strength to reshape and improve a theory according to emerging cases (Ratcliff, 1994). This dissertation research is spurred by lack of adequate measures

and models to explain common stressors and coping strategies, such as mental health and housing concerns in refugee communities. By building and organizing patterns and relationships derived from data into theoretical categories and abstractions (Creswell, 2007), analytic induction helps the researcher to explain the meaning and function of refugee experiences in a culturally sensitive manner. Analytic induction fits for a subject that entails a person's action proceeding in a broader social context over an expansive period of time. Analytic induction is closely aligned with the theoretical perspective of symbolic interaction (Katz, 2001). It posits that "a person's actions are built up and evolve over time through processes of learning, trial-and-error, and adjustment to responses by others" (Katz, 2001, p.5). Analytic induction has been used in ethnography research due to its principle of relying on the cases from the insider's point of view. "By redefining phenomena from the actor's perspective and by discovering and testing an analysis of how given forms of social life come into existence, analytic induction makes unique contributions that may be appreciated without gainsaying the contributions of statistical research" (p.13 Katz, 2001, p.13).

Development of Hypotheses

To perform the analytic induction method, the researcher followed the six steps suggested by Robinson (1951), which together are known to be a typical approach to analytic induction (Ratcliff, 1994): (a) definition of phenomena; (b) formulation of hypotheses or theoretical propositions; (c) evaluation of the formulated hypotheses based on an incidence/case; (d) alteration of the hypotheses or definition when falsified by a negative case; (e) continuous falsification or confirmation of the hypotheses with new

cases; and (f) reformulation of the hypotheses until no exception is found. This six step procedure guided the definition of the phenomena, the formation of hypotheses, and testing and modification of the developed hypotheses in this study.

Defining the phenomena. The first step is to define phenomena of interest. As analytic induction is to develop universal statements to explain certain phenomena, it needs to start with delineating the essential features that illuminate the core value and characteristics of the phenomena (Rettig et al., 1997). The problematic phenomenon of focus in this study is accumulated challenges, often expressed as a form of homelessness, which affects psychological distress and lack of coping resources, particularly social capital, upon resettlement among refugee families. Due to the paucity of knowledge on this issue, the author conducted comprehensive research on the empirical studies on related topics or with populations in similar conditions. The core theoretical concepts identified in this process include: stressors, coping, resources, and psychological outcomes. These concepts were allocated in a social ecological web that is comprised of time (i.e. migration and resettlement phases) and social systems (i.e. social ecological systems that consist of individual, family, group, community, and broader society). Each definition was provided in the previous chapter.

Hypothesis formulation. The second step is to formulate hypotheses in a tentative manner. Gilgun (1995) pointed out that unlike other qualitative methods, analytic induction enables investigators to utilize and apply their theoretical knowledge based on academic insights and professional experiences. Developing working hypotheses is the most critical part of the analytic induction method as it provides

researchers with guiding heuristics and leads to consistent comparison across cases (Robinson, 1951). The formed hypotheses, however, are still tentative because they can be rejected or revised whenever a case against the hypotheses emerges (Ratcliff, 1994). According to Gilgun (2001), the sources to build hypotheses vary, ranging from "hunches, intuition, experiences, descriptive hypotheses, derived from related research and theory, or deduced from higher-order hypotheses" (p.12). To establish working hypotheses, the author used both her experiences in working with refugee populations and the existing body of knowledge on the topic. The theories that the author applied to the phenomena of focus in this study were social ecology, stress and coping, and social capital theories. These three theoretical frameworks guided the researcher to shape the research hypotheses.

Evaluation of hypotheses based on cases. The next step is to evaluate the hypotheses with a case. While some studies utilize the first case, often derived from an interview method, to develop hypotheses, many others use the first case for testing the formulated hypotheses (Gilgun, 2001; Ratcliff, 1994). The author conducted an interview and used it to compare with the hypotheses to adjust them to the emerging theme or concept, if any, from the actual case. This process was not limited to the first case, but repeated through comparisons within and across cases until the end of data gathering. Gilgun (2001) suggested that this process will let researchers alter their hypotheses or narrow the scope of the subject matter according to their finding when a case disproves the researcher's theory. The author did not find a substantial discrepancy between the

hypotheses and the finding from the first interview, so she moved on to the next steps to test hypotheses with further incidences.

Negative case analysis, revision, and reformulation. Steps 4, 5, and 6 are to falsify and modify the concepts and hypotheses. During these phases, researchers conduct negative case analyses, which are the critical process of analytic induction similar to continuous comparative method in grounded theory (Gilgun, 1995; Gilgun,, 2001). Continuously comparing emerging negative cases with the hypotheses, the author revised the hypotheses by removing falsified concepts and relationships and adding newly cropped themes and links. Two examples of applying theses steps for testing hypotheses are demonstrated in Table 3.1.

Table 3.1. Testing a hypothesis following six steps.

Hypothesis	Steps for Hypotheses Testing	Statements/Hypotheses	Negative Case(s) and/or Emerging Theme(s)
H1	1. Definition of Phenomena	Refugee families have gone through tremendous challenges and hardships through migration and resettlement processes.	
	2. Formulation of Hypotheses	It is likely that refugee families have been exposed to multiple stressors, types of which vary ranging from threat to resources, harm/loss of resources, challenges, and security.	
	3. Evaluation of Formulated Hypotheses	Stressors include change in social status and symbolic loss as well.	Emergent theme: "There is peace and no fear of losing life over starvation, disease or war. But our social status has changed. We lived in a familiar area, even though in a refugee camp, we had made friends and were familiar with everything around us. That alone gave us confidence to face the challenges. We are now in a totally strange world which we know nothing about. Not being able to communicate is like being locked in prison. You can't express your emotions, whether angry or happy, you can't ask for help from anyone unless they speak Somali (SO)."

	4. Alteration of Hypotheses	It is likely that refugee families have been exposed to multiple stressors, types of which vary ranging from threat to resources, harm/loss of resources, challenges, security, and symbolic loss such as social status.	
	5. Continuous Falsification/ Confirmation	Hypothesis confirmed.	Negative Case: N/A
	6. Reformulation of Hypotheses	It is likely that refugee families have been exposed to multiple stressors, types of which vary ranging from threat to resources, harm/loss of resources, challenges, security, and symbolic loss such as social status.	
H8	1. Definition of Phenomena	Refugee families have experienced a high level of psychological distress during migration and resettlement processes while experiencing multiple stressors.	
	2. Formulation of Hypotheses	As a result of imbalance between stressors and resources and failed coping, refugee families are likely to experience tremendous psychological distress (H8).	
	3. Evaluation of Formulated Hypotheses	Psychological distress is not only due to a gap between stressors and coping resources, but also because of trauma, including family loss.	Negative Case: "I left [Somalia] in 2006 and I left for lack of safety. My husband was killed and I couldn't sleep (SO)."

		Although family loss can be interpreted as a loss of family resources, it does not necessarily have to do with failed coping or imbalance between stressors and resources.	<u>Emergent theme</u>: Trauma causes psychological distress before and during migration.
4.	Alteration of Hypotheses	Refugee families are likely to experience tremendous psychological distress as a result of imbalance between stressors and coping resources as well as experience of trauma including family loss.	
5.	Continuous Falsification/ Confirmation	Coping style and capacity influenced the level of psychological distress that the family experienced. Religious coping, for instance, was one of the most salient preventive factors for better psychological suffering. Thus, stressors and lacking coping resources may not necessarily impede refugee mental health.	<u>Negative Cases:</u> N/A <u>Emerging themes:</u> Religious coping as a preventive factor for psychological distress. *Ex1*. "It was not you can do something with. It's God's will (SO)." *Ex2*. "Personally if you believe in God you know you win some and lose some. We never lose hope, even though I don't speak English I applied for jobs and I want to work if they hire me. I am hopeful (SO)."
6.	Reformulation of Hypotheses	Refugee families are likely to experience tremendous psychological distress as a result of	

	imbalance between stressors and coping resources as well as experience of trauma including family loss, although religious coping is a preventive factor.	

Sampling

The current study used a purposive sampling technique in order to collect data that may satisfy the purpose of hypothesis-testing. Although refugees are known to have many issues in common, including experiences of traumatic events, significant losses of social support, a language barrier, and acculturative challenges, this study focused on collecting samples of refugees in the most vulnerable situations.

At the same time, the researcher was aware that homeless refugee families consist of various ranges of groups with diverse characteristics, such as different family compositions, household size, living arrangement, experience in secondary migration, presence of domestic violence, disability or physical health problems, diverse cultural backgrounds, length of residence in the U.S., and so forth. In this respect, diversity of the group is considered to contribute toward the representativeness of the population. To include a variety of cases and grasp diverse experiences of refugee families, it is important to achieve comparability across different types of cases.

During the data collection, the researcher focused on the most marginalized group of refugee families, who have experienced homelessness or currently reside in a homeless shelter. By this purposive outlier sampling, which is selecting a case at the ends of distribution of targeted population, this study can provide a wide scope of potential risk factors (ex. lack of resources or ineffective coping strategies) for resettlement stressors among refugee families (Clark & Creswell, 2008).

Several unique factors make it difficult to identify and study homeless refugees. The meaning of homelessness and the degree of housing stability may differ according to

the resettlement status and adjustment stage (i.e. where they are situated in the resettlement process) as well as cultural background and beliefs about residence (i.e. how they perceive permanent residential arrangements). In addition, considering the refugees' inclination to seek help within the community rather than accessing mainstream social services, homelessness is invisible in many cases.

In view of these difficulties, it is safe to conclude that homeless refugee families who are found in a homeless shelter satisfy the criteria of being homeless. The author also believed that shelter users are likely to have depleted the resources that they possessed and/or that they have little social capital to rely on to manage housing crisis. In either case, the refugee families in homeless shelters, particularly those in non-county shelter systems, meet the criteria for potential participants of the current study to explore the topic of mental health and social capital in homeless refugee families.

Participants

A total of 26 families, including 15 Somali and 11 Hmong families, participated in this study. One parent of each family was interviewed. A brief description of the participants is presented in the Table 3.2. Average length of stay in the U.S. was 90 months (7 ½ years) for Hmong families and 10 months for Somali families. Twelve participants (eight Hmong and four Somali) were a single parent (i.e. mother) family. The number of children of the families ranged from 3 to 11 (mean= 6.85).

Table 3.2. Demographics of interview participants.

Ethnicity	Gender	Age	Family Structure	Number of Children	Length of Stay in the U.S.
Hmong	Female	44	Single mother	Nine children	6.5 years

Hmong	Female	42	Single mother	Eight children (two with ex-husband)	7 years
Hmong	Female	39	Single mother	Seven children	7 years
Hmong	Female	40	Single mother	Eleven children	12 years
Hmong	Female	38	Single mother	Five children	6.5 years
Hmong	Female	36	Two parent family	Seven children	7 years
Hmong	Male	40	Two parent family	Ten children	9 years
Hmong	Female	39	Single mother	Eight children	6 years
Hmong	Female	28	Two parent family	Nine children (a few from husband's ex-wife)	7 years
Hmong	Female	31	Two parent family	Five children	8 years
Hmong	Female	27	Single mother	Four children	7 years
Somali	Female	46	Single mother	Seven children (three left in refugee camp)	10 months
Somali	Male	46	Two parent family	Eight children	5 months
Somali	Male	43	Two parent family	Four children	1 year
Somali	Female	25	Two parent family	Four children	9 months
Somali	Female	32	Two parent family	Eight children	3 months

Somali	Female	33	Two parent family	Six children	8 months
Somali	Male	49	Two parent family	Seven children	1 year and 2 months
Somali	Female	25	Single mother	Three children	4 months
Somali	Female	43	Two parent family	Seven children	1 year and 5 months
Somali	Female	44	Single mother	Eight children	11 months
Somali	Female	39	Two parent family	Seven children	7 months
Somali	Female	37	Two parent family	Eight children	11 months
Somali	Female	29	Two parent family	Five children	4 months
Somali	Female	31	Single mother	Six children	2 years
Somali	Female	26	Single mother	Four children	9 months

Data Collection

This dissertation intended to discover patterns of psychological distress and coping strategies in the contexts of multiple stressors of refugee families and to test and modify hypotheses developed based on the literatures on the same or similar topics. This study adopted interview methods for data collection. The data were collected through in-depth individual interviews with Hmong and Somali refugee families who are currently homeless, and have been living in a homeless shelter. The semi-structured interview method allowed the researcher to explore issues and experiences that refugee families have gone through to identify factors associated with homelessness and compounding variables in broader contexts, nested in ecological systems and migration experiences of

the families. In particular, since refugees' experiences in homelessness and housing insecurity have been little investigated, in-depth interviews with homeless refugee families provided a vivid picture of the circumstances where refugee families have been and are currently situated. In addition, interviewing both ethnic groups (Hmong and Somali) of homeless families enabled the researcher to examine the differences and similarities in patterns in stressors, resources, and coping strategies as well as culturally specific and unique issues in mental health and migration.

Procedures. This dissertation was planned and initiated by the author during her field placement in Hennepin County, working both in the Office to End Homelessness and the Office of Multicultural Services. The author submitted an application form to the University of Minnesota Institutional Review Board (IRB) in January of 2010 and received IRB approval on April 2, 2010 (IRB Code Number: 1001P76432).

Three bilingual interpreters were integral in completing data collection for this project, since the author speaks neither Somali nor Hmong. The paid interpreters assisted in interpreting during the interviews and with interview transcription. The author recruited two volunteer Somali interpreters, one female and one male, and one female Hmong interpreter, who are experienced service providers working either in Hennepin County or in a homeless shelter in Minneapolis. All three interpreters are familiar with refugee housing issues as well as resettlement challenges through professional as well as personal experiences as either a Somali or a Hmong community member and a professional in related areas. As recommended by IRB, they went through required

training for data management and confidentiality, by completing the Collaborative Institutional Training Initiative (CITI) program.

To recruit participants, the researcher contacted four homeless shelters in the Twin Cities area, particularly in Minneapolis, with support from the author's supervisors in Hennepin County. Some shelters were sponsored by Hennepin County while others were affiliated with religious organizations. Most of the shelters that the author approached had few refugee residents at the time of contact. One shelter, named Mary's Place, run by Caring and Sharing Hands, had more than ten refugee residents at the time, mostly Somali and Hmong families.

After visiting Mary's Place and explaining the research project to a family advocate, the author received permission from the head of Caring and Sharing Hands to access and interview families at Mary's Place. As maximizing variations in qualitative research is important to capture "the central themes or principal outcomes that cut across a great deal of participant or program variation" (Patton, 2002, p. 172), the author tried to recruit families with various family structures (both two-parent and single-parent family), gender (male and female parents), ethnic groups (both Hmong and Somali), and resettlement history (i.e. inclusion of secondary and tertiary migrations). The author provided Mary's Place staff with written criteria for recruiting and selecting families, describing types of family structure and ethnicity and resettlement experiences. With the criteria, the family advocate staff asked resident families, mostly Somali and Hmong, if they might be interested in participating in an interview after providing a brief introduction of the research. Then, the staff sent the author the contact information of

resident families who agreed to participate in the interviews and to release their contact information. The author and three well-trained, experienced volunteer interpreters scheduled interviews with the families over the phone. All the interviews were performed in a tutor room in Mary's Place with both the author and a bilingual interpreter, matching the language and ethnicity between the interpreter and family. One parent, either father or mother, in a family participated in the study. Two of the interviews were conducted in English, both of which were with Hmong families who preferred to use English.

When the parent came to the tutor room, the author and an interpreter greeted him or her, introduced themselves, and read the consent form after introducing the research project (See Appendix A for the consent form). The consent form was interpreted as needed. The participants were asked to raise questions or concerns before agreeing to participation. After confirming that there were no questions left, the participant was asked to sign the form and keep a copy that has the contact information of IRB and the researcher for further inquiry. Then, each participant was asked if it was all right for the researcher to record the conversation only for the purpose of transcription. All but four (two Somali and two Hmong) participants agreed to audio recording. An audio file was shared only between the researcher and each interpreter and the voice files were securely stored in Netfiles, the secured web storage run by the University of Minnesota and in encrypted computer owned by the author.

Each in-depth individual interview was conducted for about two hours. The shortest one took 80 minutes and the longest one took two and a half hours. The author asked a question in English and then the bilingual staff interpreted it in a native language to the

informant. The responses from the respondents were interpreted into English and the researcher posed additional questions to clarify meanings and details when necessary. To acknowledge the participant's time and input, a $25 value Target gift card was given to each participant family after the interview was completed. Each interpreter received $100 as remuneration for interpretation and transcription for each interview. All the research expenses were covered by grants from Minnesota Family Housing Fund and the Annie E. Casey Foundation.

Due to the unstable situations of homeless families in the participating shelter, the interviews were conducted once per family. When the researcher started preparation for interviews in the shelter, she found that refugee families were in various situations in the shelter. The allowable time for a stay in the shelter, which is limited to six months, was about to be over for some families and many were not sure if they could stay for the following weeks in the shelter. The author and interpreters, in fact, missed some families as they moved out of the shelter between the time of initial contact by the family advocate and the time for the scheduled interview. Under this circumstance, the author judged that two interviews per family were not realistic for some participants, due to the high probability of family mobility in a short span of time.

Data collection started on April 10th, 2010, and thirteen interviews with Somali and Hmong families were completed by May 2nd, 2010. The author paused data collection to analyze the first half of data to evaluate the sampling strategies. The author came back to Mary's Place and conducted the rest of 13 interviews between April 17th and May 8th, 2011.

The author determined to recruit all the participants in Mary's Place due to a few features of the residence. Because of the unique relationship between the leader of the Caring and Sharing Hands and Hennepin County, Mary's Place has remained less connected with the county system than many other shelters in the Twin Cities area. For this reason, Mary's Place has attracted many marginalized families to its shelter system, who are not eligible for county benefits or mainstream services. For instance, according to an internal document of Mary's Place that the staff shared with the researcher, more than half of the residents are not eligible for Hennepin County benefits since they recently moved from a different county or state or exhausted mainstream assistance. Also, the author found through the conversations with community professionals that Mary's Place is very well known and approachable for both Hmong and Somali communities and thus attracts the most vulnerable families struggling with housing from these communities. As the focus of the current study is to investigate the families having housing instability and dealing with psychological distress due to limited access to resources, the author decided that the Mary's Place is an ideal place to conduct this study.

Interview instrument. The author developed a written interview guide to promote reliability of the data collection (Kvale, 1996; Rosenblatt & Fischer, 1993). The interview guide is presented in Appendix B. The interview started with a set of broad, general open-ended questions, called "grand tour" to overview the migration and resettlement path that refugee families experienced (Leech, 2002; Burnard, 1991). To probe hardships and challenges, several open-ended questions were designed according to the migration phases. For example, a question to identify stressors during the pre-

migration stage, the researcher said “What made you leave your country?” and a few other phrases to delve deeper into family experiences followed, such as “What happened to your family?” and “What difficulties did you and your family have in your country?” In each phase of migration and resettlement, the researcher asked questions in the order of stressors, resources, coping, and psychological outcome. The author also focused on social networks and support as well as personal, family, environmental, and cultural resources that are embedded to social capital theory. With theoretical sensitivity, the author developed the questions to approach the phenomena in a culturally appropriate way. The final question set was vetted with the interpreters to assure that concepts had cross-cultural fidelity and slight revisions were made to the interview protocol before the first interview occurred.

In exploring mental health issues in refugee experiences, one of the critical factors is to understand traumatic experiences and unique refugee situations and to contextualize refugees’ psychological distress in these contexts of stressors. The author adopted representative symptom items from Hopkins Symptom Checklist (HSC-20) (Lee, Schulberg, Raue, & Kroenke, 2008) and Posttraumatic Diagnostic Scale (PDS; Foa, 1995) to identify symptoms of psychological distress. The author also attempted to provide brief psychoeducation to facilitate families’ report on their psychological stress, as mental health issues are highly stigmatized in both the Hmong and Somali communities.

The questions were modified after the first two interviews. The revision did not change the structure or major questions of the research. Instead, it specified some

questions for clarification.

Rigor of Study

Several methods were utilized to establish and increase trustworthiness of the study. To increase credibility, the author adopted member checking, debriefing, triangulation, reflexivity, and negative case analysis (Creswell, 1998; Padgett, 1998; Patton, 2002; Lincoln & Guba, 1985; Sherman & Reid, 1994).

Member checking. Member checking is a process to corroborate findings, which is the most critical part of data collection in increasing the credibility of an inquiry (Lincoln & Guba, 1985). Member checking was conducted during and after each interview with both families and interpreters. During interview, the author confirmed or corrected her understanding about the cases through paraphrasing and summarizing the responses from families. The author discussed each case with the interpreter right after the interview was completed in order to verify whether the researcher grasped the data correctly. To assure that the researcher fully understood the case and gathered all the information shared in the interview, the author inserted a set of open-ended questions at the end of the written interview guide to ask interpreters to share their insights about the interviewees, while identifying any specific issues or non-verbal expression that might be relevant to the study. Since the sample of the current study is highly mobile, direct member checking with the interview participants was not feasible. Instead, the author shared the results of data analysis as well as a part of interview data with community members, including bilingual MSW students from Hmong and Somali communities and

service providers in VolAgs and CBOs, to be assured that the author's understanding of the samples and the data is in the right direction.

Debriefing. Debriefing is to reduce researcher's bias and reactivity (Maxwell, 2005) and thus increase credibility and trustworthiness of qualitative research (Shenton, 2004). The author utilized formal and informal conversations with various people, including advisors of the project and supervisors of the author's field place (Hennepin County), colleagues in the field placement and school, homelessness service providers, and professionals in resettlement service organizations. Some are rather regularly scheduled discussions, while others are non-recurring conversations. Through collaborative discussion, the author confirmed the usefulness and practicality of social capital theory and replaced the acculturation stress model with the stress and coping model to better explain the strength and resilience of refugee families.

Triangulation. Triangulation is multiplication of the ways of approaching reality to build credibility of findings (Denzin, 1989; Lincoln & Guba, 1985). There are four types of triangulation: triangulation of data, investigator, theory, and methodology (Denzin, 1989). The author used data triangulation in the current research. Data triangulation uses different sources of data to approach the same subject matter. The author conducted two focus group interviews and multiple individual interviews with staff stakeholders of refugee resettlement and homelessness services. The author interviewed service providers from Hmong and Somali community-based organizations, refugee resettlement agencies, and a county office serving refugees. Then, the author also conducted two focus group interviews between the first and the second phases of data

collection. The first focus group was conducted with resettlement service providers and community leaders, while the second one was with Somali and Hmong MSW students who have rich experiences in serving refugee communities (See Appendices C, D, & E for interview protocols). The interviews helped inform the author of the meaning of using a homeless shelter in the refugee community and the current status of service provision at the county and state as well as federal levels. The findings from both individual interviews and focus groups led the author to re-developed the hypotheses of the study and expand the scope of the question area to pre-migration, while narrowing down the focus of the study to a few core notions.

Reflexivity. Horsburgh (2003) defined reflexivity as "active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation" (p. 308). It is also the process that "involves deconstructing who we are and the ways in which our beliefs, experiences and identity intersect with that of the participant" (Lietz, Langer, & Furman, 2006, p. 447).

The author's personal and academic experiences before and during the research project have shaped her perspective and knowledge not only on the subject matter but also the refugee populations in general. Through a prior research practicum, the researcher was involved in a community-based research on refugee housing in Twin Cities, where the author had a major responsibility for developing and implementing a survey study with 250 refugees. This ignited the researcher's interest in and passion for working with this vulnerable population facing multiple challenges including housing

instability upon resettlement. While working through two field placements, both of which were closely involved with refugee communities, the researcher developed collaborative relationships with local and refugee communities and expanded her understanding of how service programs intervene with refugee populations and what barriers lie in front of resettled refugee families.

These prolonged engagements in the field, although not with direct participants of the study, helped the researcher to develop "an early familiarity with the culture of participating parties [organizations] before the first data collection dialogues take place" (Shenton, 2004, p. 65).

Given that a researcher is a critical tool of investigation in qualitative research (Gilgun, 2008), the author has improved her credibility through trainings, research participation, community engagement and outreach, while reflecting practice and learning, and developing expertise in the field. As a means to facilitate reflection, the author has written research journals for over a year since she started preparing for data collection. A part of the journal notes were developed and integrated into memos during the coding and analysis process.

Negative case analysis. Negative case analysis is a process used by a researcher to falsify hypotheses or theories using a case defying them. It is not only an effective way to increase generalizability, but also a critical part of analytic induction (Gilgun, 2001). According to Gilgun (2011), negative case analysis has to occur at least twice in analytic induction research. The first negative case analysis is needed during the data collection process in order to improve variation of the study and include cases that potentially

challenge and thus improve research statements. The next negative case analysis is required during the final data analysis. While or after a researcher develops narratives or descriptions of conceptual relationships to test hypotheses, she can conduct a negative case analysis by looking for deviant patterns from the theory from the coded data. "Through negative case analysis, researchers will produce a description of processes/concepts that account for patterns, or multiple dimensions of the phenomena of interest" (Gilgun, 2011, p. 2).

Data Coding and Analysis

In qualitative research, the coding process requires simultaneous interpretation of the meanings in the data (Rettig, et al., 1997). For coding and analysis, the author recorded the interview data, which was transcribed verbatim by the interpreters and the author. Three participants refused recording during the interview, so the transcription of these interviews were documented from the author's and the interpreter's notes that were taken during interview and typed as an electronic copy after the interview was done. All the data were entered into NVivo version 8 and 9 for analysis.

In analytic induction, there is no specific coding guidance available, although many researchers follow the coding methods of grounded theory. Gilgun (2001; 2011) pointed out that it is possible to use the coding schemes developed by Strauss and Corbin (1990), which include open coding, axial coding, and selective coding. The difference in coding between analytic induction and grounded theory is when a researcher uses concepts (Gilgun, 1995; 2001). Using pre-developed coding themes for a hypothesis test is named *a priori coding* to distinguish this from using coding themes developed from

grounded theory coding (Rettig, et al., 1996). Since the author purported to test the hypothetical statements while exploring emerging themes and concepts to modify the hypotheses, both types of coding processes are needed in this study.

A priori coding themes were created based on the literature review that also led to the formulation of research hypotheses. Then, these themes were applied to the first interview to check if a set of a priori coding themes are comprehensive enough to test the hypotheses. According to Bogdan and Biklen (1998), a researcher should use cases to challenge themes as well as hypotheses and should adjust them to fit in the negative cases.

To promote a consistent coding process, a coding table was created to list the coding themes, which consists of hypotheses based on the theoretical heuristics adopted in this study (see Table 3.3). Each a priori coding theme was clearly defined and then constellated in the theoretical frame that presents the social ecology of migration phases and social systems revised based on social capital theory. Before coding the data, the author thoroughly read the transcription more than three times: the first time for a general overview, the second time for negative case analysis, and the third time for gaining insights about coding and themes. The author decided coding units at varied levels depending on the meanings of the data: ranging from words, to phrases, to sentences, and to paragraphs (Miles and Huberman, 1994).

Once the preparatory steps were completed, the author conducted open coding. Open coding is defined as the "analytic process through which concepts are identified and their properties and dimensions are discovered in data" (Strauss & Corbin, 1998, p.101). The coding was close to In Vivo coding, although the author used theoretical

sensitivity to determine coding labels. Examples of open coding are demonstrated in Table 3.3. There was no need to categorize open coding based on the common subject as they could be easily sorted in NVivo. Also, axial coding, the next coding process, helped the author develop subcategories and match the new codes with the a priori coding categories.

Table 3.3. Coding schemes, substantive codes, and emergent themes.

Theoretical Domain	**Theoretical Coding Categories (A priori codes)**	**Definition**	**Subcategories**	**Examples of Emergent Substantive Codes and Themes**
War Trauma Forced Migration Resettlement Homelessness	Stressor	Stressors, as a cause or source of psychological distress, refer to the issues and events that individuals in the situation perceive to actually or potentially threat normal functioning and resources (Schneiderman, Ironson, & Siegel, 2005).	- **Threat to resources** Risk of losing resources and insecurity of resources - **Loss of resources** Actual deficit of resources - **Failure of resource gain** Frustrated attempt to increase resources after investment of other resources - **Trauma (life-threatening experiences)** Emotional shock following a stressful event or a physical injury, characterized as uncontrollable, unpredictable and life-threatening events that lead to challenges to coping, which occurs at physical, emotional, cognitive, behavioral, and social levels (Schneiderman, et al., 2005). - **Acculturation Stressors**	[Substantive codes] - Afraid of being robbed. - Rebels fighting within my province - War trauma - Conflict getting bigger and pointing guns to each other - Loss of social status* - Loss of social identity* - Family separation - Unstable housing - Homelessness - Gap between expectation and reality after resettlement - Fear about children losing cultural/religious identity - Paying rent and bill - No appropriate medical assistance - New types of challenges out of coping capacity - Health problems - Children's disabilities

			Stress caused by or during a dynamic process of psychological and behavioral adjustment and adaptation to a new culture (Sam & Berry, 1995).	- Chronic exposure to lack of resources - Situation of multiple challenges - Lack of coping means - Restrictive regulations in homeless shelter - No ability to communicate in English - Loss of family members - Horrendous experience during flight - Migration between camps - Insecurity in camps - Conflicts between clans in home country and refugee camps [Themes] *- Stressors are replaced or substituted** *- Trade-off of stressors** *- Prioritizing challenges/problems of focus** *- Vicious stressors that impeded coping capacity and means and thus consecutive stressors** *- Definite types of stressors with high intensity in refugee camps, while various types of new stressors after resettlement** *- Unexpected input or loss of*

				*resources as a great stressor after resettlement**
Social Capital	Resource	- Resources are defined as "objects, personal characteristics, conditions, or energies that are valued by the individual, or that serve as a means for attainment of these objects, personal characteristics, conditions, or energies" (Hobfoll, 1989, p. 516)	**- Personal resource** Personal ability to cope with stressors, consisting of financial or material (ex. savings and property), educational (ex. school diploma or degree, literacy), health (ex. disease in negative direction), and psychological resources (ex. self-esteem, self-efficacy) (Kwai-sang Yau & Li-Tsang, 1999). **- Family resource** What family members can draw from family systems for coping. They include socio-economic (ex. social status, employment and family income), psychological (ex. emotional support), and physical (ex. human capital in household and family health) resources (Burr et al., 1994). - **Social capital** Social and organizational ties that individuals can draw	[Substantive codes] - Bonding social capital - Bridging social capital in asylum and/or host countries - Ethnic community as a role model* - Informal help through bonding social capital - Children as family and cultural assets - Hope is a great coping resource - Religious beliefs and faith as a source for optimism and thus a psychological buffer - Informal help with interpretation and transportation - Distrust in linking or bridging social capital as a negative resource - Family resource - Lack of education and illiteracy as a negative personal resource - Symbolic resource - Minnesota as a resource-rich place in terms of bonding and linking social capital

			upon for assistance (Stanton-Salazar, 1997) and thus the resources available through social relationships and network (Kawachi & Berkman, 2000). - **Cultural resource** A 'toolkit' that is provided by one's culture" and include linguistic skills, literacy, education, computer skills and occupational skills. Cultural resources also can be expanded to cultural knowledge such as familiarity with various services and system in a particular cultural environment, such as public transport systems and banks, and knowledge of physical surroundings and climate (Ryan et al., 2007). - **Environmental resource** Conditions that are advantageous to coping.	- Lack of case management as a negative resource [Themes] - *Material resources are mainly from linking social capital** - *Types of resources matter: Some resources are not consumable and require additional resources –such as cultural resources- to utilize** - *Health as a preventive resource** - *Social capital, especially bonding social capital, as a critical type of resource in that it supplements lack of cultural resources* - *Certain resources or coping strategies are stigmatized to use (such as medication for Somalis and a homeless shelter for Hmong families)** - *Environmental resources need to be discerned based on both accessibility and availability**

	Coping	- Coping is broadly defined as cognitive or behavioral process to react the stressors to avoid the stressful situation or reduce stress (Folkman & Moskowitz, 2004; Lazarus & Folkman, 1991; Thoits, 1995).	- **Cognitive coping** (or appraisal): A process of actively evaluating stressful demand (primary appraisal) and one's own ability to manage the situation using resources (secondary appraisal). - **Problem-focused coping** Coping strategies aimed at solving problem or attempting to change the source of stress (Carver & Scheier, 1994; Moos & Schaefer, 1993; Lazarus & Folkman, 1984). - **Emotion-focused coping** Efforts to reduce psychological distress caused by stressors (Carver & Scheier, 1994; Moos & Schaefer, 1993; Lazarus & Folkman, 1984). - **Avoidance** Either or both cognitive and/or behavior efforts to stay away from a stressful event and situation by ignoring or repressing the stressor (Compas, Connor, Saltzman, Thomsen, & Wadsworth,	[Substantive codes] - Saving, reserving, and exchanging material resources as a coping - Secondary migration - Family separation (temporary) - Learning English - Language as a constraint of coping - Taking a walk as emotional coping - Praying as emotional coping *[Themes]* *- Reappraisal of stressors and resources occur after resettlement* *- Chronic conditions of lacking resources have impeded coping capacity and narrowed coping options and means among families* *- Some coping strategies have yet to be developed as stressors are new and resources are sparse.* *- Meeting a psychiatrist is to gain additional psychosocial support (mixture of problem-focused and emotion-focused coping strategies)**

			1999; Bernard, Cohen, McClellan, & MacLaren, 2004). **- Proactive coping** A coping process through which people predict and estimate potential harms, loss, threat, and challenges that tend to cause distress and prepare for them or prevent by taking an action in advance (Ouwehand, de Ridder, & Bensing, 2008).	*- Problem-focused coping as a dominant type or coping strategies* *- Family is a unit of coping agent** *- Proactive coping is almost impossible when: 1) resources are sparse and it's hard to arrange resources for future; and 2) whether/what stressors lie upon arrival in the U.S.**
Mental Health (PTSD, Depression, Anxiety disorder etc.)	Psychological distress	Psychological distress is a negative outcome of failed coping or imbalance or unmatched result between stressful events or problems and coping resources (Carver & Scheier, 1994; Moos & Schaefer, 1993; Lazarus & Folkman, 1984).	**- Sleep problem** **- Anxiety** **- Too much worry** **- Fear** **- Helplessness** **- Anger** **- Nightmares** **- Hopelessness** **- Depression** **- Loss of weight/appetite** **- Headache, stomachache, and other boy symptoms**	[Substantive codes] - Can't sleep - Worry a lot - Feel helpless and frustrated - Feel hopeless - Lost weight - Can't eat - Headache - Paralyzed - Anxious - Fear *[Themes]* *- Psychological distress is attributed to the most urgent issues that the families face, such*

				as homelessness *- Instability of living is one of the most prevalent source of acute stress*

* Newly emerged themes and subcategories.

Once open coding was completed, the author conducted axial coding, which is a process of "relating categories to their subcategories at the level of properties and dimensions" (Strauss & Corbin, 1998, p.123). As Gilgun (2011) pointed out, this procedure is well aligned with the analytic induction process. In fact, Glaser (1978) called axial coding theoretical coding, which indicates that theoretical conceptualization or sensitizing theory is the core part of this process. In other words, the categories to match with the codes are based on preconceived hypotheses rather than new categories directly emerged from the data. The researcher matched the codes from the open coding with a priori coding categories, while letting the newly constructed concepts form subcategories. Table 3.3 shows some examples of the axial coding process. Then, the author performed selective coding. The author sorted out irrelevant coding themes and focused on the concepts and themes that are directly related to hypotheses in the study.

As the final step of the coding process, the author integrated categories and generated themes and patterns for the study. Utilizing theoretical memos created during the previous coding process, the author drew connections among themes, both newly emerged and pre-developed, and searched for patterns. This process also contained multiple negative case analyses to test the established hypotheses, including new links and concepts as well as modifying the hypothetical statements based on negative cases.

Ethics of Study

The initial step to address ethical issues potentially involved in the current study was to receive approval from the Institutional Review Board (IRB) at the University of Minnesota. As mentioned earlier, this study was approved by the IRB for conducting

research with human subjects. The initial approval was in April 2, 2010 and lasted until January 13, 2011. The researcher applied for renewal of the IRB approval with an update report of research progress and a revision of the detailed questionnaire and received approval in January, 2011, for an additional year. The main ethical issues came along with the consent form, as the interviews were with very vulnerable populations who speak a different language from the investigator. The informed consent form was developed by the author in English and then translated into Somali and Hmong respectively by bilingual interpreters who interviewed the families. Two copies of the consent form were ready for each interview and the form was carefully read to families while allowing them to have a hard copy in hand to read and keep it themselves. The participant families were asked to raise a question and were told to stop participation or skip any question if they prefer.

There was no dropout, while a few participants raised a question or two regarding any direct impact of the participation of the research on the families. As a part of responses to these questions as well as from some concerns brought up during the interviews, the author contacted staff in one of the representative CBOs serving the Somali population in Minneapolis to request assistance with interpretation and transportation for the families in need. One family whose member was kicked out due to the violation of a rule in the shelter was referred to Hennepin County to search for another family shelter run by the county. The author also received some questions out of her scope of assistance or knowledge. Some asked the author if she could help them to bring their family from a refugee camp to the U.S., while others were curious about

whether and how the interview could directly improve the family's situation. The author explained briefly about how the resettlement process is determined and how the interview could influence the families and community in the long run, but would not immediately impact the participant families.

The author also gathered information regarding resources for housing assistance in Twin Cities area, including a refugee housing program, county offices, and information about other shelters, and this information was handed to the families who were in desperate need for housing search due to impending time to leave the shelter.

Limitations of Research Design

The current study's research design has a few limitations. First, even though this study included the contexts of pre- and post-migration as well as resettlement into the frame of the study, a longitudinal research design would be ideal to investigate coping strategies for migration and adjustment processes. This study focuses on the perception and interpretation of resettlement experiences from the perspective of refugee families, which are based on cross sectional interview reports.

Second, more cases and more varied incidences could be collected. The author collected data until there were no new themes emerging and no new types of experiences. The author also conducted negative case analysis during data collection and attained a certain level of saturation. However, the data gathering and saturation process in analytic induction is rarely satisfied (Katz, 2001). Experiences of refugee families are diverse and all the variations of the general population can be hardly included in a study. The two refugee groups, Hmong and Somali, were selected because these two refugee groups

comprise the largest refugee communities in the Twin Cities area and this fact heavily influences decisions for secondary migration and housing instability across the states. In this regard, the author could discover common issues and similar patterns of coping and stress.

Third, this study does not adopt probability sampling for the quantitative data collection for practical reasons. This drawback, however, is mediated through purposive sampling and judgment sampling methods. Nevertheless, because this sample is not random, one must be careful not to draw generalization beyond the specified sampling frame.

Chapter 4. Findings

In this chapter, the author presents the findings according to the conceptual themes that comprise of tentative hypotheses. The current study intends not only to test the hypotheses but also to find emerging themes and new concepts to improve the hypotheses and eventually build a theory on stress and coping processes of homeless refugee families. The findings from the method of modified analytic induction filled the knowledge gap of the experiences of refugee families, from a stress and coping theory and a social capital theory in social ecological systems and contexts. Then, the procedure of analytic induction enabled the author to test the hypothetical statements and modify them, embedding newly found themes and relationships from the data.

This chapter is organized primarily by the specific hypotheses tested in this study, as outlined in a previous section. The hypotheses are organized under three main lines of research inquiry: stressors, resources and coping, and psychological outcomes. Each of the nine hypotheses will be dealt with distinctly, with overall conclusions to follow.

Stressors

The first set of research questions and hypotheses is about the stressors that refugee families have gone through and currently face. Among myriad stressors that refugees experience through migration processes, what are the major stressors experienced by refugee families? The author also wondered if the stressors are newly emerging types during migration and resettlement and what the contexts of housing problem may be.

Hypothesis 1: Refugee families experience multiple stressors. The first hypothetical statement pertaining to stressors is that refugee families have been exposed

to multiple stressors, including harm, loss, and challenges of resources, through migration and resettlement processes. This was not disproved by any case from the data. In fact, refugee families have experienced various kinds of stressors that occur one after another. To the contrary, the author heard common stories from respondents, with life threatening stressors during the flight, abysmal living conditions in refugee camps, and a myriad of stressors after resettlement being common to all informants.

In all cases, accounts of acute stress began in the process of flight from the home country. A Hmong mother shared her story of migration and living in camp.

> *"F (Family): I remember crossing the river at night and seeing other parents traveling with us feed opium to their children. I had left my mother and stepfather to leave with my uncle to come to Thailand when I was eight years old. We traveled as quietly and quickly as possible during the night. During the day we rested and could not create any sounds or have a lot of movements. It took about two weeks to get to the Mekong River."*
>
> *I (Interviewer): What happened after crossing the river?*
>
> *F: We lived in Ban Vinai camp one year and another year in Xiang Khuang camp.*
>
> *I: How was your life in camp?*
>
> *F: We moved to one camp to another. They were pretty much the same. Nothing special. We had only small amount of rice and had to farm to plan vegetables. There is nothing you can do. Women made a sewing project and helped each other. We made work for each other. But we were always poor. The vendors and*

doctors in Thai camps were mean to us. Being unable to earn in the camp also affected seeking treatment for the ill. Seeking help from a shaman required some stipend and rituals cost money because you have to sacrifice a chicken. Those who were poor did not have chicken.

One Somali mother shared her migration experiences as below, indicating the stressors she and her family faced in the prelude to their departure from Somalia.

F: In Somalia, my husband had a store, and sometimes he would get robbed and we would suffer. The kids used to go to 'dugsi' (religious school). We went back to Mogadishu in 2000 because we lived in Kismayo and when a new clan took control of the city, there was lots of conflict. So we went back to Mogadishu. I had 5 kids at this point. There was no peace in Mogadishu, because if two kids fight, the father of one child will get a gun and kill the other. We had to leave quickly. I walked to Afgooye with my children and two bags. Finally, I went to the refugee camps. My family and I have struggled a great deal and still continue to struggle here in America.

I: Did your family live together all the time?

F: Yes, we all lived together when we arrived in the United States. However, during the war I was separated from my kids for one year. My 4 older boys got lost and my late husband went back to the war zone to find them. Eventually, I found my 4 older boys, but my husband was killed when he went back to look for

them. The boys were with some man that lived in the rural areas, but he didn't tell us. After one year, the boys came back to where we used to live and previously fled and went to our old neighbors. The neighbors told them that I was in a refugee camp and that they didn't see their father. Those people put money together and my boys were put on a bus to "Dhoobley" (city). When they came to Dhoobley they took another bus to the refugee camp. One day I was at the market and was told 4 boys came to the camp. When I went home, I found my 4 boys sitting there. I put my kids on my refugee camp card and 2 days later papers (names) were posted.

Family separation and loss were commonly found during the interviews. High risk of threat to security and family loss in the home country were great stressors that forced families to flee, and they were not over after arriving in refugee camps in many cases. Life in refugee camps was filled with multiple stressors as well. Not only lack of resources (commonly reported issues such as lack of foods) but also concerns about security and conflict in camps were identified. Conflicts between clans or between hosting neighbors and camp residents were often reported.

"We had a lot of hardships. My husband was beaten severely by other refugee camp residents. Then there was arson to my residence while my children slept caused by the same who beat me. Food was scarce. The camp only gave us wheat

and oil, it was not enough. We had to sell half of our food so we could get money to buy other necessities (SO: Somali).”

“Even though there is a medical clinic, the Ethiopian staff at the camp would rather you die than refer you to the hospital in the city. Their treatment to camp residents is horrible. There are currently people missing, dead and in jail. You cannot have any visitors because they are required to have a permit to come in and even then they may be accused of not having a permit and then get in trouble (SO).”

The family concluded their life in camp as below, portraying the severe stress that is present even after escape from war or political violence. The stress of losing resources and fear of losing even more was constant for many respondents, as indicated by this Somali informant.

“There was really no good life in the refugee camp. We were not living and we were not dead. We were afraid constantly of either going to jail or being killed. Nobody can visit you there. It was like a prison (SO).”

Another Somali woman described her stressors that happened in the refugee camp and still concerns her family. When family members were separated and left behind in the camp or other places, it became a source for constant worries and concerns.

F: My husband died in the camp in 2008 after complication with asthma and some other infections. Our lives have been rough and tough since we fled our country. We fled on foot holding my two young ones by the hand for two days until we found a trailer truck that was ferrying people and charging them money. The truck didn't take us far and abandoned us on the way after taking our money. We walked for two more days until Ethiopian troops picked us up on the way and took us to the camp. The hardships in the camp were many. The food was not very good, and we lived on a single diet for 19 years. We only ate to live because there was never enough to fill our bellies. When my husband fell ill, I became helpless and we had to send the children to work for food herding goats and sheep for the locals including other manual jobs while I took care of my ailing husband. It was painful when I had to part ways with my three sons in the refugee camp when we resettled in America.

I: So, you had to go through all the difficulties, taking care of your ill husband and children. And you were also concerned about your three children working outside.

F: Yes. Now, three of my sons were left in the refugee camp in Ethiopia. They were away from the camp looking for work to support the family when the refugee registration process began. The authorities wouldn't include any absent persons even after pleading with them. Life during migration was as tough as it could be. The hardships affected our family in many ways but we had to strengthen our

bonds and relationships to face the daily situations. The loss of their [children's] father affected us the most. We felt completely broken and helpless. Even though he was weak and sick for a long time, he was still the fatherly figure we looked up to. His absence affected the kids a great deal. I was forced to "sell" the older kids to work at manual jobs for extra food. I hated it but it was the only way out. The local population took advantage of the vulnerable needy refugees and exploited them for food.

The cases from the interviews confirmed the authors' assumptions and pre-knowledge about difficulties and challenges that cause stress to refugee families. Tough conditions in refugee camps along with family loss led the family to live apart to gain resources for livelihood. Due to insecure situations both in the home country and the camps, family separation sometimes led to family loss or unpromising reunification and turned into chronic stressors. Refugee families were also exposed to stressors repeatedly for a long period of time.

"The UN provided us with one type of food for the whole 19 yrs. It was wheat all the way. My children were all born in that environment so I guess they kind of adapted because they hadn't experienced the change. They didn't like it either but there was nowhere else to go. Safety was our main concern. We were wary all the time (SO)."

In line with the hypothesis of multiple stressors at multiple time points in the migration experience, stressful situations and events did not stop after resettlement. Rather, refugee families repeatedly said how many challenges that they had to face and manage after resettlement. Even after some stressors were temporarily reduced by a resettlement agency (ex. rent paid for three months) or other members in the community, resettlement and adjustment challenges were still abundant.

> *"I was resettled in Tennessee where I had my rent paid for the first 3 months. We didn't get any cash assistance in Tennessee and only received food stamps in addition to the paid rent. Transportation was a major issue and I had to sometimes walk my children to school in the cold winter without proper winter gear (SO)."*

After rent was taken care of and food stamps were provided, refugee families did not have means to access needed resources, such as foods and proper clothes. Transportation and information about the places where resources are were two major things that the families missed when they started a new life in the U.S., suggesting the acculturative process as a potential source of stress.

> *"The international Institute helped us move to an apartment. When they paid for the first two months they told us to pay from then on. We were getting $500 cash from the government and the rent was $800. There was nobody to help buy*

groceries, we had food stamps but my kids were hungry because we did not know where to find a grocery store and how to get there (SO).”

As all the families that the author met were staying temporarily in a shelter, all families had been struggling and stressed due to housing issues in addition to other types of stressors.

The author was sensitized theoretically with the conceptualizations of social capital theory and stress and coping theory during the coding and analysis process. This led the author to develop themes for the types of stressors to identify what are prevalent causes of stress among refugee families. According to Hofboll (1989 & 1998), stressors are mostly associated with threat, harm, or challenges regarding resources. Three categories that he sorted as major sources of stress are: threat to resources, loss of resources, and failure of resource gain. While adopting these three categories, the author also included two different types of stressors: trauma, including exposure to violence, and acculturation. To identify types of stressors, the author carefully sorted and categorized the first codes and specified the types, matching with the theoretical concepts. Six different types were confirmed by the data: threat to resources, loss of resources, failure of gaining resources, trauma, symbolic loss, and acculturation stress. Each type of stressors was matched with the stage of migration to test the Hypothesis 2.

In summary, the data support the hypothesis of multiple stressors. While the prevailing categories for stress from the literature are supported by the findings of this study, the author would advocate for a more wide ranging conceptualization of stressors

than would be afforded by Hofball (1998), for instance. In addition to Hofball's three stress categories, the testing of this hypothesis suggests that additional categories for trauma and acculturation must be added to the categorization of stressors, as these are also present in the majority of the stories told by the refugees who participated in this study. This expansion of categories would provide a fuller understanding of refugee stress, and enable the testing of future hypotheses that looked at the interplay between different types of stress.

Hypothesis 2: Stressors by migration stage. Refugees have experienced a common process of transition, which is often categorized into pre-migration, migration and post-migration stages. The second hypothesis regarding stressors is that refugee families have gone through different and often new kinds of stressors unique to each migration stage. Based on the literature review as well as the researcher's experience in working with the refugee population, it is hypothesized that certain types of stressors are salient in each phase. For instance, traumatic events and security issues are of most concern before migration, while lack and loss of resources are likely to be most stressful during migration. After migration to the host country, the biggest concerns and stressful situations include loss of cultural resources and challenges of adjustment to new culture, named acculturation stress.

Pre-migration. First, concerns about security were pervasive among families in the home country. Indeed, in most cases this is also the cause of migration. Security issues were both related to threat to life and threat to resources. When families reported threat to resources, it was often attached to the issue of threat to life and safety. The

physical safety was sometimes traded off with security of resources. In most cases of families, therefore, the threat to resources thus resulted in actual loss of resources. Many Somali families started with how unstable and unsafe the home country was and how threatening the situation was to the families.

> *"In Somalia, my husband had a store, and sometimes he would get robbed and we would suffer (SO)."*

While the family above discussed the loss of security in terms of resource loss, other informants put the threat to life more starkly, as this individual who recounts her family's sudden departure from their home under the cover of darkness.

> *"We were scared to death when hearing gunshots outside. My husband decided to leave for his uncle's house in a rural area. We planned to leave in a week but the security got worse so fast. We had to leave in the middle of night when his cousin drove a truck to our house. We had no time to pack luggage. We were well-heeled in Mogadishu. Now we are homeless. We thank to God for being safe but we lost a lot (SO)."*

The sense of loss stemming from threat to resources was profound for many individuals in this study, who wished to take material possessions with them to maintain a sense of normalcy in dire circumstances. For many informants, such as the informant

quoted below, there was a desire to stem the threat of loss of resources for the sake of the family's children, even if they could not preserve resources for the adults of the family.

> *"We had to leave every belonging back home. My brother stopped me to come back to home to get things for my kids because he told me that it is too dangerous to be around the neighborhood. I was very sad and angry but I had no choice but to leave with nothing (SO)."*

Most of the refugee families reported life-threatening experiences in the home country that are very traumatic, such as loss of family members, fear of being attacked by soldiers, and witness of death or murder. Death of family members and family separation during exile were most frequently reported in both Somali and Hmong families. Based on this study's findings, it is this threat to life that provides the most acute stress for many refugee families.

> *"My real mother gave birth to the five of us. The Vietnamese killed my mother, a sister, and two brothers in the water as we were crossing the Mekong River. I don't recall exactly all the details because I was young and each of the children were split up between my uncles and parents. My uncles carried us over. When we reach the border, all we heard them repeatedly say your mother died (HM)."*

Even when the threat to life did not affect an informant's immediate family, the collective threat to life for the broader community was still a powerful form of stress.

> *"Life was tough ever since we fled our home country. Many people died on the way and didn't make it to safety. My wife was pregnant with our first born and that made me more worried (SO)."*

Young Somali refugee parents have little memory about war and other traumatic events except for living in the camps, and this was the case for most of the Hmong parents as well since they experienced the "secret war" as a little child. However, most of the participants, both Hmong and Somali, could recall what happened during exile and some reports were very vivid and still emotional to some of them, particularly to Hmong female parents. A majority of the Somali participants' children were born in camps and raised there for the most of their lifetime. Three of the Hmong parents themselves were born in refugee camps in Thailand. Life-threatening events and family loss were common types of stressors across the groups, while Somali families added threat to resources as a common form of stressor, as many of them were from prominent families prior to the onset of war.

This differentiation between the Somali and Hmong respondents may be an important one: many of the Somali respondents were from well-heeled families prior to displacement, while the Hmong respondents tended to be of lesser economic means before migration. While additional study may be necessary to draw stronger conclusions,

there is some suggestion that the socioeconomic status of the refugee prior to migration may affect his or her perception of stressors as migration begins. It is possible that individuals of higher SES may perceive greater threat to resources than would an individual of lower SES, since the individual of higher SES begins with more abundant material resource, which they may lose.

The testing of this hypothesis regarding the high presence of stress related to threats to security in the pre-migration stage is certainly well-founded, and well supported by the data. However, this hypothesis may be reshaped to some extent, as the threat of losing resources is also a significant stressor for many families in this migratory phase. However, more study is necessary to determine whether SES may be related to the emergence of stress as a result of the threat of resource loss.

Migration. It was hypothesized that the migration stage would be characterized by dominant stressors related to the loss or lack of resources. Most of Hmong parents did not recall what happened in the home country. But most of them could recall what happened during exile and often times the memory was very vivid.

> *"I was 9 years old and orphaned during the Vietnam War in Laos. In 1975 when General Vang Pao left Laos to Thailand, my family and I suffered and lived in the jungle. I have not seen torture in the war but I was running from bullets. I felt the bullets zoom over my shoulders and passing the side of my head. I heard explosions and loudness of the guns being fired. While living in the jungle, me and my group were always under cover. We were quiet most of the time because we*

did not want to give away our location to the Vietnamese soldiers. We would stay in the same spot for two to three months and then relocate. One day I was looking for food and had traveled far from the group. I was too hungry to even notice I am not safe because of tigers and other meat eating animals track the jungle (HM)."

This above quotation from a Hmong participant indicates the extreme stress that lack of resources can cause. While the primary stress portrayed by this passage may suggest stress stemming from the treat to security, it is the desperation in searching for food, which is lacking, that is driving the participant's desires and actions. However, the threat to life was an ever-present stress as Hmong informants recounted their journey from Laos to Thailand.

"It was very scary during the move from Laos to Thai. All I could recall was my head kept dipping in the water preventing me from seeing much. I could hear the gun shots and see the sparks when a shot was fire. If a person was hit by the bullet, that person is dead. They were at the border shooting and shooting at us (HM)."

Similarly, the informant below discusses not only the stress related to his fear of the Vietnamese soldiers, but also the stress and isolation caused by the loss of his family. In this case, it is the lack of family support as a resource that drives the decision to join

the group seeking passage to Thailand.

> *"Living with my brother and feeling unloved, I decided to journey from Laos to Thailand in 1979. I was 13 and heading out with a group. I knew some people in the group but was not close to them. There were soldiers to escort and protect the group. The men had weapons and guns. Also, there was a Laos man in the group who led the way to Thailand. [[crying]] He [Laos man] loved me so much. Everyone in the group had family to care for them. I had only myself and this Laos man knew that. He protected and healed me. He boiled water and washed my bruised, blisters, and sores created from the long walks. Then he bandage me and gave me medicine for my fever. I would not be alive if not for this man because he would carry me when I cannot walk any more. We were attacked once on our journey to get to Thailand. We were close to the Mekong River when the Viets [Vietnamese soldiers] ambushed us. Luckily we outnumbered the Viets after killing two of them. I didn't see the Viets get killed but knew because of I overheard the men talking after we regrouped (HM)"*

When Hmong participants shared their migration experiences, most of them had graphic memories and described the detailed story of migration. The stories of trauma were very intense and distressing. Further discussion regarding the psychological impact of trauma experience is presented in the later section on psychological distress.

Somali families also described the meager conditions while fleeing the country. Most of them did not have enough resources, particularly food and water as well as proper shelter, and had to move a long distance without transportation. Threat to life was still imminent and both safety and basic necessities for survival were the biggest stressors during flight from the home country.

> *"We walked for days in the midst of the crossfire which killed a lot of the fleeing refugees who were on foot with us. We walked for more than 10 days without food and were rescued by Ethiopian troops patrolling the border. Our feet were all blistered and could barely walk. They took us in and ferried us to a refugee camp in Jigjiga, Ethiopia (SO)."*

The threat to resources was found mostly at the very beginning of migration or before migration. More common issues during migration and in refugee camps were actual loss of resources or paucity of resources.

> *"Life in the refugee camp is extremely hard. There was not enough [food] to eat. We were given 10 cups of wheat every 30 days to survive on and a little bit of oil.*
> *"The refugee camp we lived in is called Qabri Bayah in Ethiopia. There are about 16,000 Somalis living there like that (SO)."*

Lack of resources as a chronic condition was the most common type of stressor after arrival at the refugee camps. Additional harm or loss of resources was not much reported as the given resources in the camp were minimal for sustaining living. The author found that the lack of resources must be a stressful situation, although the real problem causing acute psychological suffering is when lack of resources actually leads to serious outcomes that result from a lack of resources, rather than the mere paucity of resources.

> *"My children were all born there and we lived in a small shack made of pieces of wood we collected and a huge plastic cover provided by the UN to cover us from the rain. We ate plain wheat and it was the only food for the whole 19 years. There was no medical facility apart from occasional pain killers provided. You had to travel hundreds of miles to the capital to get treatment when there was a serious need for it. There was never enough food or medicine or clean water. Thanks God we didn't have any major health problem for the whole period (SO)."*

Family loss and separation did not stop in such an urgent and intense time. The case of the Somali mother with three sons left in camp, for instance, implied that living in refugee camps still has potential risk for something going wrong. Families still experienced fear for safety due to unstable status in the camp and many restrictions, which might lead to repatriation when violated.

"[I was in] Nong Khang camp. I don't recall what it was like but I remember it being fenced in. Ban Vinai camp was a long row of houses all connected and separated by wood. Xiang Khang is much the same but it has barb wires fenced all the way around the camp. You cannot purchase anything outside of the camp. If they caught you going to the fence and buying something, they will lock you up for a week about. Lock up inside their office within the camp. The reason they would not allow anyone to buy from outside the fence is because they want the people to buy from the vendors inside the camp. The vendors charge at a higher rate. Therefore, those who are poor would normally buy from the people outside of the camp. Nothing is done to the person selling from outside the camp, only to the person buying from within camp (HM)."

The hypothesis that lack and threat of loss of resources are of primary concern during the migration stage is well supported by the present data. Although different families viewed the threat of resource loss in different ways, the stress associated with lacking resources was a constant and powerful form of stress, and overcoming this stress was a constant endeavor so that people could have the basic necessities of life. In addition to the hypothesized stressors for the migration phase, it was also clear that many individuals also felt ongoing stress related to threats to security. While active war was not present after arrival in the refugee camps, poor treatment by the local population, and restrictive rules for conduct made for ongoing fear of repatriation, death, or other serious punishment even after arriving at what was to be the safe haven of the refugee camp.

Thus, this stage of migration may still be associated with the stress of security threats than was initially hypothesized.

Post-migration. Post-migration in this study refers to the resettlement process. After arriving to the U.S., all the families, both Hmong and Somali, expressed a high level of stressors, providing numerous examples of challenges and hardships. The preponderant type of stressors was acculturation stress, in line with what was initially hypothesized. The wide array of acculturative issues faced by many refugees is summarized in this passage, from a Hmong respondent.

"I felt sorry for myself because I was illiterate, couldn't drive, and do simple stuff such as going to the grocery store. In America, you're handicap if you don't know how to drive. Then even if I knew how to drive; I couldn't read directions or signs to get me where I needed to go. When I am at the cashier I am nervous because I don't know how to count money. On top of all of this I was pregnant with my first child (HM)."

While most Americans take the function of household appliances for granted, even a task as simple as turning on a stove can cause tremendous stress for refugees, and the outcome of these difficulties in acculturation can be severe, as in the case of this respondent who went hungry when she was not able to turn on a stove, and did not know who to turn to for help.

"We are stuck in our apartments. I did not even know how to turn on the stove, I attempted one time and it made a loud noise I thought it was going to explode, so I shut it off. We slept hungry for three days (SO)."

The sentiments are echoed by another respondent:

"When I came to Virginia I was pregnant and became ill, I was hospitalized and I had nobody visiting me at the hospital and I had nobody cooking for my kids so it was a struggle. We had food support and nobody to show us where to go get food. Even if we manage to go and walk to the market, we don't how to ask the meat that we want, we don't know if it pork or other Halal meat. We were confused and we decided to eat only rice (SO)."

Acculturative stress can be so severe and so multifaceted that it can prevent community functioning, even in cases when others do attempt to be helpful. In this passage, a Somali mother describes how her lack of financial resources, as well as the acculturation stress related to language barriers resulted in difficulties in obtaining food.

"I went to a market and stood in front of the butcher for a long time, because I can't ask him what kind of meat it is and how much I can afford. He would write and write things on a piece of paper and I can't read or understand what he is telling me and I finally left with nothing (SO)."

Refugee families were in vulnerable situations after resettlement especially when they did not have social support, even from people from their own community. Even while the families were supported by a resettlement agency and under case management, families still suffered from the failure to access needed support and resources. Some, including the mother quoted below, found that establishing resources in terms of social capital was difficult due to regulations.

> *"I talked to a Somali woman who was our case worker at the resettlement agency. She told me there was nothing she can do for me other than interpreting for me when I come to the agency. She would not help me get to the hospital or even take food for my husband and she wouldn't take me grocery shopping (SO)."*

This Somali woman needed more in-person assistance with not only recovery for herself but also care for her family. Since her husband was a 71 year old man who is suffering from chronic illness, the family could not handle any emergency situation without social support.

> *F: I was hospitalized twice, one time for two days and another three days because of the miscarriage. The first time they sent me home and the bleeding didn't stop so the next time I went in, they aborted the fetus. My husband doesn't know how to cook, he would only put the kids on the bus, at least they were eating at school, but the other had only had milk and tea for few days. When I came home from the*

hospital I had no energy and because of bleeding so much I developed anemia. When I attempted to cook or do things for my family I would faint again.

I: Did you get care after that?

F: At the emergency they gave pain killers and at another clinic I got pills to boost my iron and that helped me. I had a follow up appointment on the 8th and I come to MN on 6th. I have not been to doctor since I got here.

I: Does your husband know that you are worried and losing sleep?

F: Of course my husband knows about my illness and he even tried to help and decided to do laundry and shopping and he slipped on ice broke his leg. That is when my worry became worse because he had a surgery and ended up getting a piece of metal to replace his broken leg. He was hospitalized for days; his situation became worse and was no longer worried about myself and my illness. My husband is a 71 yrs old and sickly as well.

One thing notable is that some resources were not immediately consumable or usable and require another means to use the resource. Even when refugees received food stamps, for instance, this form of resource did not function well to refugee parents. To use that resource, refugees need to know where they can find foods and particular places to use the food stamps. Not only directions and information, but also help with transportation is needed in many cases. Also, it takes interpretation to navigate stores and find necessities and culturally appropriate foods. Food stamps are useful only when you are confident and capable navigating and finding adequate foods. Refugee families

expressed high levels of constraint to using this type of resources that require other resources to utilize them.

The importance of type of resources available for refugee families became obvious from the analysis of interviews. Hmong families also reported that they needed different types of resources other than food stamps for a different reason.

> *I: What was most concerned when you came here [to the U.S.]?*
>
> *F: Money. Everything depends on money. If you don't have money to purchase a car, you can't go anywhere. If you buy a car, you are now in debt and have bills. That's if you were getting a good condition car to last you. If you work then maybe you could afford the car. If you don't work, then you don't have the money to pay for the car. When you can't pay for the car, you can't have the car. This makes it hard on everything. Not only that, you have house bills. If you use electricity, you have to pay for it. If you use water you have to pay for it. By now everything adds up to become bills and debt. In the end, the only solution to this would be money.*

When the financial concern came up, refugee families, both Hmong and Somali, expressed how important the type of assistance is to meet their needs and cope with the issues that they face, such as paying rent and bills and buying other necessities.

"I wish food support amount from the county and cash portion would be in equal amounts. You can take the cash portion and purchase food but you can't take the food support to help with the housing bills. I feel there's a huge unbalance here (HM)."

The lack of financial resources was most stark when refugees first arrived in the United States. Given a small stipend for rent and a limited amount of cash assistance to help with startup costs, many refugees find that the economics of living in the United States, especially in more expensive urban areas where jobs may be found, do not work in their favor. As a result, they may need to make sacrifices very quickly after arrival.

"We were getting $300 for public assistance and the rent was $650. They [resettlement agency] did not help us find jobs and we needed money not only to pay rent but to buy diapers for the children and other necessities."

Cash assistance, however, is not the most preferable form of resources either to solve the housing problems. This will be discussed in later sections along with housing issues.

Acculturation stress was not only found in the concerns about resources, but also in parenting and the relationship with children. Parents were stressed about both adjustment to the new culture and adherence to cultural and religious tradition. Both Somali and Hmong parents had a strong desire for their children's education, which is

also the major expectation that refugee parents harbored when coming to the U.S. Cultural differences in the U.S., however, are not only the barriers and challenges for living to parents but also a source of stress and worries for children.

> *"The most challenging thing in those cultural gaps is maintaining the children's attitude towards their culture and religion. The freedom of sexuality we have here is not common in our culture, we don't have 15 yr olds who have boyfriends and girlfriends back home. Maintaining their attitudes towards our morals and culture is my biggest fear for now concerning the cultural differences (SO)."*

The cultural gap between generations is often apparent in the discussions with respondents in this study. While the cultural divide ranges from minor issues to major topics such as faith, education, and family responsibility, in almost all cases, there is stress associated with the differential acculturation among different generations of immigrants.

> *"Mostly my kids listen to me, but one of my children tells me 'this is America, I am free', when I ask him to do something. If he is talking to me like this right now, at age 13, I am worried about how he will treat me when he gets even older.*
> *I was expecting for my kids to go to school and eventually university and a good life. But, I was also worried that my kids would lose their religion and I was told*

that if I discipline my children, I would lose my kids and my documents and eventually go to jail (SO)."

Hmong families, most of whom resettled in the U.S. earlier and have stayed longer in the U.S. than Somali families in this study, reported stress due to children's Americanization and actual change in attitudes. Embedded in this narrative is not only stress related to the Americanization of the children, but also the stress associated with loss of family structure, which may have been a buffer against stress prior to migration.

"Sometimes when I look at my kids, I know they are being naughty and I should discipline but I don't. I don't because all they have is me. When I punish them, there's no one to pull them into an embrace like a father normally would do and say it's okay. When I think of this, I feel sad for myself and my children (HM)."

"I feel my children are lazier, don't speak Hmong any more, are tougher, dresses different, and are easily influenced negatively by friends. They are just harder to coach because I don't remember ever disobeying or disagreeing with my parents/elders. There was a fine line of respect drawn back then. I feel children don't work hard because they've got it easy (HM)."

Relationships between parents and children seemed to keep changing as their stay in the U.S. gets longer. The intergenerational gap between children and parents was

normally found and it has both positive and negative meanings to the family. Children who can speak English are great family assets in one hand, while children changing attitudes and behaving differently are of great concern to parents on the other hand. In spite of this, children were great resources to families and particularly social capital and cultural assets who bridge the parents to the host society and broader community for family's adjustment and successful resettlement.

Although acculturation stress and all the hardships that refugee families have gone through often resulted in stronger bonding and attachment, some families had to deal with great stress due to changed family dynamics and structure.

> *"Life during migration was as tough as it could be. The hardships affected our family in many ways but we had to strengthen our bonds and relationships to face the daily situations. The loss of their [children's] father affected us the most (SO)."*

Domestic violence and abuse, among others, impeded the family in terms of health, resources, and other relationships involved with the family, such as extended family, relatives, and the community.

> *"As if things were not tough enough in America, my husband threw a bomb at me breaking my heart. The first month or so when we have been in US, my husband said to me one day out of the blue, 'You want to know why I married you?' He*

paused for me to answer and then he said, 'I married you because you were close on the waiting list to come to America.' I know he intentionally said it to hurt me and I believe it's true because I knew his parents did not want to come to America (HM)."

The author gained the sense that some stressors break down resources and impact relationships and potential resources in a destructive way. Vicious stressors, as the author would call them, tend to break the relationships and social network and thus social capital, as well as other crucial means for coping, among refugee families. As refugee families have experienced loss of family and community and therefore are deficient in social capital, this can bring an especially negative impact when families experience additional loss of family and social relationships. It may be even more the case in the culture where interdependence is a common norm and that forms extended family systems and community. In fact, a Hmong single woman explained how her relationships with her family got broken due to her ex-husband's abuse.

"My ex-husband was a cruel man and caused my mother and me to drift apart. When I was still married my mother came to visit us. My mother heard things of my ex-husband's treatment towards me from here and there but has not seen it herself. She was hesitant to sleep at my place over night because of this. She slept over my place because I repeatedly asked her. That night, my husband showed her no respect and didn't even acknowledge her visit. It was like she was

not even there. He was sitting on the sofa and kept making demands from me. Before my mother left the following morning, she said, 'My daughter, I will not visit you again. My reason is I can clearly see that your husband does not love you.' And since, she never visits me again. A while back before my mother arrived to US, my relatives who visited me in Wausau received similar treatment when we were doing a house gathering. My relative's said, 'My sister, we're leaving now and please understand why we cannot come see you again.' I felt their sadness and cried (HM)."

Stressors among refugee families after resettlement got diversified as the time of staying in the U.S. got longer and life in the host society settled down. During the early stage of resettlement, although the timeline may vary, refugee families (mostly Somali participants) described more cultural barriers and challenges regarding access to resources, while some Hmong families who resettled at least in 2005 or earlier year reported more family stressors such as domestic violence and discord with extended family members.

On balance, the results of this study support the hypothesis that different forms of stress gain salience at different times in the migration experience. Typically, threats to security and stress related to trauma are most prevalent in the pre-migration stage, with some refugees also experiencing high degrees of stress due to the threat of resource loss. The threat of resource loss continues in the migration stage, and is accompanied by stress related to a lack of resources during migration. Finally, in the post-migration phase,

acculturative stressors, taking many forms, predominate. While the main hypothesis of different stressors gaining salience at different phases of the migration experience seems to hold true, additional research may be warranted to look in more depth at how the SES of the refugee prior to migration may affect his or her perception of resource loss as a stressor. It would also warrant further study to look in more depth at how social capital changes over the course of the migratory experience, and how this affects the perception of stress.

Hypothesis 3: Homelessness is associated with multiple stressors. The third hypothesis is that homelessness is not an isolated issue, but is associated with other multiple stressors. Housing is not a mere independent incidence of stressor. The author assumed that homelessness is experienced as an outcome of accumulated stressors and confirmed this from the interviews with the families in the shelter.

First, the families reported that they started with temporary housing in either Minnesota or other states. In fact, the first housing for the Somali families, for instance, was expected to expire in a short time period, ranging from two months to eight months.

> *"The international Institute helped us move to an apartment. When they paid for the first two months they told us to pay from then on. We were getting $500 cash from the government and the rent was $800 (SO)."*

Two single Somali mothers who resettled in different states and migrated to Minnesota have similar stories showing how acculturative challenges barred handling housing issues in the early days after arrival in the U.S.

"Arizona was our first settlement when we came to the US. The agencies that resettled us had prepared an apartment for us in which they paid the first three months rent. The kids were enrolled in school and were away the most part of the day. It was a very strange in new environment for us at first. I didn't know where to start life. I wanted to work and support my family both here and back home but wasn't able to. The three months ended and I had to come up with half of the fourth month rent which was $310. I didn't have any means in mind to pay that amount. I then decided to leave for Minnesota and even then didn't have any means to travel. The few Somalis we met there helped and contributed to our bus fare to Minnesota (SO)."

"I was resettled by UNHCR in Tennessee where I lived for 3 months. My family was resettled and moved into an apartment whose rent was paid for by the resettling agency for the first 3 months, after which I was supposed to find a job and pay myself. I was a total stranger with a family of 9 to take care of in a new world in which I didn't know the language nor anybody who spoke my language. The kids were enrolled in school and I was looking for some help to get me started. I didn't find any social support and the 3 month rent subsidy ended before

I could find a job. I was then forced by circumstances to board a bus and move to Minnesota where I heard had a large number of Somalis and better social services (SO)."

As hypothesized, housing turned out to be not an independent problem but it was a clear indicator of unsuccessful resettlement in the first place of resettlement. Most of the Somali families in Mary's Place had gone through a similar course of how they lost housing: being housed in a very tentative housing often with limited time given for self-sufficiency (i.e. mastery of basic English, employment, and navigating systems by oneself, etc.). Becoming homeless in the first state (i.e. losing an apartment) was replaced with becoming homeless in Minnesota (i.e. staying in a temporary shelter).

"The resettlement agency that brought me rented a place for me and they paid the rent and utilities for 6 months. They asked me to take care of the rent after 6 months and I my income was very little so I couldn't pay rent and I ended up moving to Minnesota. When I came to Minnesota I didn't have enough income to rent an apartment right away so I came to this shelter (SO)."

Housing issues were interwoven with multiple challenges among language barriers, transportation, lack of information, unemployment, and lack of childcare and so forth. In fact a combination of multiple resettlement challenges directly impacted families' housing situation in most cases.

"I expected to work and my husband to work and even my 19 years old daughter to help us and work. Then when the three of us earn money, everything would be easy. But I did not realize how difficult finding a job is and that nobody will hire people who don't speak English (SO)."

"The biggest worry is about getting a job and paying for my own rent. I need both. For this I also have to learn English. Transportation is another concern. I have to say two major things are job and housing (SO)."

Living in a homelessness shelter brought the family temporary relief after a fear of losing a place to stay for few months, although the situation was still highly stressful. The alleviation of the fear did not last long and living in a shelter itself was experienced as a great stressor causing frustration and sense of shame to many families.

"I am more worried and less confident due to being homeless. I looked a lot healthier and happier, but since coming here I lost a lot weight and I am sick because of the stress. In the U.S rent is expected from someone who doesn't have an income. In the camp shelter is free. We never expected to come to the U.S and be beggars, we thought people were going to beg us (SO)."

Life in the shelter also generated additional stressors due to strict regulations of the place and continuous lack of information and resources. The direct impacts of the shelter life on the families included negative changes in family relationships, particularly those between parents and children, due to changes in discipline and parenting manner and high level of psychological distress for both parents and children.

> *"The children are not very comfortable given the strict rules of the shelter and we have to make them sit at one place and not jump around in the unit in fear of causing disturbance to the neighbors. Language barrier and permanent housing is our biggest concern (SO)."*

> *"They [my kids] perceive me differently because I tend to be extra harsh and strict on them about playing around and touching things that might result in us being kicked out of this place. I'm forced to keep a constant eye on them (HM)."*

Multiple types of acculturation stresses were found in homeless refugee families and the emotional burden was intense. Somali families were struggling with housing issues while experiencing pressure for self-sufficiency with what they report to be an unrealistic time goal, usually around three months.

Hmong families, meanwhile, have reported different patterns of housing issues: domestic violence and/or conflicts with extended family or relatives, who otherwise would support temporary housing. Except for the four two-parent families, seven Hmong

families had an issue of either domestic violence/polygamous relationship or conflicts with extended family members. This resulted in homelessness since a lack of social capital within the family resulted in limited housing options, while some family conflicts began due to housing issues, which eventually led them to separate.

> *"Housing problems are part of the reason why my husband and I ended up separating. He and I would quarrel over saving money for rent or other necessities. My husband is the type of person that after we have paid all our bills and have a little bit of money left; he would want to spend it. I am different in the way that I want to save what's left for other necessities for the following month such as a higher utility bill. We had many disagreements on housing. My children are worked up over not having quiet study place [HM]."*

In the meantime, the two-parent families were struggling with economic suffering. Five of the eleven Hmong participants were recurrent homeless families, while at least two of them experienced homelessness, aside from double-up, multiple times.

> *"This is our second time being homeless. We were close to homeless and it was when our house in Minnesota foreclosed three years ago, before we moved to Oklahoma. Our house had gone into foreclosure because my husband lost his job as a medical assembler (HM)."*

"I have been homeless at least seven times in my life including living with relatives when moving from place to place. Once when I left with my uncle to Thailand, twice when I came to stay with husband relatives for a month, thrice when I moved to stay with relatives in Milwaukee for a month, fourth when I moved to stay with mother, fifth when I moved to Mary's Place, and seventh when I came back to Mary's Place after I moved out (HM)."

To some families, being homeless or lacking stable housing was rather a chronic condition of living. Female Hmong parents, regardless of what the direct reason for losing the previous housing, mentioned their lack of adequate education and job skills as a major issue that eventually led them to the current situation: homelessness.

"Moving so much takes away hope, security, and stability but it is unsure if migration is a cause for housing experience today. The skills learned in Thailand and Laos cannot be applied to US jobs because it does not require written language (HM)."

"In all, if I am literate, I don't think my migration would affect my housing as much (HM)."

The size of both Hmong and Somali families in this study was 8 people on average. This impacted their search for affordable housing, and it often ended up living in overcrowded conditions.

"The system needs to change somehow because I am in this shelter because we can only afford to a 3 bedroom apartment and we are 8 people, and we can't live in a 3 bedroom apartment because the laws say 2 people per bedroom (HM)."

Before becoming homeless, the affordable housing for the families was a place at low cost of rent and accordingly of meager conditions. That is, to afford a rent, the families needed to compromise the cleanliness and safety for affordability.

"The first place we lived in was a large two bedroom. The place had lots of roaches and the rent was $650 a month. We stayed here for one year. My uncle helped us with some furniture, blankets, and dishes. Our second place was also a two bedroom but it had a loft. This place had rodents and roaches. My children feared the roaches and rodents. The rodents were terrible. They nibbled our clothes. My daughter's clothes normally contain milk and snacks. I forgot to wash it right away so the mousse ate her clothes. The places that had roaches made me worry about roaches getting into my children's ears. We stayed here for a year. Both of these places we lived in were foreclosed. We then came to Mary's Place in 2005. After we moved out of Mary's Place, we lived in a three

bedroom for $850 a month. Mary Jo Copeland helped subsidize $350 a month. We lived in this place for two years. We moved back to Mary's Place because our place foreclosed (HM)."

"There was a lot of issues with the place, there were roaches, mice and it was also small we could not all fit in it. The Child Protection asked us to move and we could not find housing so they asked to move into the shelter and I said I don't even know where a shelter is. Then they called Mary's Place and arranged for my family to come here (SO)."

Emerging themes regarding stressors. New themes regarding stressors emerged from the data analysis. First, stressors after resettlement were mostly not only unpredicted but also against expectations and plans that refugee families had. Although the analysis showed that both positive and negative information about the U.S. was pervasive in the camps, some expectations that did not reflect reality in the U.S. frustrated refugee families significantly. Wrong information and rumors shaped the families' expectation before resettlement and became unmet needs or frustrated hope, which is a cause of psychological distress such as frustration and disappointment. Some of the frustrated expectations became actual stressors because they eventually devastated other resources and coping plans as well.

"Okay, first of all the idea I have of America and the reality was totally different. Before I left the refugee camp, the people I left behind I told them each how much money I will send them once I come here. So my phone is always ringing they are asking me what happened where is the money and I don't have anything to send them. If they only knew I am in a shelter with no money and homeless and stressed out, they think I am in heaven (SO)."

"People were getting resettlement money what we call "welcoming money" and our family never received anything other than $ 40 for 8 people. With all that aside we had food support that we could not use even though we needed food because we did not know where to buy food. So my experience in that state was horrible (SO)."

"I never expected I would struggle like this. I thought the U.S was going to be like entering heaven. I was 100% happy to be coming to the U.S. I was shocked when they gave me $40 to buy household items and to do laundry with. I was expecting thousands of dollars and my biggest concern was how I will carry all that money. I was so disappointed I could hardly walk (SO)."

Not all expectations were based on rumors or naïve expectations. Some reasonable hopes and prospect were not met either, such as the desire to work and establish stable housing.

"We know we had to pay rent, but we did not know how expensive it is to rent and we didn't know how difficult it would be to find a job (SO)."

"There are major differences in the systems. Back home if you find a place, you can move in the same day and pay the deposit at the end of the month. Here you have to do a background check, rent history and must pay the first month's rent and deposit on the same day (SO)."

Another theme that emerged during the data analysis was trade-off. Some type of stressors were common in refugee camps, many of which were resolved after resettlement, such as fear about starvation, threat to security, ongoing worry about being sent back home, and extreme paucity of necessities. However, new types of challenges emerged upon resettlement and these replaced the previous stressors.

"In the refugee camps, we only had fear and hunger. You have to pay off the cops. However, we are worst off here [in the U.S.] because we don't know the language, we can't defend ourselves. My children get beat up but they get in trouble because they can't speak the language. We are not hungry, but I am a single mother and we have many more issues now, other than hunger (SO)."

"The place we lived in the refugee camp was a semi-permanent structure that isn't suitable for any human being. What we have here is more decent. But the

issue is stability. We didn't feel any pressure and restriction in the camp. We were free although the conditions were pathetic. Children were free to play wherever they want and they were familiar with everything (SO)."

This implied the importance of access to resources, rather than either objective information or subjective perception about the amount of resources in the environment. Most of refugees were, in fact, struggling with language barriers, lack of transportation, and cultural barriers that impeded access to the environmental resources. The issue of accessibility was often forgotten or uncounted among refugee families before resettlement. The information related to availability and approachability of resources, therefore, was missing in cognitive appraisal of anticipated stressors. With the gap between expectations and the reality as well as lack of resources, proactive coping tends to contribute to additional distress and burdens for the families.

In considering the hypotheses about stressors, the discord between expectations and actual living situations, particularly after resettlement in the U.S. may present an additional form of stress that is unaccounted for by any other categories of stress. While it may seem apparent that financial struggles will be encountered upon settlement in a new country for most refugees, this is often not the belief that is actually held, due, in part, to myths or commonly held misperceptions about the ease of accumulating material wealth in the U.S. This discord assuredly results in increased stress, as refugees must temper their enthusiasm as they reconcile their expectations with their realities. These findings

are difficult to account for in the current hypotheses, and certainly warrant future investigation.

Resources and Coping

This section explored how stressors impact resources and coping and how various types of resources have been changed in refugee families, identifying both loss and gain according to migration. The author also tested the hypotheses on transition of resources and social capital as well as coping patterns, including problem-focused and emotion-focused strategies.

Hypothesis 4: Loss of resources. As revealed in the previous section, resources are one of the main domains that are closely associated with the cause of stress. Various types of resources, such as personal, family, cultural, and environmental resources as well as social capital, are exposed to high risk of loss and devastation. The data of this study confirmed that the stressors that refugees have experienced significantly and adversely impacted resources of various types.

First, some stressors impeded refugees' personal resources that are directly associated with coping skills and capacity, such as health, education, job skills, and language skills.

> *F: I want to work but I can't because I cannot lift a heavy thing with my arms. I have pain in my arms since refugee camp.*
>
> *I: What was the reason for the pain in your arm? Did you get injured? Did you see a doctor?*

F: No. I haven't shown this to a doctor. The pain started in the camp. I had no doctor to show. They have medication. But if you want to see a real doctor and go to better clinic, you need to go to big city. I didn't get treatment. My eleven year old daughter helps me but I need more help. It is too difficult to take care of six other kids without husband and help.

Second, significant loss of social capital, particularly bonding, was obvious in the refugee community. Loss of family members, including adult children, spouses, and relatives critically hampered resources for livelihood to the families. Although the single mothers that the author interviewed all wanted to work, most of them still had no resources or social support for childcare. Without family resources or additional social support from extended family members or relatives, employment of single mothers did not seem to be a feasible option for the refugee families. The burden of childcare is also likely to impede the development of new livelihood skills, by attending employment education or English classes, for instance.

"I needed to work and I couldn't find any work and there wasn't anybody to watch my children (SO)."

"I took my children with me to [English] class because I did not have access to childcare (HM)."

Once social capital is broken, it takes quite a time and commitment of resources to rebuild and redevelop it. Refugee families with limited or lacking resources have a harder time establishing social relationships and eventually social capital.

> *"I don't have a chance, time, energy or transportation to maintain a social life. It's just me and my kids. ..... In my country, you had a chance to socialize, but there is just no time in America. Twelve hours here is like one hour back home. It is because I have no help. Help even comes in the form of social activity, but nobody has time here because they are busy with their own lives (SO)."*

Third, cultural resources, one of the most devastated forms of resources in refugees, became a source of great distress to many families after migration to a new environment. Cultural resources are not necessarily within personal capacity or under control of an individual. In other words, even if obtaining cultural resources may be facilitated by high education, good health and positive psychological traits, personal resources are not a sufficient condition, and the success of gaining cultural resources depends on external factors: cultural resources belong to cultural groups and the community, so the person needs information and support from the community for its members to enter the system. For this reason, many refugees, including many in this study, migrate to areas where they may find a community of other refugees of their ethnicity, in order to gain some degree of cultural resource, at least within their sub-section of the broader community.

The value and functions of cultural resources were often dismissed until emigration to a different culture proceeded. Many forms of cultural resources, such as language and information about the neighborhood and community, tend to be taken for granted. When lost or impeded, however, the cultural resources impacted other types of resources as well since they provide coping means and methods to access to other resources.

> *"Moving to America was hard. We experienced winter, the bills, and language barrier. I went to the grocery store and it was so hard for me to count money to pay for it. I did not know how to get to the grocery store because I couldn't read signs or directions. In Laos and Thailand, there's no need to write checks and there's technically no bill. You earned and used it right away or you grow enough food for your family so you don't have to make garden purchases (HM)."*

Cultural and environmental changes called for a whole different set of coping skills and resources for survival. Families had limited resources to rely on to gain and develop basic cultural resources. The author asked about cultural orientation both before and after migration and it turned out that the quality of which was not enough to establish or develop cultural resources for the U.S. Many Hmong families whose relatives were also resettled in the U.S. reported that informal assistance with cultural orientation worked better.

"Before we left Africa they told us not to open doors for strangers, because there are people in the U.S that kidnap children and kill people. So every time our case managers or people from other agencies came and knocked the door [we did not open the door]. When three months had passed they brought a Somali interpreter with them because we were supposed to respond and fill out paperwork and we did not know (SO)."

"My uncle sponsored us and supported us for about a month. He helped us find a place and taught us how to pay the bills. He helped write out the bills a few times for us until we got a hang of it (HM)."

Cultural resources often function in a family unit. Refugee parents with limited personal resources to develop cultural resources in the host society may have to rely on children who learn a new culture much faster than adults. The findings of this study showed that expectations of parents for children were associated with social integration strategies through which children adjust to the new culture getting good education while preserving their own religion and respect for cultural traditions. In this ideal, refugee children who can speak and understand in English tend to play a role as "cultural broker" who can communicate between parents and the host community. Children are regarded as a cultural asset to the family and this is a valued resource for the entire family to survive and thrive in the host society.

"I see my children supporting me when they are done with high school and gotten a higher education. I see myself having a home for her children and a reliable car unlike the one I has now (HM)."

"We [mom and older kids] are adjusting to life very slowly. The younger children are more flexible and I'm sure they'll integrate faster than the rest of us (SO)."

Parenting, however, is challenged by other stressors that families face, and this may challenge the notion of the children as a cultural broker resource for the family. Homelessness, for example, was ascribed to the factor that negatively influences the relationships between parents and children. When housing instability was prolonged, parenting tended to be distorted (eg. over-monitoring, harsh punishment, etc.) and accompanied by additional challenges. Often families with unstable housing cannot provide enough resources needed for their children, which made the children think that their parents had changed. Cultural resources at the family level are also related to changes in family dynamics. Some parents were told that they could be sent to jail if they discipline children and thus worries and helplessness as well as hope and expectations for children were coexistent. A Hmong single mother who divorced her husband due to domestic violence and has eleven children expressed her difficulties in parenting as below, as a result of her lack of resource in the form of a supportive partner and father.

"The older kids are being difficult now and they don't listen to me. Their father

would be able to discipline them because they fear their father and would listen to him. It's hard to coach and give direction when you have so many kids (HM)."

Environmental resources were sparse in the home country. As most of civil structures were underdeveloped or destroyed in the home country, refugee families found that there are abundant resources available in the U.S. In spite of the difficulty in access to those resources, refugee families still valued and felt relief about coming to a rich environment. Most of all, both Hmong and Somali refugees experienced collapse of the governmental or group authorities.

"I moved to Xieng Khang camp which closed in 1993. Then, I moved to Wat Thamkrabok camp. Here there was no government support like the others so we had to provide for ourselves. In 2004, USA announced their registration to come to the USA. I registered and came to the USA (HM)."

"America is much better than our home country because of transportation, luxury, no bugs, and endless food. In Thailand or Laos, you worked hard and the bugs were scary. You would carry water from a faraway well and worked hard in the fields. Here, you can't die because there's the government support (HM)."

Resources available for refugee families. The analysis of the interview data revealed that various types of resources were utilized by the refugee families. The

resources, although in various forms, were available or accessible to a limited extent.

Personal and family resources. Although loss of resources was more salient than resources remaining for the families, common forms of personal and family resources available for the families were identified. They included optimistic attitudes (often based on religious faith), hope and effort for family resilience through children's education, family bonding, a balanced view on the American and traditional cultures, sense of humor, and solidarity between community members.

> *"I am very optimistic about the future of my family. I envision a bright future for me and my children (SO)."*

> *"I have had some education in Thailand so I hope to learn English and be an accomplished person in the future (HM)."*

However, the degree of personal resources, particularly psychological strengths, was varied depending on the circumstances. Most of the families presented how difficult it is to learn English and adjust to a new culture. The perceived resources, especially cultural resources, exist as family resources rather than personal capability based on educational levels or health status. In other words, even when personal resources are not enough it can be compensated with personal resources of other family members, who tend to be children in many cases.

"If I was educated, I would be able to see my dream and have ideas of how to help myself. Now I can't see a future where I would be successful. I only see myself as I am now. I can only try to help my kids to be successful now. This is the way our family can be well (HM)."

One Somali single mother having a child with disability shared her expectation before resettlement and perception about services that she has received.

F: I was one of those people who thought in the U.S there are walls where you just withdraw money; instead of money I received an abundance of snow [laugh].
I: When life here did not meet your expectation, how did you feel? Did you feel angry or upset?
F: No I am not angry. I promised to make sure my kids get the education they need so that they can have walls they can withdraw money from.

Support and care from service agencies were also recognized as critical resources, which are either material/financial or in-kind (eg.: interpretation service or provision of information). Although the families have experienced high barriers to access to services and struggled with such basic issues as getting foods and finding interpreters, many families possessed positive feelings and gratitude to the service providers and American culture in general. Appreciation of a different culture is also a positive resource that seemed to help their adjustment to the host society.

"We arrived in Minnesota and were taken to Hennepin County Economic Assistance. There we found Somali speaking staff who helped us apply for benefits. We were then brought to this shelter where we live now (SO)."

"There's a world of difference between the two cultures [Somali and American cultures]. Both have pluses and minuses. Hard work and time management are one of the things I admire most about this [American] culture. No wasting of precious time. My fear is for my kids to join bad company and go astray (SO)."

Family reunification was a direct way to restore family resources when family members, relatives or members of the same clan formed a community in the U.S. Education to children was another adaptive coping that results in increase in family and cultural resources. To some families, restoration of social relationships was another potential resource. Although refugee families have lost an amount of social capital during and after migration, they hope to reconnect with the social networks and the community, who they had to separate due to complex stressors, such as family discord, lack of material resources, lack of information, and shame or stigma associated with homelessness. A Hmong single mother who has not communicated with her relatives for a long time expressed her desire for reconnectedness after escaping homelessness.

"I also see myself getting invited back for relatives' spiritual events and having earned their respect (HM)."

Cultural and environmental resources. Cultural resources relevant to one's home country and own culture were not all negated during and after migration. In fact, they have functioned as a powerful source of emotional and cognitive coping resources. Religious faith and beliefs in God's will, for example, were frequently reported by the families when they recalled how they could survive such traumatic and stressful situations. Some of these cultural resources were not only a source of optimism but also a framework to interpret their hardships and trauma.

> *"I have a paralyzed child who needs to be turned over every time, when I pay attention to my situation being new here, not having stable housing and nobody to help me with the small children I get helpless, but then again I remember God, and I think he will help me and I don't lose faith in him (SO)."*

> *"The waves were starting to push us to the dark side. I kicked and kicked and could gear us to change direction. I called out, 'Mother and creator of all things! Please take me to Thailand. The water is too great. We will certainly die if we end up on the shores of Laos.' I am always looking to do good and make choices to improve my life but I end up suffering. At this very moment after my prayer, a huge wave hit us and faced us towards Thailand and carried us to Thailand shores (HM)."*

Environmental resources refer to the resources that belong to certain place or

space, either natural or social. They are available for the members or elements of its environmental sphere. As the host country tends to be a society with more stable and plentiful environmental resources, compared to refugees' home country, many refugee families tend to harbor a hope to gain rich resources after migration and resettlement. In fact, the resources in the U.S. are relatively affluent and secured and thus provide a better social environment to the refugee families. The identified environmental resources after resettlement were government support, including not only the actual government resources (i.e. health insurance, public assistance, food stamps, etc.), security in the neighborhood, health care, abundance of goods and wealth of the society, and steady systems. It was frequently reported that these environmental resources were expected even before migration or resettlement and some families had bigger or more resources than those in the reality as seen in the previous section on the unmet expectations.

> *"Well we already received safety in America which is very important; we are also expecting the community and the government to help us with housing, income, education and health care (HM)."*

> *"We left [Somalia and the refugee camp in Ethiopia] because of no safety and we wanted future for our children and health care because we have sick children. In the U.S we found safety, health care and education, the only problem is we have no housing (SO)."*

A theme that emerged and repeated through the cases was a distinction between the resources present in the environment and actual environmental resources that refugees can access. Most of the families reported that whereas there are plenty of resources in the U.S., families feel frustrated about not being able to reach those resources.

> *"I first arrived in Portland, Maine. I left Maine because I got sick and needed help with my disabled son, so I was looking for Somali's. I came to Boston to have surgery. When I had surgery people tried to take my kids from me so I got scared. There were no interpreters and no Somalis. I went to Boston first because I was told I would find a good doctor for my disabled son, but I didn't end up finding one (SO)."*

> *"We had access to health care there provided by UNHCR. If there is lack of health care it is in the U.S., not in the refugee camps (SO)."*

The information or expectations that refugee families had were about the environmental resources that would be available only if there was no constraint to access. Actual resources that the families could approach or obtain were much less or limited due to the barriers, mostly cultural, to the resource access.

> *"We can't do much we are helpless. We don't have access to anything. There are language and cultural barriers (SO)."*

"There are a lot of empty houses out there. There is not a single small one for me and my kids. Company can give you a hard time. School teachers give you a hard time. Neighbors give you a hard time. America gives you a hard time (HM)."

Even when there were resources that families might utilize, basic necessities were still hard to obtain for the newcomers, mostly due to the cultural constraints to access the needed resources. For instance, most refugee families received food stamps or other types of assistance, but they were still struggling with gaining foods and other necessities. Amount of resources may be important, but actual use of the resources was separate from the mere possession of the resources. Usability as well as accessibility of resources matter in refugee families, particularly those who resettled without social support from the community members or relatives.

"We had so much food support on the card but we were so hungry because I did not even have anyone to help get groceries for us (SO)."

"I get $700 cash, $800 for food and $674 for social security for my son. I have enough income for a house, but there is no access to an adequate home with a ramp. [……] I have been looking for a house for my disabled son for eight months and now we are homeless (SO)."

A form of resources mattered particularly with those lacking cultural resources. Cultural resources functioned as a resource-inducing resource and were the core resource to coping mechanisms in the resettlement country. Accessibility to environmental resources and usability of other types of resources heavily relied on the level of cultural resources that the families have or can approach. To the newly arrived refugee families, however, cultural resources were hard to obtain by themselves and the obtaining process itself took a lot of resources, including significant amount of time. Thus, the most commonly found strategies to gain cultural resources among the families were to seek for social support, mostly in the form of bonding social capital, which can assist the families until they are self-sufficient.

In summary, this hypothesis seems to be supported by the evidence of this data set. While refugee families do have access to some resources, whether financial, cultural, social, or otherwise, the stress of the resettlement process seems to negate the utility and accessibility of those resources, leaving many refugees, including those in this study, with a reduced resource bank. While this hypothesis seems to be supported, it is unclear as to which forms of stress are most responsible for the deterioration of resources, as it is unclear whether stresses in each stage of migration are equally damaging to resources available to refugees. Conversely, it is unclear whether certain coping mechanisms are more helpful than others in gain access to more resources to offset the negative impact of stressors. It is clear, for instance, that informal cultural orientations delivered by peers who have been in the U.S. for longer periods of time are useful in helping refugees accrue cultural resources, but it is unclear whether this method of resource building is suitably

robust to justify formalized use of peer-to-peer support networks in the refugee resettlement process.

Hypothesis 5 & 6: Coping through social capital. It was hypothesized that failure to rebuild social capital after migration impedes adjustment to the new living environment and thus that refugee families tend to utilize coping strategies that may increase social capital. This section will examine these hypotheses based on evidence from the data set. Social capital as a resource played a role as a substitute for personal and family resources among members of this sample. Bonding social capital has been a great resource for many refugee families to survive the meager situations in the home and migration countries. When economic activities were not possible, other refugee families became a source of support for basic needs when circumstances warranted, such as foods and childcare. To understand the importance of social capital after migration, it is useful to first establish the centrality of social capital in how refugees lived in refugee camps prior to resettlement.

> *"We got along with the residents of the camp. They were all Somali. We relied on each other. They would give you food when you run out and vice versa. They were there for us and we were there for them when needed. Now I have no one with me (SO)."*

Although minimal, economic life in the refugee camps in Thailand was based on mutual aid and communal projects aimed to boost each family's livelihood.

"Everyone earned money through sewing. We worked in teams. If I had a family who requested a sewing project, then I would split the job and pay others to help me with the sewing project. When I am done with my project and someone else had a project, I went to work for them. It didn't matter if the project was twenty to thirty baht profit. It was something to provide dinner on the table. It's very little money earned but we can't work outside of the camp (HM)."

"Thai food costs are like the costs here in US. So we and some Hmong would rent a farm plot and farm. If we don't farm, we don't have food to eat. Again, we also pay each other to harvest and plant the farm. For example, when rice is ready for harvest we would pay them. When it's time to weed the farm, we pay people inside camp to help us weed. Basically, the people within the camp would create jobs for each other and to help each other (HM)."

It was a general way of coping to rely on community members as well as family in order to generate needed resources in the refugee communities, both Hmong and Somali. The coping through social capital before resettlement operated well, even if within a limited scope of activities due to sparse resources and many restrictions in the camps. After resettlement, social capital was reshaped due to separation from the familiar community and relocation into a different culture. Social capital was heavily dependent on family social capital or limited to only small amount of bonding social capital when

families resettled in a remote place from refugee communities. Bonding social capital, even if at a low level, was especially useful for the families in early the resettlement stage as it provided cultural resources and thus helped coping process.

> *"For grocery, I used to get help from many single Somali people who would come on the weekends and get grocery for me (SO)."*

The Somali families also received assistance from Somali people, many strangers, when they traveled from the previous state to Minnesota and found a temporary place to stay, including Mary's Place.

> *"A mosque paid for our ticket to come to Minnesota. When we came to the airport a Somali cab driver took us to a home that we don't even know where it is located after telling him we didn't know anybody in town. Next morning he brought us to Mary's Place and we were told it is full. So were taken to Hennepin County and filled paperwork (SO)."*

Secondary migration among refugee families, particularly Somali families, was a process to reconnect to bonding social capital. In fact, most of the refugee families actively sought bonding social capital in the U.S. even when it was not the easiest strategy to reach to the ethnic community. Indeed, migration did not guarantee resource gain all the time. Even if the families gained the resources they were seeking, it also

happened that the families lost other resources that were assumed to continue without doubt. For many refugees, the tradeoff in this relationship between gaining social capital and forgoing other potential resources is not apparent. Faced with mounting challenges in acculturation, however, many individuals make the choice to relocate to a place where building community is possible, and where the development of social capital holds the promise of greater stability.

Sometimes, migration was based on inaccurate and misleading information or naïve expectations. A Somali mother who was also a secondary migrant expressed her regret about the resettlement to the U.S. itself.

> *"My husband is in Ethiopia, he is not in a refugee camp, and he was not registered at the camp so the U.N only brought me. If I have the means to go back to him I would. He is no longer in the camp now. [……] I never expected to be locked up in an apartment stuck there not having anyone to call or to come to your rescue. I expected to make all the money and return home with money to take care of my family. That is why I didn't wait for my husband to come with me. If I knew I would be struggling this much, I would have never left my husband (SO)."*

Migration changed or rearranged the environmental resources available or accessible to refugee families. In spite of the risk of losing the remaining resources, however, migration had an active and often adaptive meaning among refugee families. Secondary migration to Minnesota, in particular, was to reconnect with the ethnic

community and restore bonding social capital that is needed to increase or develop cultural resources.

Bonding social capital remained among the most needed type of social resources and support to many refugee families who participated in this study. First, bonding social capital provided cultural resources, particularly functional information for navigating the host community and thus a means by which to access other resources. Resources gained through bonding social capital were likely to be culturally adequate and customized to refugee family's needs. Transportation and interpretation, two major coping means, were only derived through social capital when families were not equipped with cultural resources.

Considering the most challenging issues upon resettlement to many families were acculturation stress, it was an understandable consequence to cope with such stressors for the families to choose migration to rebuild bonding social capital.

> *"I was concern about robbers and bad people. Also, I didn't know English and had no car so I stayed home most of the time. Even if there were few [Somalis], you can't find them because they are driving or elsewhere. We are stuck in our apartments. I did not even know how to turn on the stove, I attempted one time and it made a loud noise I thought it was going to explode, so I shut it off. We slept hungry for three days (SO)."*

"Here we don't have those issues [lack of transportation for grocery shopping]. We can ask a Somali person to help and say my children are hungry can you help or ask them to do grocery shopping for you (SO)."

The meaning and function of bonding social capital to families was not limited to the increase in family and cultural resources but was also related to symbolic resources that offer psychological relief and buffering. The bonding social capital created a role model to refugee families, even when there is no direct communication or interaction and thus no actual resources come out of the relationships. It became a source of hope and empowerment to the families.

"They [other Somali families] are handling everything with grace and courage gained from past experiences. We are optimistic when we see other Somalis well adapted and speaking English. We believe we will get there too one day, through thick and thin (SO)."

Bonding social capital, however, was not a panacea to all the stressors that the families face. A majority of the families well recognized this. Families reported that there are some issues that people in the community, including relatives and people of the same clan, can support and help while there are several core issues that few people in the community can help solve.

"Your family can only help you out so much before you exhaust them especially because it's a family of 11 living with a whole other family. I don't blame them and I understand it hard taking in a family of 11 so we decided to come to Mary's Place. (HM)."

The families were clearly aware that the resources that they could obtain from the refugee community (i.e. bonding social capital) are too little to solve housing problems and other livelihood issues. To become self-sufficient, refugees realized that they would need another type of resources, which are often in a form of temporary assistance or service programs from the government and social service organizations – that is linking social capital.

"We are expecting all of our basic need from America. Somali can help us with language and assistance with directions and or give us information, but they can't give us one dollar because they are struggling themselves (SO)."

Families started realizing each form of social capital would not replace the other. A family expected interpretation and transportation services from a resettlement agency and found that it was not likely to be met through the agency.

"I talked to a Somali woman who was our case worker at the resettlement agency. She told me there was nothing she can do for me other than interprets for me

when I come to the agency. She would not help me get to the hospital or even take food for my husband and she wouldn't take me grocery shopping (SO)."

Trust in service professionals and members of outgroups tended to deteriorate through bad experiences during migration (i.e. in refugee camps), which in turn affected the refugee families' interaction with and attitudes toward the professionals to a certain degree.

The results of this study suggest mixed conclusions for this hypothesis: that refugees who do not establish social capital struggle to succeed after resettlement. While the data set contains abundant evidence that supports the importance of bonding social capital among refugees, and the lengths that refugees will go to in order to find in-group social capital building opportunities, bonding social capital has limits in promoting successful integration. Bridging social capital is also required for successful transitions to the host country, and it is here where many refugees struggle. Language barriers, discrimination, cultural differences, and a long history of mistrust of outgroup members inhibit the development of bridging social capital, which may be of optimal utility in assisting refugees to find stable work, that may lead to more stable housing. Thus, it does appear that refugees who do not build social capital will struggle in their resettlement, although the balance between bonding and bridging social capital that optimizes resettlement outcomes may be a research question of greater utility.

Coping process. The findings from the inductive analysis revealed various types of coping and associated themes. Cognitive appraisal, as an initial coping step, was

carefully sorted, and a few themes emerged from those codes that explain refugee families' cognitive coping process.

The previous sections showed that the exposure to a new environment was a core feature of refugees' stressors, such as migration and resettlement. Living in a new culture has reshaped the resources and thus changed the meaning and function of coping mechanism that used to work in different contexts. This environmental transition required refugee families to reappraise resources and stressors in the given contexts.

Cognitive appraisals usually operate to collect as much information as families could and to plan for behavioral coping options. Some stressors as well as the environment, however, were completely new to refugee families, so it called for reassessment of environments to identify the source of the problem and find new resources, including cultural resources and other coping means. The functions as well as meaning of resources also changed according to the transition of contexts and accompanying challenges. Thus, cognitive appraisals that refugee families used were characterized as an active reappraisal of meaning and function of stressors and resources.

> *"Before coming to America, I thought I would work right away and become wealthy. I realized the reality a few weeks after I settled down in North Carolina. There were few Somalis and no one who we could talk to. They [the staff in the VolAg] didn't know Somali and I didn't know English so we couldn't talk to each other. I started thinking I was wrong and got stressed. When I happened to see a Somali guy who was from Minnesota, I asked him for advice and I learned there*

will be more opportunities in a big city like here. We all realized that English and transportation were the biggest worry. That's why we decided to move here in a few months after continuous disappointment and stress (SO)."

"[When resettling in the U.S.] I was happy but did not expect to have any of these problems with finding a home. I wasn't expecting that I would ask myself: "how will you feed your children?" I wasn't expecting to ask myself: "how will you pay the rent this month"? I am grateful for the U.S. because I did not have a husband, and Americans became my extended family (SO)."

Themes found in the codes of cognitive appraisal included comparison, trade-off, and prioritizing. During active evaluation on the current situations, refugee families often mentioned their previous living conditions in refugee camps and compare what they used to face with what they are currently situated.

Life in Somalia, I don't know if I can even call that life, we were waiting for the day we will die. Refugee camp was safer, but still it was struggle, we worried about if we will be selected to be sponsored to come to America. Texas was great until I was told to pay rent and I didn't have the means, so I become unhappy. [In] Minnesota I am in a shelter, so you can imagine living here. Overall comparison life in America is much better than life in Africa even with housing problems.

This pattern of cognitive coping also found in the previous section on the evaluation of stressors, which was named trade-off. Not only stressors but also resources were often regarded as something traded.

> *"We couldn't navigate the system, ask for help or look for jobs. We had basically become handicapped. We knew we had to support ourselves and come up with the rent after three months and that was our biggest fear. Nevertheless we knew we were in a peaceful country and didn't fear for our lives or afraid to die of malnutrition or lack of medicine (SO)."*

Although many families reported comparison as a cognitive coping style bringing a positive result, the comparison between previous and current living situations led some families to worsened psychological outcomes and increased frustration, as they appraised the home country or even the refugee camp to be superior to life in the U.S.

> *"In home country, if you wanted to go somewhere, you would just go. If it was too far then you took the bus. The buses only run on the main routes here. In the U.S. you need a vehicle to get to places whereas you walk to your destination in Thailand. In US, you need a vehicle because during the winter time, it's too cold to walk. The weather in US ranges from hot to cold that it's unbearable to walk to your destination (HM)."*

When comparison is functioning, the reassessment of the stressors and resources in different environments often led to prioritizing goals and coping methods. These helped families to focus on the major urgent issues.

"My first priority and concern is stable housing. The second one is learning English for all of us especially the children who need it for school. The children's future education is also a major concern (SO)."

"The most important thing to my family is stable housing, children's education and health care. For this we need to speak English and have transportation. Others can wait (SO)."

Comparison and prioritizing were not only a coping method to evaluate the contextual situations and plan for behavioral options, but also played a role to degrade other stressors out of focus.

"The UN provided us with one type of food for the whole 19 yrs. It was wheat all the way. My children were all born in that environment so I guess they kind of adapted because they hadn't experienced the change. They didn't like it either but there was nowhere else to go. Safety was our main concern. As far as we could eat it was okay (SO)."

Hypothesis 7: Problem-focused vs. emotion-focused coping. The seventh hypothesis speculated that refugee families would adopt problem-focused coping styles to a greater extent than emotion-based coping styles. The analyses showed that the problem-focused coping style was dominant in the refugee families, in line with the hypothesis. Even when they could not control the situation, such as war and threat to security, emotion-focused coping style seldom came up from the families.

F: I am constantly under stress and so are my children. I have to constantly keep my kids inside the home so that they do not encounter trouble outside. I worry all the time about my kids and their wellbeing.

I: Have you or your family made any effort to reduce the stress? What was it?

F: [pause]

I: Some people talk to others and others may take a medicine for better sleep.

F: There isn't much to do. I make tapes with recitations of the Qur'an for my boys to listen to. I also find them Somali movies and plays for them to watch, so they are busy at home and I can keep them from going outside. I just lock myself in my room to relieve from kids.

Although the Somali mother answered that listening to Qur'an recitation, it was unlikely for her to use it to soothe or relax her stress. Rather, it was related to her concern and worry about her children losing their cultural and religious background in the U.S. There were other cases that undergird this pattern.

I: Have you or your family made any effort to reduce the stress? Something like talking with other family or friends or talking to the staff here. Some people may take a medicine for better sleep or go for a walk or so. Have you or your family done anything particular to feel less burdensome?

F: No, because until we have a solution to our housing problem we will still be stresses.

I: When you have worries, trouble in sleep, or no appetite, what would you do? Would you talk with a doctor?

F: A doctor. A doctor would talk to you give you advice. A doctor, even if they can't help you, would refer you to someone who can. But a Somali may listen to your problems and say okay then may God give you relief because they can't do anything for you.

I: What you mean by help?

F: Doctors know more people who may have a solution for your problem.

I: such as?

F: Housing or jobs.

"Nothing much I can do. Only God knows what will happen and which culture the kids will take but I only hope for the best and for them to be on the right path (SO)."

In contrast to the prevalence of problem-focused coping style, there were a few families using emotion-focused coping to deal with psychological distress. When the author specified the question on psychological impact of stressors and coping results, the families reported sleep problems and loss of appetite as well as worries and anxiety. Three of Hmong families and one of the Somali families reported that they had seen a doctor or therapist due to their mental health issues. Although limited, the reported emotion-focused coping tended to degrade the families' psychological symptoms.

F: "I have a therapist that I see. They prescribed me some depression pills and sleeping pills."

I: Did it help?

F: "The sleeping pills help me sleep. I don't know if depression pill does anything. I feel the same."

I: Why is it [feeling the same]?

F: I have the same problem. Housing and all others. Pill does nothing with housing.

"I was prescribed sleeping pills and depressions pills. I know these are only temporary help. I need long-term help for solution (HM)."

When the families used emotion-focused coping style to soothe their psychological symptoms, they commented on the limited role of medication and doctor's

help due to the external source of the problem that led to psychological distress and symptoms. Other than the families having seen a doctor, the rest of the families had either no emotion-focused coping strategy or a coping through religious faith and prayer.

> *"I pray and try to keep faith to reduce my stress. I am close to getting medical attention if things don't start turning good (SO)."*

In fact, some families reported that their religious belief is the core of coping strategies. A Hmong single mother who used to be paralyzed and blind emphasized how her religious faith helped her through all the hardships and trauma. She believed that her faith not only relieved her from depression but also cured her body, so she could now see and walk.

> *"To cope I console myself in prayer and the Lord. "Father, creator of me, only you can lift the depression and sadness away from me." The moment I said this, I felt the heavy burden lifted right out of me and a sense of peace. Reflecting from the present to my past, I feel the Lord has sent each of his disciples to watch over me; the Laos man, Thai Lady, and the church. I am ever more at peace because of this place. My health and face has colored and become livelier. I can actually wear clothes and look decent in it now that I have seen the Lord's work (HM)."*

When Somali families had little idea about a coping method focusing on emotional relief, which was the case for the majority of the families, they often reported helplessness.

I: When you lost your place, how stressful were you and your family? [Pause]

F: We really feel helpless. We do nothing here. We are in the shelter 24 hours except when we doing grocery shopping. Nothing we do.

In the meanwhile, Hmong families used the term "hopelessness" in describing their psychological distress and more people have used medication for their depression and anxiety symptoms. These are discussed in the later section in details.

Another type of coping style that the author expected to find was avoidance. Only a few codes that implied avoidance coping were found, such as "migration to avoid homelessness" and "locking oneself home."

"I was concern about robbers and bad people. Also, I didn't know English and had no car so I stayed home most of the time (HM)."

"I forget to eat at times and avoid telling others about my situation [homelessness] so no one would talk negatively about me and my family. I think so much I have headaches (HM)."

Considering the given contexts of the families in terms of the vulnerability and lack of resources including social capital, the families' coping that seemingly aimed to avoid the problem was not mere dismissal of the situation. Rather, those strategies were functioning to prevent aggravation of problem such as evacuation without alternatives, causing additional trouble in the shelter, and negative stigma and following stress. Again, these families tended to have neither adequate or sufficient personal resources nor social capital to compensate for limited family resources. Lack of resources constrained the families to few options for coping and thus to high distress. Thus, avoidance coping was a forced choice to the families in such vulnerable situations.

Proactive coping style was also found. In refugee camps, the families were able to expect what resources would be available in the near future as the routine in refugee camps is rather punctual. After resettlement, however, the families tend to rely on external assistance to navigate the new systems, which is often out of their control, so the families have a hard time managing or arranging resources. In the example of housing, the families started living in their first place in a form of temporary housing, either living together with the anchor family or living in an apartment where only the first few month rent was paid. It is hard to anticipate what resources as well as challenges will be available after the given time for subsidized or temporary housing is over.

> *"My uncle sponsored us. We stayed with him for a month. From his house, we moved into a one bedroom apartment. First place rented was a one bedroom*

apartment in Montana. I didn't work at that time. I worried about what will happen next month and how I can pay rent all the time (HM)."

"We had an apartment when we arrived. It was nice. The church people paid the rent for three months. They told us to pay after. I started worrying too much. I couldn't sleep (SO)."

Positive and adaptive proactive coping was not an option for many families with few resources. Most of the Somali families in this study resettled in the U.S. as "free cases," which implies that there is a high chance that the families had no direct family who could support their resettlement process. In fact, all of the Somali families in the shelter reported that they have no family or relatives in the U.S., although they know people from the same clan resettled in the U.S. Hmong families, on the other hand, sometimes had family support, which the respondents relied upon as they coped with resettlement.

"My uncle sponsored us. We stayed with my sister when we arrived to U.S. I felt we were well supported. The Hmong agencies provided coats for us and my uncle gave us dishes. We paid help my sister out by giving her $300/month. (HM)."

Lack of actual resources combined with unstable reliance on family social capital placed the families in jeopardy. As shown in the earlier part of this chapter, family social

capital is often vulnerable to family conflict and discord according to the change in family dynamics and other hardships. When housing was lost under these circumstances, the families, mostly Hmong families, developed significant mental distress such as depression and anxiety disorder.

Coping strategies utilized by the refugees in this sample tended to be problem-focused rather than emotionally-focused, though both types did appear. The problem-focused coping strategies appeared to enable the participants to leverage resources to build towards the formation of bonding social capital within their own ethnic group, which, in turn, opened up additional resources.

Psychological Outcomes

To understand the psychological outcomes of coping processes among refugee families, this study set two tentative hypotheses along with one major research question. Then, the inductive process of the data analysis revealed the forms of psychological distress that refugee families experience. Since the families were asked to report their psychological distress in the contexts of multiple stressors, the author sorted the responses of psychological outcomes according to the three migration stages plus the current time of being homeless. Given that stable housing is a basic as well as urgent need, the author wanted to separate psychological outcomes before and after becoming homeless in the post-resettlement phase. It was useful to identify both psychological distress and ascribed reasons and to link them in order to better understand the families' psychological experiences in given contexts.

Hypothesis 8: Exposure to trauma and psychological distress in the migration process. As revealed in the earlier sections, refugee families have been exposed to one or multiple traumatic events, including living in a war zone, witness of murder, family loss and separation, and/or chronic fear for security, before and during migration. Dominant types of trauma slightly differed between Hmong and Somali families due to unique contexts of refugee situations in the two populations.

Pre-Migration Trauma. Most Somali families reported that the living conditions in Somalia were life-threatening and many of them identified actual loss of family members by murder. The worries, fear, and sorrow about losing families were most frequently reported. As psychological symptoms of the trauma, families, particularly mothers, mentioned having trouble in sleeping and crying continuously.

> *"I left [Somalia] in 2006 and I left for lack of safety. My husband was killed and I couldn't sleep (SO)."*

The Somali families tended to be more open to talking about psychological distress in the later part of the interview, once a degree of rapport had been firmly established with the author. When the author went back to the earlier questions on trauma and stress before migration, most families did not respond directly and thus emotional expressions were not rich. What the families said includes:

> *"Past is past. Future is more important (SO)."*

"I haven't had a nightmare. I don't dream (SO)."

For Hmong families, meanwhile, most of them recalled how frightening and dreadful the flight from Laos to Thailand was and how much emotional suffering they experienced even at a young age, like four to thirteen.

"It was very scary during the move from Laos to Thai. All I could recall was my head kept dipping in the water preventing me from seeing much. I could hear the gun shots and see the sparks when a shot was fire. If a person was hit by the bullet, that person is dead. They were at the border shooting and shooting at us (HM)."

Aside from one exception, all the Hmong parents who experienced the war as a little child, all under 13 years old, recalled traumatic situations. One male parent who experienced the war and exile had a coma and lost memory due to chemical exposure during the Vietnamese war. He called it "yellow rain" and he only recalled when he was in the coma and laid in a shaman's room. The rest of the Hmong families were born in refugee camps and have depressing memories about life in the camps.

Among those who experienced the migration, some of them had only a fragment of traumatic memory. One mother, who was 44 years old, shared a full story of her migration experience in great detail with pictorial memory. She, as other Hmong families

mostly did, expressed her emotional suffering during the hard time in an indirect way, using a few words while describing her experience, such as “my sadness” “fear was gone” “I was scared” and “it was painful.”

> *“During this time, there was no way of coping with fear and sadness because it all happened so fast. Reflecting back I felt it was God’s help that I am alive today. I am able to cope now because of God. Time helped me forget and let go some of the bad memories of the war (HM).”*

The mother, however, shed tears several times, which apparently told of her emotional distress and psychological pain. This was repeatedly found in Hmong female participants. When they recalled the migration or other traumatic events in the camps, most of them shed tears. In contrast, no Somali families showed tears, except for one young single mother whose mother was killed in Somalia and whose husband abandoned her four years ago.

While staying in the refugee camps, both Hmong and Somali families were suffering from meager conditions, conflicts with locals, and lack of resources, all of which lasted for the most of the lifetime of many of the families. Although families experienced additional loss of family members, miscarriage, and other traumatic situations, their identified symptoms and emotional expressions were limited: worry, fear for repatriation, uncertainty, and helplessness.

Resettlement stress. To most of the families, either Hmong or Somali, resettlement was the most stressful event and provoked mental distress, which was experienced by many as a traumatic series of events.

> *"The refugee camp was troublesome because you had to worry about violence and getting into conflict with other families because kids play with each other and sometimes fight. The same thing happens here, but since me and my kids don't speak the language, we cannot explain or defend ourselves. In the refugee camps, there were Somali's so we could communicate in the same language. Since we cannot defend ourselves here, we are constantly perceived to be the guilty party. [……] We are stressed and helpless (SO)."*

With no means to communicate, refugee families felt extremely vulnerable to the situations that they have dealt with in the camps and the home country. Although the source of stress after resettlement was similar to stressors in the refugee camps or even less dreadful, the perceived stress level was more intense due to the vulnerability caused by unfamiliarity, and instability. The families enumerated resettlement as well as acculturation stressors and reported plenty of corresponding psychological symptoms according to the distress. Most of the worries related to survival in a new environment without adequate resources, including social capital.

"I lost sleep. I was in Missouri for six months and I can say I was okay for one month and I had no sleep since then and even now. I am constantly worried about who will do this and that for me (SO)."

"I don't sleep very well since I came to the U.S. [……] I constantly worry (SO)."

"We are not stable. We are not happy. We are clueless and lack information. I cannot sleep (SO)."

"Another reason I didn't want to stay in the U.S. was I kept worrying about people breaking in the house and all of the dangers that could happen. I worried about getting around and if I walked to grocery store, will there be bad people out to attack me (HM)."

Not only challenges in navigating the new environment and systems, but the discord between expectations and what it actually means to live well in the U.S. made the families struggle even more.

"I expected thousands of dollars [for the welcoming money] and my biggest concern was how I will carry all that money. I was so disappointed and I could hardly walk (SO)."

This broke her down because her initial plan was to come back to Ethiopia to bring her husband to the U.S. by means of the welcoming money. Frustrated coping or failure to gain resources was the major stressor for her and induced a high level of psychological distress.

Homelessness was a great source of psychological distress. Lack of stable housing among the refugee families was a part of the high level of mental distress derived also from the other resettlement challenges.

> *"We were happy for a little bit, then we realized the housing problem and then we were really stressed. The older kids would see me upset and wondering where we would all end up. And then, they start to worry. They told me it was better in the refugee camp because we had free shelter and why I brought them here (SO)."*

> *"But the worry of being kicked out of our former apartment in Memphis for not paying rent was sickening. We never had to worry about rent in the camps, we could move our shacks as we wished. The strict rules we found at Mary's Place didn't apply there. So, even though we are in better housing, we feel more worried about housing than when we were in the refugee camp (SO)."*

The families' worries and anxiety about unstable housing started as soon as the families realized that their current place is only available for a short time period and all

the means for housing needs to be handled all by the family with a paucity of resources and limited coping capability.

Although some refugee families perceived living in a shelter as a temporary relief or tentative solution for housing stress, housing stability and permanent shelter cannot be crossed in the families' mind. As housing is one of the most basic and urgent needs, living homeless created great psychological distress and mental trauma. When acute stress develops, it tends to deteriorate as time goes by and the time for temporary housing is up.

> *"I have been sleepless for the last three months because of that [housing problem]. I constantly worry about our housing crisis which weighs double burden on me as a single parent in an unfamiliar land. My kids were worried and still are about where we will end up (SO)."*

Lack of stable housing is likely to develop acute stress in refugee families and it is likely to get worse combined with accumulated mental health issues due to impeded coping.

> *"I feel exhausted and hopeless after constant worries about housing. Affordable housing seems impossible in my life time. I feel nothing I can do (HM)."*

Housing issues not only affected the parents but also influenced children, which added more concerns to the families and provoked self-blaming and guilty feelings on them. The quotation below indicates not only the parent's sense of helplessness, but also the effect of the psychological trauma that has manifested as a result of prolonged stress.

> *"I feel angry at myself for being unable to support my family. I am anxious and irritable. I forget to eat at times and avoid telling others about my situation so no one would talk negatively about me and my family. I think so much I have headaches (HM)."*

Although being able to find and live in a shelter was a temporary relief, it was not a solution for housing stress. In fact, the impact of homelessness on the refugee families was not limited to the parents' psychological distress but also their parenting and relationships with children, and thus the entire family dynamics. Many families, both Hmong and Somali families, reported how stressful it has been to live in a shelter with many regulations and constraints. The regulations in a shelter, for instance, were very specific and require all the residents to clean and arrange the room in a certain way by a certain point of time every morning. These might not be too difficult or stressful to follow without children.

"I barely sleep at night. I'm always watching the kids for any misbehavior that could result in dismissal from the shelter. I have headaches and body aches from the sleeplessness (SO)."

"I am constantly under stress and so are my children. I have to constantly keep my kids inside the home so that they do not encounter trouble outside. I worry all the time about my kids and their well being (SO)."

Worries about being homeless and living in a shelter were not only on the parents' plate. Parents frequently mentioned how much their children were influenced by the housing stress.

"Now my oldest four children are sitting around and worry with me instead of being children and playing with friends (SO)."

To avoid devastating situations such as eviction from the shelter, the families had few options but for monitoring children and using harsh parenting, which negatively impacted the relationships between parents and children.

"There are strict rules in the facility and we constantly monitor the kids' movements in fear of being kicked out as a result of them breaking or damaging property. We keep them in the house mostly and prevent them from playing with

the other kids because they don't understand their language and could easily get in trouble (SO)."

The current distress of being homeless and lack of resources led to an impediment of confidence in coping and managing future, as the cycle of psychological distress continued to wear down the coping ability of the informants.

"I am more worried and less confident due to being homeless. I looked a lot healthier and happier, but since coming here I lost a lot weight and I am sick because of the stress. In the U.S. rent is expected from someone who doesn't have an income. In the camp shelter is free. We never expected to come to the U.S and be beggars, we thought people were going to beg us (SO)."

"Housing difficulties caused changes in the children, social environment and education because my children's grades has fallen back somewhat. None of them has an A grade. My family is losing hope (HM)."

The resources that the homeless families lost were not just material resources or social capital, which were rather a major contributor to homelessness. Rather, the types of resources mostly affected by homelessness were psychological resources, either at a personal or a family level, which otherwise would boost coping capacity to deal with

both stressors and mental distress. The families with faint hope and confidence reported apparent psychological symptoms and appalling mental health.

Accumulated stress. Some families reported that they did not have too much worry and anxiety before, while others reported accumulated stress either since coming to the U.S. or living in the camps. Regardless, all the families identified resettlement stress and homelessness as the most acute and intense stress have never had such stressful situations

Some participants showed mental impediment seriously affecting normal function and coping. Below is an interpreter's comment on a Hmong single mother who reported deep depression and a long history of medication.

> *"Interviewee couldn't think far. She is at such a loss and very confused. I would say she has major mental health problems not just from housing but also years of emotional and physical abuse. She lacks guidance and is a traditional Hmong woman who holds emotions and expressions inside."*

In fact, constant worries were frequently reported by both Hmong and Somali parents. Housing instability and lack of coping means or constraints for coping were the source of constant worries. A prolonged situation of being homeless or lacking stable housing drove the families to vicious circle of stressful situations. Uncertainty of what would be laid in front of the families provoked constant worries and distress. Facing such urgent issues as housing, families constantly worry, which deprived them of opportunities

for developing coping skills and social capital as the families' appraisal, building social network is not prioritized.

> *"I haven't yet found the chance to mingle with my community members as I've only been here for a short time. I don't have any close relatives that might have been a doorway to the community. Until I settle my housing crisis, I will not be able to focus on anything else (SO)."*

Then, the worries and psychological distress impeded daily function and coping resources, such as hope psychological strengths. Psychological distress is also a constraint to coping capacity and thus becomes a stressor.

Variation in psychological distress. All the families reported psychological distress to a certain degree, although the level of reported symptoms and distress varied. The analysis indicated that coping style and capacity mattered with the decline of mental health. First, religious coping buffered the mental distress in the most families who use this copying method.

> *"Personally if you believe in God you know you win some and lose some. We never lose hope, even though I don't speak English I applied for jobs and I want to work if they hire me. I am hopeful (SO)."*

Even though this single mother has a child with disability and commented how stressful the situations have been for her family, her religious coping seemed to hold her distress from developing mental health symptoms and serious impediment of psychological function.

> *"To cope I console myself in prayer and the Lord. 'Father, creator of me, only you can lift the depression and sadness away from me.' The moment I said this, I felt the heavy burden lifted right out of me and a sense of peace (HM)."*

Religious coping was apparently functioning in dealing with emotional distress as it offered meaning-making process. Other type of emotion-focused coping was not frequently reported from the families. Many families felt too swamped to do things other than something directly related to housing issues. For the refugee families, one of the repeated themes around psychological outcome was that there are not many things to do for coping. Not only were coping resources to solve the source of the problem (i.e. homelessness) absent, but also there was little bonding and family social capital to obtain emotional support in the families. Thus, coping with psychological distress was heavily influenced by the families' resources.

Summary of Findings

As hypothesized, refugee families experienced multiple stressors that vary from threat, harm/loss, and paucity of resources as well as various types of security issues and traumas. Stressors in refugee situations also included symbolic loss of social status and

cultural bereavement that came along with forced migration and displacement in culturally divergent country. Each migration stage had unique challenging issues, although pre-migration and migration stages were filled with stressors related with resources and security, while stressors in the post-migration or resettlement stage tended to be new and unexpected. Homelessness or unstable housing, as an outcome of accumulated stressors, was also a new type of challenge that refugee families had not experienced before, which led to exacerbated psychological distress as resources and strategies for coping were often absent in the families.

Psychological distress was deeply associated with challenges and transition in resources at various levels. Various types of resources were threatened and vanished during and after war. Rearrangement of resources and cultural resources in particular occur after resettlement, which tended to impede coping capacity of refugee families and cause acculturation stress. Due to generational variances in adjustment, families functioned as an adaptive coping unit: children tend to acquire English skills and the nuances of the host culture much faster than their parents do and become family resources in navigating systems and building social capital in the community. This reliance on children, however, also became a source of acculturation stress as parents sometimes lost control over children's assimilation to the new culture and parenting became more challenging especially after losing family and bonding social capital.

Social capital, both bonding and linking, functioned as a critical form of resource for refugee families to resettle and adjust to the host community by supplementing personal, family, and cultural resources that are often sparse in refugee communities.

Thus, it is a critical coping strategy for refugee families to build or increase social capital, which sometimes leads families to migration after resettlement to a different state or city with better bonding social capital. Although critical in coping, refugee families were aware that bonding social capital has its limitation in that material resources to fulfill basic needs, including housing stability and job security, come mostly from linking social capital rather than other types of sources. Linking social capital was far more elusive, however, as informants often struggled to integrate with the broader community. Bonding social capital functioned mainly as a substitute for cultural resources that promote refugee families' accessibility to environmental resources and thus increase coping with stressors. Also, thriving refugee communities empowered the families by providing a role model and a source of hope and optimism.

This study also revealed that a high level of psychological distress among refugee families, ranging from traumatic experiences before migration to acute psychological and sometimes physical stress after homelessness. Exposure to traumatic events before and during migration was salient in refugee families, while a lack of resources and frustrated coping strategies predicted tremendous distress, which has been a chronic condition for the refugee families. Options for coping with psychological distress among refugees, however, were underdeveloped and underutilized. Problem-focused coping among the families was apparent, which tended to aggregate psychological distress due to unmatched resources for stressors, while only a few utilized emotion-focused coping strategies, most of which were related to religious practice. Lack of bonding social capital along with limited coping resources and skills tended to exacerbate psychological distress.

Chapter 5. Discussion, Implications, and Conclusions

This study purported to establish theoretical statements on stress and coping of homeless refugee families using modified analytic induction embedding a grounded theory coding method. The author tested a series of hypotheses developed based on a comprehensive literature review as well as the author's field and academic learning and insights from community members and professionals. The tentative hypothetical statements were modified according to the emerged negative cases. To fill the knowledge gap and explore refugee experiences that have been less known, such as homelessness, the author also integrated the newly emerged patterns and concepts grounded to the data by answering the research questions.

In this chapter, the author demonstrates how the emerging themes were embedded into the modified hypotheses and were tested based on the negative case analyses in the inductive analysis process. Then, the author suggests implications for social work practice, policy, and research, considering the cultural variation between the two different ethnic groups and the limitations of the study.

Discussion

Refugee families have experienced multiple stressors, which range from threat to resources to actual loss of resources, and to failed coping for seeking resources. As Hobfoll (1998) suggested and Ryan and his colleagues (2008) confirmed with refugee populations, threat, harm and challenge to resources were well aligned with the stressors that refugees experience during migration and resettlement. Identified stressors in the current study, however, were not limited to the challenges regarding resources, but

expanded to psychological suffering and symbolic loss, such as exposure to trauma and loss of psychological strength and social status derived from the pre-existent cultural assets. In addition, acculturative stress emerged as a major form of stress that was not accounted by Hobfoll (1998).

Some types of stressors, in fact, were not exactly fit for the resource-based framework. Family loss and separation as well as security issues and conflict situations in the home country and refugee camps were identified as major sources of stress. Those issues were not necessarily represented as a loss, threat, or challenge to resources. Rather, they were perceived as a direct threat to life and thus to basic psychological and social needs. Fear of persecution and intensive conflicts deprived the families of sense of control and life with dignity, destroying daily activities and a normal social life (Ryan et al., 2008), and the violation of these fundamental human needs formed a refugee condition (McBride, 1999).

Due to the unique situation that refugees face, stressors related to displacement were also pervasive. Forced migration and relocation per se tend to expose refugees to extreme stress (Beiser, 1990; Roizblatt & Pilowsky, 1996). In this study, displacement not only caused the loss of resources, but it also rearranged the meaning and function of resources as well as coping, which became a new type of stressor. The meaning as well as the intensity of stressors shifted according to changes in environmental and socio-ecological systems surrounding the refugees and this environmental transition in the migration processes drove the families to particularly vulnerable situations. Located in a totally new environment, refugee families tend to lose cultural resources, which used to

be taken for granted, which leads to significant impediment in coping capacity. This loss of cultural resources, in fact, was one of the most salient features of the post-migration experience of most respondents in this research. The disturbances were salient in the resettlement process that has been ascribed to the major source of distress among newcomer groups in previous studies (Berry, 1998; Navas et al., 2005).

Acculturation stress in the current study was identified as a major cause of acute stress among the refugee families, most of whom reported tremendous loss and deficit of cultural resources and coping means for adjustment, such as mastery of basic language skills, mobility/transportation, and information about the surrounding environment and community. Migration to a different environment also significantly reduced social capital, and thus the shortfall of resources was not filled through social networks and other informal support systems (Garip, 2008; Nannestad et al., 2008). These precursory stressors mattered for resettlement and adjustment of the families in the host community.

As an outcome of the unmet needs and unsuccessful coping responses, homelessness occurred in the refugee community, and it generated overwhelming distress to the families. When stressors impeded coping resources and the means for dealing with challenges, they triggered additional stress and exacerbated psychological distress. It was homelessness in the current study, and homelessness was claimed as the major, proximal source of stress among the families in their current situation. Thus, in this study, homelessness can be seen as the result of cumulative stressors and constant depletion of resources for coping with difficulties.

Multiple stressors in each migration stage, pre-migration, migration, and post-migration, showed unique challenging issues and demands as the author had assumed. The stressors that the families experiences before and during migration, however, dramatically differed from those that families face upon arrival in the U.S. The common types of stressors before resettlement focused on security, loss and separation of family, and threat and loss of resources, while paucity of resources applied to some families as a chronic, stressful condition regardless of migration. Instead, new challenges that emerged in the refugee camps were strict regulations and poor treatment from local professionals, who are often in a conflicted situation. Even if dislocation to asylum countries led the families to exposure to culturally different groups and intercultural environments, bonding social capital was typically rebuilt. The same cultural group remained to live together in the camps and thus the social resources, although limited, were still available to the families. However, this hypothesis regarding the development of social capital as a conscious process, based on the application of specific coping skills may need to be revised, as it is specifically bonding social capital that is most often sought and obtained by refugees in the post-migration stage. This research indicates that many refugees are not as successful in establishing bridging social capital, despite their acknowledgement that it may be necessary to do so in order to secure more stable employment, for example. Thus, the picture regarding social capital accrual in the host country remains mixed.

The stressors during post-migration, however, led the refugee families to a culturally alien environment, both social and natural, in which the chance to bring or form bonding social capital was often limited. Resettlement stressors, in this regard, are

perceived as even more challenging, due to diminished cultural resources critical to coping for adjustment. The accumulated loss of social support during migration also added distress for the families in spite of the resources newly obtained through resettlement agencies and government support. Depending on the types of the resources that the families gained or lost, the intensity of perceived stressors was different. Some resources, for instance, such as food stamps, were not directly consumable to the families without basic coping resources for interpretation and transportation, and thus the stress due to unmet needs persisted.

Acculturation stress in the current study has a double-edged side. Frequently reported worries about parenting and hope for children's education implied that acculturation can be a source of both stress and coping. Parenting children in a new cultural environment raised concerns about children's assimilation to American culture and thus loss of cultural identity, while opportunities for contemporary and advanced education brought hope for the families to escape meager conditions of poverty and the dearth of family and cultural resources (Yagmurlu, et al., 2009). Education for children also has a significant meaning for cultural resources as cultural resources tend to function in family unit. Limited personal assets needed for adaptation to a new culture are likely to be supplemented by children's resilience and intercultural learning in their role as a cultural broker between the parents and social systems (Potocky-Tripodi, 2002).

The findings of the study also confirmed that the types of resources matter in the process of coping with stressors unique to refugee situations. First, stressors affect various types of resources at different levels. Loss of resources is one of the most typical

types of stressor during migration. The representative types of resources that were eroded included cultural and social resources, particularly social capital among the families.

The perceived patterns of both loss and gain of resources led the families to the appraisal that stressors as well as resources were traded off. In other words, the common type of stressors in the home country and refugee camps vanished, but a new type of stressor replaced it after resettlement. This was somewhat outside of expectations from the initial hypotheses of the study. This perception is a reason for continuous migration among the families, who sought an optimal set of resources and manageable stressors. Some of the new stressors after resettlement request cultural resources for coping, social resources or a certain type of social capital was identified as the preferable as cultural resources can be obtained better through social networks. In revisiting the initial hypotheses, the second hypothesis (regarding encountering different stressors at different migration stages) may need to be revised to account for the continual moving in the post-migration phase. This continual relocation is, in large part, due to refugees quest for optimal support and resources, and may be seen as a coping method. Nevertheless, this hypothesis should be expanded to notate the presence of different stressors between migration stages, but also the differing stressors that occur within a phase, which may occur as tradeoffs.

Unexpected outcomes after migration also became a major source of stress as relocation in culturally alien environments does not allow the families to gather enough information for proactive coping such as planning and preparation for upcoming challenges. Therefore, gaps between expectations before resettlement and realities after

arrival in the host community created a serious impediment to adjustment and generated psychological distress, due to an absence of anticipated coping resources. The author found that this pattern was repeated across both refugee groups and understood it through the concept of environmental resources, which refer to a type of resource existent in the social and natural environment but which are not necessarily available immediately for a person in such environments. The accessibility and attainability depend on a person's coping capacity based on her personal, family, social and cultural resources.

Facing the various stressors and limited resources, the refugee families have developed a myriad of coping strategies. The results of this study demonstrated that social capital, often as a form of a substitute for personal and family resources, is particularly critical in the resettlement process for refugee families to expand coping capacity to deal with acculturation stressors. Secondary migration turned out to be an active coping strategy rather than avoidance of the problem the families faced in the first resettlement state. Secondary migration, in fact, was used to regain and build social capital, which not only include family social capital but also bonding and linking social capital. Migration also tends to result in change and rearrangement of environmental resources as well as social resources available and accessible for the refugee families. It often occurs in the way of increasing resources.

Other types of social capital (i.e. bridging and linking) were unique to migration and post-migration stages, in which the refugee families encounter different cultural groups and stabilized social systems. Negative treatment or experiences with different cultural groups and service providers tended to limit the scope of social interaction and

trust levels to homogenous groups of people. The refugee families, however, were also aware that the resources accessible through bonding social capital are not enough to solve the livelihood issues as well as homelessness, and that linking social capital is needed to access to the appropriate resources for addressing issues on early settlement and integration. In spite of the recognition and demand, accessibility was a primary barrier in reaching linking social capital. Cultural barriers, in particular, were the major obstacle to bridging and linking social capital, and they tended to be eased through bonding social capital, whereby the families could approach cultural resources. Thus, all types of social capital were needed for the refugee families to socially integrate and successfully resettle. Even when no actual material resources were available through bonding social capital, the families still had emotional support from the bonding social capital. These findings were aligned with previous studies of newcomers (Lamba, 2003; Correa-Velez, & Gifford, 2010).

Aside from social capital, other coping strategies in the current study were heavily inclined toward problem-focused coping, and little was reported regarding emotion-focused coping. The preference of problem-solving strategies to emotional care has been found in previous studies of other immigrant populations (Noh, 2003; Farley, Galves, & Dickinson, 2005). The author also found that mental distress and psychological suffering was little discussed, even when they were identified as an aspect of stressors that the families have. For instance, some families suffered from serious sleep problems and even diagnosed depression, but they did not point out psychological issues as their concern or an issue to handle. This may have been for several reasons, including genuine lack of

identification of mental health concerns, limited trust in a researcher who they had only recently met, or differing cultural conceptualizations of mental health and mental illness. When emotional coping was utilized, it was still instrumental for some families to gain more psychosocial support and services from professionals.

Almost the only type of salient emotion-focused coping method among the families was religious coping. When utilized, as the families reported often, religious coping had the most powerful effect on the management of stress and psychological self-care. Religious beliefs and values often provided a psychological buffer to stress as well as a seed for hope for the future. Optimism, in this regard, was frequently reported along with a religious coping style and some families even reported no psychological distress by reason of beliefs in God or supernatural power.

Psychological distress, however, was pervasive in most of the families and the stress level was of high concern in many more families. Commonly reported symptoms included loss of sleep, appetite, and weight, feeling helpless, and too much worry and anxiety. Although refugee families have reported horrendous situations in the home country and traumatic experiences during migration, the current psychological distress and mental health symptoms were not attributed directly to pre-migration trauma or stressors. Across both cultural groups, the families pointed out that the unstable housing is the biggest source of concerns and the most urgent issue to deal with in their current situations. Living in a homelessness shelter also worsened the families' distress due to strict regulations and cultural barriers as well as other remaining issues. Thus, the psychological distress that the families expressed was centered on housing concerns in

most of the cases, most likely since this concern was so great that it eclipsed the respondents' ability to consider stressors that occurred previously, and how those may affect their current circumstances. This finding undergirds a psychosocial model and ecological approach to refugee mental health. As Miller and Rasco (2004) pointed out, displacement stress, including that of resettlement, is the most salient psychosocial concern among refugees in spite of the impact of traumatic experiences before and during migration on mental health:

> Certainly, [……] the data do show an elevated prevalence of psychological trauma among a diversity of refugee populations. However, this does not mean that refugees themselves perceive psychological trauma as among their most pressing concerns. In fact, there is some evidence suggesting that refugees may actually be more concerned about other stressors affecting their mental health than they are about psychological trauma (p.39).

As revealed in the findings of the current study, homelessness among refugees is an outcome of combined issues of resettlement stress. The accumulated stressors during the migration and resettlement processes not only exacerbate the refugee families' mental health but also impeded coping capacity and resources of the families. Overburdening situations that have been accumulated through refugee experiences are a serious cause for mental distress, and postponed interventions and chronic absence of appropriate resources led to deteriorated psychological distress in the refugee families.

Cultural Variation

The author aimed to test the hypotheses on stress and coping by applying the modified analytic induction method to two refugee groups, Hmong and Somali, in the current study. Common themes that emerged from the families' experiences within one

group were often found in the other group and used to build generalizability of the tested hypotheses. Common concepts found in refugee experiences in both groups included experiences of war, forced migration and displacement, living in refugee camps, resettlement, and acculturation as well as resettlement challenges. There also exists variation in the stress and coping with migration and homelessness, however, between the two ethnic groups, because of the unique contexts of war and migration as well as socio-ecological systems in each cultural group. The families showed distinctive issues across the groups in terms of the meanings of some sub-concepts, such as experiences of cultural orientation, amount of structural social capital and outcome resources from the social network or relationships, and ways of expressing and severity of psychological distress. As testing hypotheses and building theoretical statements for individual subgroups was not the purpose of the study, the author used the cases of each group for negative analysis when there was divergence between and within subgroups. Some differences between two groups, however, were repeatedly found and appeared as cultural patterns.

Cases of Hmong families. In terms of life challenges and risk factors for psychological distress, Hmong families reported unique issues derived from cultural practice, such as arranged marriages, polygamy, and marriage by abduction. Family conflicts and abusive relationships with a spouse were one of the main stressors that the families, mostly single mothers, reported. Although the change in family structure due to discord between husband and wife was found across the refugee groups, severe family

conflicts leading the family (often a wife and children) to jeopardy were more frequently reported in the Hmong community.

> *"I married at 18 in Xiang Khuang but not by choice. I was a kidnapped bride. I did not want to marry him. [……] That morning he and three of his relatives tried to lure me to his house but it did not work so they hefted and carried me off. When we arrived at his house, I refused to marry him still. His relatives asked me, 'What's wrong with our son that you do not like him?' I said nothing is wrong with your son so they married us. By this time my mother had not come to Thailand yet so my uncle negotiated and gave me away in marriage."*

Domestic violence in the Hmong community has been a high concern in previous studies (Donnelly, 1989; Gallin, 1993). The vulnerable situations that Hmong women face tended to be deteriorated due to lack of personal resources, such as lack of education and economic means for living. Family and social resources were not abundant for these women, but cultural customs and values sometimes played against women's will and choice, and thus family support was not always effective. For instance, a single mother whose husband treated her badly lost her connection with her own family because her family was not welcomed by her husband. A cultural assumption that underlies this relational issue is that not showing respect to in-laws is too shameful to face, and a married woman belongs to her husband's families and the rest of her relationships are secondary.

In terms of family social capital, the Hmong participants in this study also demonstrated different patterns compared to Somali participants. Hmong families formed strong ties between extended family members either in Minnesota or in neighboring states. Most of the families had their relatives or family members in the U.S., although this does not necessarily indicate that they could get positive family resources. Family bonding was sometimes broken due to complicated family issues, such as domestic violence, a clash between traditional and new culture (eg. religious discord), and other family discord. However, family support in the early resettlement stage was not reported by all participants, which was one of the major differences between Hmong and Somali families who the author met in the homeless shelter. For instance, many Hmong participants reported that they resettled in the U.S. along with other family members, including the families of adult siblings and relatives, while most of the Somali families resettled through a free case and have few acquaintances in the U.S. This may be derived from the context of Hmong refugee resettlement, in that Hmong refugees had been resettled since the 1970s and the last wave of the population completed resettlement in mid 2000s, which implies that most of the members in Hmong community reside in the U.S. Additionally, Hmong migration sometimes occurred in large segments, such as occurred when many Hmong migrated after the closure of the final refugee camp in Thailand.

Another different pattern was the way Hmong families expressed psychological distress and emotional suffering compared to those of the Somali families. Most of the Hmong women participants in the study showed tears during the interview with the

author while talking about hardships and traumatic experiences during exile and in the camps. Domestic violence and their current difficulties were also very stressful, and they expressed emotional suffering through both verbal and non-verbal communication. Only one male among the Hmong families participated in this study. He did not have the same emotional expressions as those of the female participants, but he used psychological terms to describe his distress, such as "depression," "worries," "fear," "stress," "cannot sleep," and "anxious."

Two of the Hmong participants, including the male participant, reported culture-bound syndrome related to traditional beliefs in spirits. The male participant reported:

> *"When I was five or six, I was paralyzed because of the yellow rain. What I remember is that I saw ghosts when I was in coma. My parents and relatives said they thought I was almost dead and they brought me to shaman. I saw several ghosts surrounding me in the room."*

Another woman reported that she had had unexplainable physical illness, such as paralysis and blindness with no certain cause. Her explanation of her symptom progress was aligned with what is described about a culture-bound syndrome, such as "shin byung," which causes physical suffering to accept divinity in their body (Rhi, 2001).

Cases of Somali families. Migration is not only a stressor but is also a coping strategy to escape war and traumatic events in the home country. Some refugee families also voluntarily migrate following resources after resettlement. Although migration may

be found in many other refugee groups, it was especially salient among the Somali families in dealing with resettlement stressors. Migration was a reinforced coping strategy in both Hmong and Somali communities even before migration. Refugee families have gone through tremendously traumatic events in the home country. Migration was one of the few options for survival in such dire situations. Migration, in this regard, has an adaptive function.

The secondary migration after resettlement in the U.S., however, showed different patterns across the cultural groups. Although the basic meanings underlying migration may be common, such as seeking for resources, the patterns and sub-concepts of the migration purpose were not identical. Rather, there was a significant time difference in resettlement between two groups, which showed how refugee families in earlier stages of resettlement use migration as a coping strategy.

Secondary migration was salient particularly among the Somali refugee families. All the fifteen homeless families in this study, in fact, were secondary migrants. Even after considering the limitation of sampling issues, it may be safe to posit that there is a pull factor in Minnesota to attract Somali refugees to the community that has made the Twin Cities the capital of the Somali community in North America. In addition to relatively stable job markets and social service systems and organizations, the ethnic community and accompanying cultural and environmental resources of the greater Twin Cities area continuously draws Somali refugees. As revealed in the current study, lack of cultural resources hindered early resettlement and thus stability of the families' livelihood. The families which initially resettled in the states with little social support

from the community had few choices but migration to the cultural community in which they can benefit from bonding social capital.

Migration as an active strategy to cope with stressors and seek for resources is also explained by the Somali culture of nomadic lifestyle. The discussion with two Somali interpreters and a focus group with bilingual MSW students informed the author that Somali people have continuously migrated to seek better resources in the land for the last several centuries and thus secondary and tertiary migrations after resettlement are culturally normative coping options (although it should be noted that many of this study's respondents came from urban areas where their lives were stable prior to flight).

Implications for Social Work Practice

The current study revealed how critical early resettlement services can be for refugee families to help them settle down and adjust to the host community. Lack of adequate cultural orientation and communication breakdowns due to language barriers were the most apparent failure in the resettlement process among homeless refugee families. Even if one considers the families in the current study to be especially marginalized due to the lack of social capital, the importance of resettlement programs cannot be overemphasized in serving refugee populations in general. As many previous inquiries have pointed out, the cultural and language barriers to appropriate services are the major risk factors for unemployment (Peisker, 2006), impeded social integration (Valtonen, 1998), deficient educational outcomes (McBrien, 2005), poor health conditions (Woloshin, 1995), and mental health issues (Uba, 1992; Leong & Lau, 2001).

This study confirmed the central importance of resettlement services for the stability and integration of refugee families.

Among the resettlement services, the families in the current study identified that their needs for case management and cultural orientation were particularly unmet. Various needs and issues that the families have requested included customized assistance and special attention through case management. The families in the current study have presented various concerns of priority in addition to homelessness and other resettlement challenges, such as care for children with a disability, family conflict, family separation and thus lacking family social capital, and other health issues of the family. The complex family issues are hard to be addressed through such depersonalized service programs that focus only on basic livelihood issues. Therefore, it is needed to raise awareness of various issues in the refugee communities and to equip social workers with general practice skills in addition to specialized areas of focus for their practice.

Cultural orientation, consisting of pre- and post-departure orientations, also seemed to fail to reach the refugee families in this study. Although the outcome of cultural orientation may differ according to personal capacity for learning and understanding, as well as the immediate stressors which may distract attention, it is expected that many Hmong and Somali families, often from rural areas with limited exposure to a Western lifestyle, may not attain a level of basic mastery or confidence through a few short class sessions. Rather, the product that cultural orientation aims to achieve may require a long process of intercultural interaction through direct communication and mutual influence over time. In this regard, the unmet cultural needs

and the limited service outreach found in this study imply the importance of bonding and bridging social capital in acculturation process. Thus, social workers equipped with cultural competency can bridge the local and refugee communities by community organizing activities and help build social capital within and across the communities, while empowering and advocating for refugee families. For this reason, the author believes that social workers working with refugees should be encouraged to obtain and employ not only micro-level skill sets for case management and family support, but also skills for macro-level practice, such as community organizing and policy advocacy. Success resettlement outcomes will be support optimally when all skill sets are utilized.

The results of this study demonstrated that social capital plays a critical role in the early resettlement and adjustment of the families. Bonding social capital, including family social capital that often includes extended family members and/or a clan, functioned as cultural navigator for the newly resettled families. In the case of Hmong families, most of the participants reported their cultural learning was through other family members or relatives who had resettled earlier and the learned information was practical and effective in coping. In the meantime, all the homeless Somali families in the research venue had no relatives or family members in the U.S. and were in dissimilar situations to the most Hmong participants.

The findings of the current study also underscored how important it is to build trust between service providers and refugee clients. Dreadful experiences with some professionals in refugee camps tended to deteriorate trust in formal services and thus to shape negative attitudes toward bridging and linking social capital. Bridging as well as

linking social capital, however, are proven to be critical in the early resettlement stage and help sustain coping for social integration. The negative form of social coexistence has a potential risk for the underutilization of social services and distrust in outgroup interaction, which in return impedes the families' social adjustment and integration and thus is likely to induce the families to be segregated or marginalized in the resettling community (Grasmuck, 1997). As claimed in the previous studies, balanced development of bonding, bridging, and linking social capital tends to promote social integration of newcomers, including immigrants and refugees (Cheong, Edwards, & Goulbourne, 2007). The role of social workers and other professionals serving refugee populations, should be evolved around the goal of refugees' social integration, including both maintenance of cultural tradition and acceptance of the new culture, by helping to build bonding, bridging and linking social capital for balanced and cohesive integration.

In designing and developing social work practice for refugee populations, cultural responsiveness and competency need to be considered as a core element. Social workers need to provide culturally customized service interventions to refugee families that consider cultural norms, beliefs, and coping styles, as well as needed resources, resettlement history, and policy contexts of individual refugee groups.

It is also important to remind social workers that the stressors related to psychosocial needs have to be addressed for mental health interventions to gain intended outcomes. For instance, when housing along with cultural barriers is the most urgent demand among families, it should be addressed beforehand in order for the families to get

ready for healing of psychological trauma and symptoms (Miller & Rasco, 2004).

Implications for Social Policy Intervention

The findings of the current study suggested that there is a significant blind spot that refugee resettlement policy and service interventions by the Office of Refugee Resettlement (ORR) omit. The Refugee Act of 1980 designated the goal of the federal refugee resettlement program as provision of "effective resettlement of refugees" and assistance to refugees with the achievement of "economic self-sufficiency as quickly as possible after arrival in the United States." In fact, it is economic self sufficiency that has shaped the resettlement service programs in the U.S. resettlement policy.

> *Economic self-sufficiency is one of the most important measurements used in assessing refugee resettlement efforts. Economic self-sufficiency for the Office of Refugee Resettlement is defined in federal regulations as "earning a total family income at a level that enables a family unit to support itself without receipt of a cash assistance grant (CFR 45 400.2).*

The U.S. refugee resettlement policy has been criticized as it sets an unrealistic timeline (Stewart, 2011). Some refugee families, particularly those from rural areas with few resources in their home and asylum countries, are in especially vulnerable situations in the early stage of resettlement and need more attention to cultural orientation and adjustment due to significant personal and family loss. "Economic self-sufficiency as quickly as possible" in this regard is not feasible to those refugees with limited resources.

> *The federal definition of economic self-sufficiency encompasses only "welfare avoidance," which could mean refugee families move from public assistance into unaided poverty (Stewart, 2011).*

U.S. resettlement policy assumes that there are enough environmental resources for refugee families in the host community, such as jobs, education, and social systems, and that the resources are immediately usable and accessible to refugees. However, as the findings of this study revealed, the environmental resources are not accessible to many families lacking personal, family and cultural resources. The goal of self-sufficiency may be achieved by some families in the best conditions such as being already equipped with English proficiency, cultural knowledge, well-established social capital, and no other health or family concerns. In the case of most refugees, however, these ideas are not met, so finding employment that will support economic self-sufficiency is elusive.

The assumption and the elusive goal of the U.S. resettlement policy are likely to mislead refugee families to unfeasible expectations for resettlement. The families in this study demonstrated their suffering not only from helplessness and frustration but also from self-blaming for unemployment, communication barriers, and homelessness. Even when refugees were able to find a job, it tended to be a low-wage job with no prerequisite skills and language skills, and it drove them into an unstable market with higher potential risk for unemployment and homelessness.

Variability between the refugee resettlement policies and procedures across states poses another challenge, since resources and strategies that work in one state may not transfer to another. Absence of consistent case management is one such issue that resettlement policy faces. Case management is provided in some states, while others have little focus on it, as case management is not mandatory under the current policy.

The diverse level of support across the states is another issue that provokes disparities in settlement and adjustment among refugees and often leads to secondary migration. Some states have better or more social services and welfare through Refugee Cash Assistance Program and/or TANF than others. This lottery effect is not limited to social systems and benefits. Each state has different public transportation systems and housing and job markets as well as different levels of cultural competency and quality support by community-based organizations. As Brick and her colleagues (2010) cited from an interview with staff of the International Rescue Committee, "those individuals and families who are fortunate enough to be resettled in states with generous social welfare programs end up better off than those in states that offer less assistance" (p. 13). However, since refugees have no say in which state they go to for initial resettlement, there is little that can be done to prepare refugees for what may come in terms of their state's support.

In terms of secondary migration, U.S. policy also lacks tracking systems to follow up the progress of refugees' adjustment and integration across the states. For some refugee groups, such as Somali in the case of this study, a majority of the recent resettlement has been through free cases rather than family reunification, and thus secondary migration to seek bonding social capital and cultural support is more expected. Loose connection or breakdown of communication and stable interaction between resettlement agencies and refugees in early resettlement stage are high risk factors for homelessness and thus failed integration. The findings of this study call for further sophistication and improvement of resettlement interventions based on the realities of

refugee families and careful tracking and evaluation of policies aimed to assist refugee families in the U.S.

Implications for Social Work Research

The findings of this study demonstrated the importance of understanding different types of resources and coping options for refugees to understand their stressors and their psychological outcomes. In particular, a concept of environmental resources was used to explain unmet expectations that were pervasive among the refugee families. It provided a way to explain refugee families' frustration and early distress in the contexts of various types of resources that refugee families possess or potentially approach. This distinction enabled the author to differentiate accessibility and availability and to understand refugee families' coping strategies to increase accessibility by gaining more cultural resources.

This process tended to occur through an effort to increase social capital, mostly bonding social capital. With a framework of social capital theory, this study confirmed the important roles both bonding and linking social capital can play in the early stage of resettlement for cultural adjustment and stabilizing. Secondary migration was understood as an active strategy to increase social capital in this context and to avoid homelessness in culturally alien community.

The current study implies close relationships between social capital theory and acculturation strategies among the refugee families. Research on either acculturation or social capital shows disparities among subject matters and conceptual links with other related notions. Many inquiries have been conducted on the interplay between acculturation/social capital and cultural identity, mental health and physical health, or

self-efficacy, while some areas have been little investigated related to these subjects. Moreover, in spite of the conceptual overlapping, social capital and acculturation has been little discussed together in the previous studies. In future studies, this examination should continue, as it may hold keys to understanding the complexities of the resettlement process.

In the current study, the families were clearly aware of the extent of the types and amount of resources available through bonding social capital. This type of social support was needed not only for assistance with language and transportation but also for emotional support and cultural maintenance. The latter was closely associated with the refugee parents' expectation and hope for their children's cultural identity. On the other hand, the refugee families seek linking social capital to attain different types of resources, including the means for livelihood, health care and education. At the same time, some concerns around assimilation were frequently reported, especially for their children's future.

Bonding social capital, in this regard, was conceptually aligned with cultural maintenance (e.g. following traditional values and norms), while bridging and/or linking was matched with participation in/contact with the host culture (e.g. acceptance of American culture). For instance, bonding social capital implies more interactions within the homogenous community, and this may be closely related to acculturation strategies of cultural maintenance. In the meantime, bridging social capital is theoretically aligned with the other dimension of the acculturation process, active participation in the host society and acceptance of new culture. Thus, the amount and the quality of bridging

social capital may imply status of refugees' acculturation strategies of participation and acceptance. Even though the links between these four concepts may not be as simple and direct as mentioned above, the interactive effects of the components of social capital and acculturation may enable more precise understanding of the relationships between social networks and acculturation as well as inclusive social systems of refugees and coping strategies for adjustment. These new conceptual links of social capital and acculturation, although not a focus of the current study, can and should be explored and tested with refugee populations in a future study.

Limitations of the Current Research

The current study has demonstrated the stress and coping processes of resettlement and homelessness in the context of forced migration and displacement. The findings of the study have revealed cultural as well as general coping strategies and their psychological outcomes. The author also focused on the stress and coping processes in Hmong and Somali communities in particular, considering loss and gain of social capital. In spite of its contribution of adding new knowledge to the little discussed subject of refugee homelessness, this study has some limitations that need to be addressed for future investigation.

First, the samples of the current study were limited to two ethnic groups who comprised the two largest refugee communities in Minnesota, particularly in the Twin Cities area. This study aimed to collect data from these two groups by using purposive sampling, as these two ethnic communities are representative both in Minnesota and in the U.S. and thus attract many secondary migrants pursuing bonding social capital. In this

regard, the author focused on these two groups in the current study, but in order to build a general theory of refugee families' stress and coping upon, this study would need to be expanded to include other refugee subgroups. In addition, the current study was conducted in one homeless shelter and this may have introduced possible biases in the study.

Second, along with the first limitation, a comparison between diverse subgroups within each ethnicity, including gender, ethnicity, citizenships, and length of stay in the U.S., would be needed for a further investigation. Gender difference, for instance, was not a focus in this study, although previous studies have implied that psychological distress and coping styles may differ according to gender (Bijl, et al., 1998; Kopper, 1993). Expression of mental and emotional difficulties, for instance, is less salient among males due to cultural norms about emotional reaction and sensitivity to psychological status. The samples of the current study also did not include the criteria of immigration status or acculturation stage as a strict confounding variable, which might reveal rich dimensions of resettlement stressors according to the progression of time. While important, such factors were outside the focus of this study.

Third, this study left many research questions that need comprehensive approaches to the current topic. Refugee resettlement is an intricate process in which many components of diverse needs and interventions are involved. It also cannot be separated from the refugees' previous experiences, such as traumatic experiences in the home country, forced migration, life in refugee camps, and other challenges and hardships. Due to the complexity of the topic as well as to the lack of previous studies of

the same topic (refugee homelessness), the current study adopted a qualitative research method. This study could be extended to additional quantitative research building on the findings from the current study and integrated into a mixed method inquiry on the topic with multi-layered explanations of stress and coping processes among refugee families. Since resettlement and migration is a long term process, a longitudinal research design would also fit for revealing the stressors and coping process according to migration phases.

Conclusion: Modified hypotheses of stress and coping of homeless refugee families

Refugee families have been exposed to multiple stressors, types of which vary ranging from war trauma, threat to resources, harm/loss of resources, frustrated coping, symbolic and cultural loss. Each phase of migration has unique issues that are most urgent and salient to the families. Before migration, trauma and security issues are of primary concern, while loss and lack of resources are the main source of stress during migration. After resettlement, refugee families face new kinds of stressors, namely resettlement or acculturation stressors, which tend to cause acute distress due to frustrated coping appraisal, unmet expectations, and lack of various resources including cultural resources. As an outcome of such multiple stressors combined with lack of appropriate social service intervention and social capital, homelessness occurs to some refugee families who are in particular need for family and social as well as cultural resources. Multiple stressors through the migration process deprive refugee families of resources at all levels: personal, family, cultural, and environmental, as well as social capital. Cognitive appraisal, as an active coping strategy, leads refugee families to reassess

available and accessible resources after resettlement. The meaning and function of stressors and resources may change, because displacement and relocation rearrange or sometimes nullify cultural resources, which is a critical coping means in the post-migration stage. Social capital, especially bonding social capital, is particularly important for gaining resources that can supplement personal, family and cultural resources. Secondary migration is an adaptive coping strategy to increase bonding social capital among the most vulnerable refugee families with limited or few resources. Linking social capital is also significant for attaining material resources needed for basic needs and livelihood issues. Failure of building or rebuilding social capital, in this respect, tends to critically impede refugee families' adjustment to a new environment. As a coping style, problem-focused coping is dominant among refugee families, while limited emotion-focused coping was utilized. In the latter case, however, most of the coping was through religious beliefs and practice, which were found across gender and ethnic groups. As a psychological outcome of stressors, refugee families experienced various kinds of emotional and mental distress, ranging from sleep problems, worries, fear, anger, helplessness, hopelessness, depression, anxiety, headaches, and other negative emotions and physical symptoms. Among homeless refugee families, psychological distress was ascribed to homelessness and other urgent stressors associated with housing, such as living in a homeless shelter, language barriers, lack of job and transportation, and instability of living. The imbalance between stressors and resources, in particular, increased a sense of helplessness and worries among refugee families. Bonding as well as family social capital function positively in mental health among refugee families by

adding social resources and hope for the future through children and group solidarity, while religious coping that an individual or family practice plays as a psychological buffer to stressors.

Considering all of the findings from this research, and building on knowledge generated from previous research by different authors, the modified analytic induction approach calls for reformulation of hypotheses. In the case of this study, the majority of hypotheses held true based on the data collected. For instance, the hypothesis of the presence of multiple stressors was very well supported by the data. Likewise, the hypothesis that homelessness is related to other stressors is well grounded in the evidence, and requires no revision.

There were some hypotheses that do require a degree of revision, however, as the evidence from this data set added new understanding to what had been hypothesized based on previous literature. First, the second hypothesis (that refugees experience different stressors in different stages of migration) may be revised somewhat to account for the fact that different types of stress may predominate in certain circumstances, but they are not necessarily unique to a particular migratory phase. Threat of loss of resources, for instance may be an acute concern during the pre-migration stage, may dissipate during the migration stage, and may re-emerge in the post-migration phase. Thus, this hypothesis may be revised to account for this nuance. The revised hypothesis may be states as: Refugees will experience particular types of stressors at specific times of the migration process, though stressors are not necessarily unique to only one phase of migration.

Additionally, hypothesis five (failure to build social capital may critically impede adjustment to a new environment) should also be revised, as suggested by the analysis of this study's data. While the basic notion of this hypothesis appears true, a more nuanced approach to the hypothesis may be warranted based on this study's findings. Specifically, greater differentiation may be made between types of social capital, which may ultimately be more instructive in viewing social capital's impact on resettlement outcomes. It may be useful to set this hypothesis as a proposed continuum, where in resettlement outcomes are increased as more sophisticated use of social capital emerges. Thus, the revised hypothesis may read as follows: Refugees will experience success in integration in their new environment on a continuum with social capital. Those who do not establish social capital will experience poor outcomes, those who establish bonding social capital will fare better, and those who establish bridging or linking social capital will experience the best resettlement outcomes, assuming that bonding social capital is also present.

While all hypotheses are open to refutation and revision, the results of this study suggest that the majority of the proposed hypotheses for this study are well supported by the data. Even those hypotheses that were revised, as seen above, did receive support from the data, but needed minor revision to portray the evidence more accurately. These revised hypotheses may now be tested in future research, and possibly with different research methods to gain an even greater understanding and level of insight into the multifaceted factors that support and impede successful migration experiences. This in turn, will inform practice and policy solutions that may be instrumental in improving the

lives of refugees as they seek to gain a foothold in the social, economic, and cultural fabric of the United States.

REFERENCES

Abu-Rayya, H. M. (2006). Acculturation and well-being among Arab-European mixed-ethnic adolescents in Israel. *Journal of Adolescent Health, 39*, 745–751.

Access Alliance (2003). *Best Practices for Working with Homeless Immigrants and Refugees: A Community-Based Action-Research Project. Access Alliance Multicultural Community Health Centre*. Retrieved December 14, 2009 from http://ceris.metropolis.net/Virtual%20Library/housing_neighbourhoods/AccessAlliance/Report.pdf.

Acevedo, Gregory. "Latino(a)s." Encyclopedia of Homelessness. 2004. SAGE Publications. 21 Feb. 2010. http://www.sage-reference.com.floyd.lib.umn.edu/homelessness.html.

Ager,A. & Strang, A. (2008). Understanding integration: a conceptual framework. *Journal of Refugee Studies, 21*(2), 166-191

Alvidrez, J. (1999). Ethnic variations in mental health attitudes and service use among low-income African American, Latina, and European American young women. *Community Mental Health Journal, 35*, 515-530.

Amnesty International (1997). *Amnesty International Annual Report*. London: Amnesty International Secretariat.

Anderies, J.M., Janssen, M.A., & Ostrom, E. (2004). A framework to analyze the robustness of social-ecological systems from an institutional perspective. Ecology and Society 9(1), 18

Araya, R., Montgomery, A., Rojas, G., et al (2007) Common mental disorders and the built environment in Santiago, Chile. *British Journal of Psychiatry, 190*, 394 -401

Bassuk, E L. (1997). Homelessness in female-headed families: Childhood and adult risk and protective factors. *American Journal of Public Health, 87*(2), 241.

Bassuk, E. L., Buckner, J. C., Perloff, J. N., and Bassuk, S. S. (1998). Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. *American Journal of Psychiatry, 155*(11), 1561–1564.

Bebbington, A. (1999) Capitals and capabilities: a framework for analysing peasant viability, rural livelihoods and poverty. *World Development 27*(12), 2021-2044.

Beiser, M. (1990). *Mental health of refugees in resettlement countries. In mental health of immigrants and refugees*. Proceedings of a Conference Sponsored by Hogg Foundation for Mental Health and World Federation for Mental Health. Austin: University of Texas.

Beiser, M. (2006). Longitudinal research to promote effective refugee resettlement. *Transcultural Psychiatry, 43*(1), 56-71.

Berman, H. (2001). Children and war: Current understandings and future directions. *Public Health Nursing, 18*(4), 243–252.

Berry, J. W. (1997). Immigration, acculturation and adaptation. Applied Psychology, 46, 5–68.

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29*, 697–712.

Berry, J. W., Kim, U., Minde, T., & Mok, D. (1987). Comparative studies of acculturative stress. *International Migration Review, 21*, 491-511.

Berry, J.W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29.* 697–712

Bijl, R. V., De Graaf, R., Ravelli, A., Smit, F., & Vollebergh, W .A. (2002). Gender and age-specific first incidence of DSM-III-R psychiatric disorders in the general population: Results from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). Social Psychiatry and Psychiatric *Epidemiology, 37*, 372-379.

Breakey, W. R., Fischer, P. J., Kramer, M., and et al. (1989). Health and mental health problems of homeless men and women in Baltimore. *Journal of the American Medical Association, 262,* 1352–1357.

Buckner, J.C. (2004). "Epidemiology." Encyclopedia of Homelessness. 2004. SAGE Publications. Retrieved 31 Dec. 2009 from http://www.sage-ereference.com/homelessness/Article_n42.html.

Burnam, N., Hough, R., Karno, M., Escobar, J. & Telles, C. (1987) Acculturation and lifetime prevalence of psychiatric disorders among Mexican Americans in Los Angeles. *Journal of Health and Social Behavior, 28*, 89–102.

Burridge, R., & Ornandy, D. (1993). The legal environment of housing conditions. In R. Burridge & D. Ormandy (Eds.), *Unhealthy housing: Research, remedies and reform* (pp. 401-423). London: E & FN Spon.

Cabassa, L. J. (2007). Latino immigrant men's perceptions of depression and attitudes toward help seeking. *Hispanic Journal of Behavioral Sciences, 29*(4), 492-509.

Calsyn, R. J., & Roades, L. A. (1994). Predictors of past and current homelessness. *Journal of Community Psychology, 22*(3), 272-278.

Carlson EB, Rosser-Hogan R (1991). Trauma experiences, posttraumatic stress, dissociation, and depression in Cambodian refugees. *American Journal of Psychiatry, 148*, 1548–1551.

Center for Disease Control (2009). Promoting cultural sensitivity: A practical guide for tuberculosis programs that provide services to persons from Somalia. Retrieved November 14, 2009 from http://www.cdc.gov/TB/publications/guidestoolkits/EthnographicGuides/Somalia

Chung, R. C. & Lin, K. (1994). Help-seeking behavior among Southeast Asian refguees. *Journal of Community Psychology 22*: 109-120.

Clinton-Davis, L. & Fasssil, Y. (1992). Health and social problems of refugees. *Social Science and Medicine*, 35(4), 507–13.

Coleman (1988) J.S. Coleman, Social capital in the creation of human capital. *American Journal of Sociology, 94*, 95–120.

Colic Peisker, V. (2006). Employment niches for recent refugees: Segmented labour market in twenty-first century Australia. *Journal of refugee studies, 19*(2), 203.

Colic-Peisker, V., & Walker, I. (2003). Human capital, acculturation and social identity: Bosnian refugees in Australia. *Journal of Community and Applied Social Psychology*, 13, 337-360.

Crowley, C. (2009). The mental health needs of refugee children: A review of literature and implications for nurse practitioners. *Journal of the American Academy of Nurse Practitioners, 21*, 322-331.

Cullen, M. and Whiteford, H. (2001). The Interrelations Of Social Capital With Health And Mental Health: A Discussion Paper Commonwealth of Australia: Canberra.

Dalgard, O. S. & Tambs, K. (1997) Urban environment and mental health: a longitudinal study. *British Journal of Psychiatry, 171*, 530 -536

Davidson, G.R., Murray, K.E., & Schweitzer, R. (2008). Review of refugee mental health and wellbeing: Australian perspectives. *Australian Psychologist, 43*(3), 160-174.

Davies, P T. (1997). Gender-specific pathways between maternal depressive symptoms, family discord, and adolescent adjustment. *Developmental psychology, 33*(4), 657-668.

Department of Homeland Security (2009). Profiles on legal permanent residents: People born in Somalia. Retrieved November 13, 2009 from http://www.dhs.gov/files/statistics/data/DSLPR08c.shtm

DeShaw, P .J. (2006). Use of the emergency department by Somali immigrants and refugees. Minnesota Medicine, 8(89), 42-45.

Easterlow D, Smith S J, Mallinson S. (2000), Housing for health: the role of owner occupation. *Housing Studies, 15*, 367 – 386.

Ell, K., & Castaneda, I. (1998). Health care seeking behavior. *In S. Loue, ed., Handbook of immigrant health.* New York: Plenum Press, pp. 125-144.

Ellis, B.H., MacDonald, H.Z., Lincoln, A.K., & Cabral, H.J. (2008). Mental health of Somali adolescent refugees: The role of trauma, stress, and perceived discrimination. *Journal of Consulting and Clinical Psychology, 76*(2), 184–193

Farley, T. (2005). Stress, coping, and health: A comparison of Mexican immigrants, Mexican-Americans, and non-Hispanic whites. *Journal of immigrant health, 7*(3), 213-220.

Fazel, M., & Stein, A. (2003). Mental health of refugee children: Comparative study. *British Medical Journal, 327*, 134.

Fitzpatrick, K. M., Irwin, J., Lagory, M., & Ritchey, F. (2007). Just thinking about it - social capital and suicide ideation among homeless persons. *Journal of Health Psychology, 12*(5), 750-760.

Frazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in Western countries: A systematic review. *Lancet, 365*, 1309-1314.

Fung, K. & Wong, Y-L. R., (2000). Factors Influencing Attitudes Towards Seeking Professional Help Among East and Southeast Asian Immigrant and Refugee Women. *International Journal of Social Psychiatry, 53*(3), 216-231.

Gailly, A. (1996). Providing mental health care for immigrants. *European Psychiatry, 11*, 171–172.

Gallin, A. J. (1994). The cultural defense: Undermining the policies against domestic violence. *Boston College law review, 35*(3), 723-745.

Gilgun, J. F. (1995). We shared something special: The moral discourse of incest perpetrators. *Journal of Marriage and the Family*, 57, 265-281.

Gilgun, J. F. (2005). Qualitative research and family psychology. *Journal of Family Psychology*, 19 (1), 40-50.

Golding, J. M., & Burnam, M. A. (1990). Immigration, stress, and depressive symptoms in a Mexican-American community. *Journal of Nervous and Mental Disease, 178*(3), 161–171.

Goldstein, R. D., Wampler, N. S., & Wise, P. H. (1997). War experiences and distress symptoms of Bosnian children. *Pediatrics, 100*, 873–878.

Gong-Guy, E., Cravens, R. B., & Patterson, T. E. (1991). Clinical issues in mental health service delivery to refugees. *American Psychologist, 46*(6), 642-648.

Gorst-Unsworth, C., & Goldenberg, E. (1998). Psychological sequelae of torture and organized violence suffered by refugees from Iraq: Trauma-related factors compared with social factors in exile. *British Journal of Psychiatry, 172*, 90 –94.

Green, B. L. (1996). Cross-national and ethnocultural issues in disaster research. In A. J. Marsella, M. J. Friedman, E. Gerrity, & R. M. Scurfield (Eds.), Ethnocultural aspects of posttraumatic stress disorder: Issues, research and applications (pp. 341–361). Washington, DC: American Psychological Association Press.

Grigoleit, G. (2006). Coming home? The integration of Hmong refugees from Wat Tham Krabok, Thailand into American society. Hmong studies journal, 7, 1- 22.

Gunderson, L.H. & Holling, C. S. (2002). *Panarchy: Understanding transformations in human and natural systems.* Island Press, Washington D.C., USA.

Hauff, E., Vaglum, P. (1994). Chronic posttraumatic stress disorder in Vietnamese refugees. *Journal of Nerve and Mental Disorder, 182*, 85– 90.

Heptinstall, E., Sethna, V., & Taylor, E. (2004). PTSD and depression in refugee children: Association with pre-migration trauma and post-migration stress. *European Child and Adolescent Psychiatry, 13*, 373–380.

Hilton, W. L., Tiet, Q., Tran, C. G., & Chesney, M. (1997). Predictors of depression among refugees from Vietnam: a longitudinal study of new arrivals. *Journal of Nervous and Mental Disease, 185*(1), 39-45.

Hoshman, L.T. (2007). Cultural-ecological perspectives on the understanding and assessment of trauma. In J. P. Wilson & C. So-kum Tang (Eds.). *Cross-cultural assessment of psychological trauma and PTSD* (pp. 31-50). Springer, US.

Hubbard, J., Realmuto, G. M., Northwood, A. K., & Masten, A. (1995). Comorbidity of psychiatric diagnoses with posttraumatic stress disorder in survivors of childhood trauma. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 1167–1173.

HUD (2011). Federal Definition of Homeless. Retrieved from http://portal.hud.gov/hudportal/HUD?src=/topics/homelessness/definition

Ineichen, B. (1993). *Homes and health: How housing and health interact*. London ; New York: E & FN Spon.

Julia, M. & Hartnett, H. P. (1999). Exploring cultural issues in Puerto Rican homelessness. *Cross-cultural research, 33*. 318 – 340.

Kaniasty K, Norris F. H. (2000). Help-seeking comfort and receiving social support: the role of ethnicity and context of need. *American Journal of Community Psychology, 28*, 545–581.

Kaplan, M. S., & Marks, G. (1990). Adverse effects of acculturation: Psychological distress among Mexican American young adults. *Social Science and Medicine, 31*(12), 1313–1319.

Karunakara, U. K., Neuner, F., Schauer, M., Singh, K., Hill, K., Elbert, T., & Burnha, G. (2004). Traumatic events and symptoms of post-traumatic stress disorder amongst Sudanese nationals, refugees and Ugandans in the West Nile. *African Health Science, 4*(2), 83-93.

Khan, F., & Waheed, W. (2006). Suicide and self-harm in South Asian immigrants. *Psychiatry, 5*, 283–285.

Killworth, P. D. (1998). Estimation of seroprevalence, rape, and homelessness in the United States using a social network approach. *Evaluation review, 22*(2), 289-308.

Knipscheer, J. W., & Kleber, R.J. (2007). Acculturation and mental health among Ghanaians in Netherlands. *International Journal of Social Psychiatry, 53*(4), 369-383.

Kopper, B. A. (1993). Role of gender, sex role identity, and type A behavior in anger expression and mental health functioning. *Journal of Counseling Psychology, 40*(2), 232-237.

Kroll, J., Yusuf, A. I., & Fujiwara, K. (2011). Psychoses, PTSD, and depression in Somali refugees in Minnesota. *Social Psychiatry and Psychiatric Epidemiology*, 46(6), 481-493.

Lamba, N K. (2003). Social capital and refugee resettlement: The social networks of refugees in Canada. *Journal of international migration and integration, 4*(3), 335-360.

Leong, F. T. L., & Lau, A. S. L. (2001). Barriers to Providing Effective Mental Health Services to Asian Americans. *Mental Health Services Research, 3*(4), 201-214.

Li, Y., Savage, M. and Pickles, A. (2003). Social Capital and Social Exclusion in England and Wales (1972–1999). *British Journal of Sociology 54*(4), 497–526.

Lochner, K., Kawachi, I., & Kennedy, B. P. (1999). Social capital: A guide to its measurement. *Health and Place,* 5, 259–270.

Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D., et al. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(1), 24-36.

Marger, M. N. (2001). The Use of Social and Human Capital among Canadian Business Immigrants. *Journal of Ethnic and Migration Studies 27*(3), 439–54.

Markovic, M., Manderson, L., & Kelaher, M. (2002). The health of immigrant women: Queensland women from the former Yugoslavia. *Journal of Immigrant Health, 4,* 5–15.

Marsella, A. J. (1995). Urbanization, mental health and psychological well-being: Some historical perspectives and considerations. In Urbanization and Mental Health in Developing Countries, Harpham, T. and Blue, I (eds), Avebury, Aldershot.

Marsiglia, F.F., Kulis, S., Hecht, M.L., & Sills, S. (2004). Ethnicity and ethnic identity as predictors of drug norms and drug use among pre-adolescents in the Southwest. *Substance Use & Misuse, 39,* 7, 1061-1094.

McBrien, J. L. (2005). Educational Needs and Barriers for Refugee Students in the United States: A Review of the Literature. *Review of Educational Research, 75*(3), 329-364.

Menjivar, C. (2002). Immigrant women and domestic violence. *Gender & Society, 16*(6), 898-920.

Miller, M. J. (2007). A bilinear multidimensional measurement model of Asian American acculturation and enculturation: Implications for counseling interventions. *Journal of Counseling Psychology, 54*(2), 118-131.

Mollica, R F., Donelan, K., Tor, S., Lavelle, J., Elias, C., Frankel, M., & Blendon, R.J. (1993). The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps. *Journal of the American Medical Association, 270*(5), 581-586.

Mollica, R. F., Donelan, K., Tor, S., Lavelle, J., Elias, C., Frankel, M., & Blendon, R. J. (1993). The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps. *Journal of the American Medical Association, 270*(5), 581-586.

Mollica, R., Wyshak, G., Lavalle, J., Truong, T., Tori, S., & Yang, T. (1990). Assessing symptom change in Southeast Asian refugee survivors of mass violence and torture. *American Journal of Psychiatry, 147*, 83-88.

Morgan, D. (1998). Practical strategies for combining qualitative and quantitative methods: Applications to health research. *Qualitative Health Research, 8*, 362-376.

Morris, M. D., Popper, S. T., Rodwell, T.C., Brodine, S. K., & Brouwer, K.C. (2009). Healthcare barriers of refugees post-resettlement. Journal of community health, 34(6), 529 - 538.

Muntaner, C. and Eaton, W. W. (1998). Psychosocial and organizational factors: Chronic outcomes—Mental Illness. In J. Stellman (ed.), International Labour Organisation Encyclopaedia of Occupational Health and Safety, Geneva, International Labour Office.

Nannestad, P., Svendsen, G. L. H., & Svendsen, G. T. (2008). Bridge Over Troubled Water? Migration and Social Capital. *Journal of Ethnic & Migration Studies, 34*(4), 607-631.

National Coalition for the Homeless. (2006). "Mental Illness and Homelessness: NCH Fact Sheet #5." Washington, DC: National Coalition for the Homeless. Retrieved December 28, 2009 from http://www.nationalhomeless.org.

Nee, V. and J. Sanders. 2001. Understanding the Diversity of Immigrant Incorporation: A Forms-of-Capital Model. *Ethnic and Racial Studies 24*, 386–41

Nguyen, L. & Peterson, C. (1993). Depressive symptoms among Vietnamese-American college students. *Journal of Social Psychology, 133*, 65–72.

Nicholson, B.L. (1997). The influence of pre-emigration and post-emigration stressors on mental health: A study of Southeast Asian refugees. *Social Work Research, 21*, 19–30.

Noh, S., & Kaspar, V. (2003). Perceived discrimination and depression: moderating effects of coping, acculturation, and ethnic support. *American Journal of Public Health*, 93, 232-238.

Nyamathi, A., Longshore, D., Keenan, C., Lesser, J. & Leake, B. (2001). Childhood Predictors of Daily Substance Use among Homeless Women of Different Ethnicities. *American Behavioral Scientist, 45*(1), 35 - 50.

Onwuegbuzie, A.J., & Leech, N.L. (2004). Enhancing the interpretation of "significant" findings: The role of mixed methods research. *Qualitative Report, 9*(4), 770-792.

Pernice, R., & Brook, J. (1996). Refugees' and immigrants' mental health: Association of demographic and post-migration factors. *Journal of Social Psychology, 136*, 511–519.

Pickett, S.T.A. & Cadenasso, M.L. (2002). The ecosystem as a multidimensional concept: Meaning, model, and metaphor. *Ecosystems, 5*(1), 1-10.

Plante, Thomas G., Simicic, Azra, Andersen, Erin N. & Manuel, Gerdenio (2002). Stress

and coping among displaced Bosnian refugees: An exploratory study. *International Journal of Stress Management, 9*(1), 31-41.

Plunkett, S. W., & Bamaca-Gomez, M. Y. (2003). The relationship between parenting, acculturation, and adolescent academics in Mexican-origin immigrant families in Los Angeles. *Hispanic Journal of Behavioral Science, 25*, 222-239.

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *Journal of the American Medical Association, 294*, 602-61.

Potocky-Tripodi, M. (2002*). Best practices for social work with refugees and immigrants*. New York: Columbia University Press

Pumariega, A., Rothe, E., & Pumariega, J. (2005). Mental health of immigrants and refugees. *Community Mental Health Journal, 41*(5), 581–597.

Putnam R. (1993). The prosperous community: Social capital and public life. *The American Prospect, 13*, 35–42.

Ricardo A., Dunstanb, F., Playleb, R., Thomasc, H., Palmerb, S., & Lewisa, G. (2006). Perceptions of social capital and the built environment and mental health. *Social Science & Medicine, 62*, 3072–3083.

Robinson, D. (1998). Health selection in the housing system: access to council housing for people with health problems. *Housing Studies 13*(1), 23-41.

Roizblatt, A. & Pilowsky, D. (1996.). FORCED migration and resettlement : Its impact on families and individuals. *Psychiatry: Interpersonal and Biological Processes, 18*(December 1996).

Ross, C. E. (2000) Neighborhood disadvantage and adult depression. *Journal of Health and Social Behaviour, 41*, 177 -187

Sack, W. H., Him, C., & Dickason, D. (1999). Twelve-year follow-up study of Khmer youths who suffered massive war trauma as children. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*, 1173–1179.

Salaff, J. W. and Wong, S.L. (1998). Network Capital: Emigration from Hong Kong. *British Journal of Sociology 49*(3), 358–78.

Sam , D.L., & Berry, J.W. (1995). Acculturative stress among young immigrants in Norway. *Scandinavian Journal of Psychology, 36*, 10-21.

Schaid, J. & Grossman, Z. (2007). Somali Immigrant Settlement in Small Midwestern U.S. Communities: The Case of Barron, Wis., in Kusow, A. & Bjørk, S. (eds) *From Mogadishu to Dixon: The Somali Diaspora in a Global Context*, Lawrenceville, N.J.: Africa World Press/The Red Sea Press, 2007.

Servan-Schreiber, D., Lin, B. L., & Birmaher, B. (1998). Prevalence of posttraumatic stress disorder and major depressive disorder in Tibetan refugee children. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*, 874–879.

Shen, B. J., Takeuchi, D. T. (2001). A structural model of acculturation and mental health

status among Chinese Americans. *American Journal of Community Psychology, 29*(3), 387-418.

Shinn M; Knickman J R; Weitzman B C (1991). Social relationships and vulnerability to becoming homeless among poor families. *The American Psychologist, 46*(11), 1180-7.

Shinn, M., Gottlieb, J., Wett, J. L., Bahl, A., Cohen, A., & Ellis, D. B. (2007). Predictors of homelessness among older adults in New York City - disability, economic human and social capital and stressful events. *Journal of Health Psychology, 12*(5), 696-708.

Shinn, Marybeth, and Ellen Bassuk. "Families." Encyclopedia of Homelessness. 2004. SAGE Publications. 21 Feb. 2010.

Shor, R. (2007). Differentiating the culturally-based help-seeking patterns of immigrant parents from the former Soviet Union by comparison with parents in Russia. *American Journal of Orthopsychiatry, 77*(2), 216-220.

Silove, D., Steel, Z, Bauman, A., Chey, T., & McFarlane, A. (2007). *Social Psychiatry and Psychiatric Epidemiology*, *42*, 467-476.

Silove, D., Steel, Z., Bauman, A., Chey, T., & McFarlane, A. (2004). Trauma, PTSD and the longer-term mental health burden amongst Vietnamese refugees: A comparison with the Australian-born population. *Social Psychiatry and Psychiatric Epidemiology*, *42*(6), 467-476

Skapinakis, P., Lewis, G., Araya, R., Jones, K., & Williams, G. (2005). Mental health inequalities in Wales, UK: multi-level investigation of the effect of area deprivation. *British Journal of Psychiatry*, *186*, 417 -422.

Smith, S. J. (1989). *Housing and health: A review and research agenda*. Glasgow. Scotland: University of Glasgow, Centre for Housing Research.

Smith, S.J., Easterlow, D., Munro, M. & Turner, K.M. (2003). Housing as health capital: How health trajectories and housing paths are linked. *Journal of social issues. 59*(3), 501-525.

Sohng, K.Y., Sohng, S., & Yeam, H.A. (2002). Health-promoting behaviors of elderly Korean immigrants in the United States. *Public Health Nursing, 19*, 294–300.

Stanton-Salazar, R. D. (1997). A social capital framework for understanding the socialization of racial minority children and youth. *Harvard Educational Review, 67*(1), 1-40.

Steel, Z., Silove, D., Phan, T., Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: a population-based study. *Lancet*, 360, 1056–1061.

Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion, 10*, 282-298.

Sundquist, J., Bayard-Burfield, L., Johansson, L.M., & Johansson, S.E. (2000). Impact of

ethnicity, violence and acculturation on displaced migrants. *Journal of Nervous and Mental Disease, 188*, 357–365.

Taylor, C. S., Lerner, R. M., von Eye, A., Balsano, A. B., Dowling, E. M., Anderson, P. M., et al. (2002). Individual and ecological assets and positive developmental trajectories among gang and community-based organization youth. New Directions for Youth Development, 95, 57–72.

Theokas, C., & Lerner, R. M. (2006). Observed ecological assets in families, schools, and neighborhoods: Conceptualization, measurement, and relations with positive and negative developmental outcomes. *Applied Developmental Science, 10*(2), 61–74.

Thomas, H., Weaver, N., Bell, T., & Lewis, G. (2007). Mental health and quality of residential environment. *British Journal of Psychiatry, 191*, 500-505.

Tischler, V. (2006). Mothers experiencing homelessness: Mental health, support and social care needs. *Health & social care in the community, 15*(3), 246-253.

Torres, J. B., & Solberg, V. S. (2001). Role of self-efficacy, stress, social integration, and family support in Latino college student persistence and health. *Journal of Vocational Behavior, 59*(1), 53–63.

Uba, L. (1992). Cultural Barriers to Health Care for Southeast Asian Refugees. *Public Health Reports, 107* (5), 544-548.

UNHCR (1996). Resettlement: An instrument of protection and a durable solution. Executive UNHCR, Geneva, Retrieved from http://www.unhcr.org/excom/EXCOM/3ae68cf618.pdf

UNHCR (2002). *Refugee resettlement: An International Handbook to Guide Reception and Integration*, UNHCR: Geneva

USCRI (2008). World Refugee Survey – 2007. Retrieved from http://www.refugees.org/

Valtonen, K. (1998). Resettlement of middle eastern refugees in finland: The elusiveness of integration. *Journal of refugee studies, 11*(1), 38.

Velez, I., Gifford, S. M., & Barnett, A. G. (2010) Longing to belong: Social inclusion and wellbeing among youth with refugee backgrounds in the first three years in Melbourne, Australia. *Social Science & Medicine, 71,* 1399-1408.

Vergara, A E. (2003). A survey of refugee health assessments in the united states. Journal of immigrant health, 5(2), 67-73.

Weich, S., Blanchard, M., Prince, M., Burton, E., Erens, B. and Sproston, K., 2002. Mental health and the built environment: cross-sectional survey of individual and contextual risk factors for depression. *The British Journal of Psychiatry, 180,* 428–433.

Weine, S. M. (2001). From war zone to contact zone. *Student Journal of the American Medical Association, 285,* 1214.

Weine, S. M., Becker, D. F., McGlashan, T. H., Vojvoda, D., Hartman, S.,& Robbins, J.

P. (1995). Adolescent survivors of "ethnic cleansing": Observations on the first year in America. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 1153–1159.

Weine, S., Muzurovic, N., Kulauzovic, Y., Besic, S., Lezix, A., & Mujagic, A., et al. (2004). Family consequences of refugee trauma. *Family Process, 43*(2), 147-160.

Williams, N. (2009). Establishing the boundaries and building briedges – A literature review on ecological theory: Implications for research into the refugee parenting experience. *Journal of Child Health Care*, *20*(5), 1-17.

Woloshin, S. (1995). Language barriers in medicine in the United States. *Journal of the American Medical Association, 273*(9), 724.

Wong, I, Culhane, D., & Kuhn, R. (1997). Predictors of exit and reentry among family shelter users in New York City. *Social Science Review, 71*(3*),* 441-462.

Wright, S., Johnston, M., & Weinman, J. (1995). *Measures in health psychology.* portfolio. Windsor.

Yağmurlu, B., & Sanson, A (2009). Acculturation and parenting among Turkish mothers in Australia. *Journal of Cross-Cultural Psychology*, *40*(3), 361-380.

APPENDIX A. CONSENT FORM OF INDIVIDUAL INTERVIEW

CONSENT FORM [INDIVIDUAL INTERVIEW]

You are invited to participate in a study about housing instability and coping strategies in the Twin Cities. You were selected as a possible participant because you have been experienced housing crisis and currently stay in a Hennepin County family homeless shelter. We ask you to read this form carefully and to ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Hyojin Im, a doctoral candidate in the School of Social Work at the University of Minnesota.

Background Information: The purpose of this study is to explore housing instability and coping strategies for housing security among native-born Americans and refugees in Minnesota and to compare culturally specific issues that each population have.

Procedures of Interview: If you agree to be in this study, we will ask you to answer all the questions in the interview, if they apply to you. The interview is estimated to take about 90 minutes in total. You have the right to refuse to answer to any question for any reason. This interview will ask you mainly about your housing experiences after resettlement and its impact on your family. For better understanding of the circumstances of your experience, interview questions also include your migration experiences and stress during resettlement. You do not need to answer all questions that interviewers ask, but can answer as many or as few as you wish. You may withdraw participation at any time.

Risks and Benefits of being in the Study: The study has one possible risk. It is possible that it could cause you to recall a stressful memory from the past or a stressful current situation. However, this risk is not very high since the question focuses mainly on housing situations that you have experienced and coping strategies to deal with the

challenges. The research questions do not go into much detail of negative events. There is no direct benefit for participation in the study.

Compensation: You will receive a $25 Target gift card for grocery shopping after finishing the interview.

Confidentiality: The records of this study will be kept private. In any sort of report we might publish, we will not include any information that would make it possible to identify an individual. Research records will be stored securely and only researchers will have access to the records.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota, Hennepin County, or any social service agency. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions: You may ask any questions you have now. If you have questions later, you are encouraged to contact:
Hyojin Im, School of Social Work, University of Minnesota
Phone number: 651-274-7157
E-mail address: hyojin@umn.edu

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), you are encouraged to contact the Research Subjects' Advocate Line, D-528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

You will be given a copy of this information to keep for your records.

If you agree to participate in the study, please circle the "Yes" below. If you do not want to participate OR if you need time to think about participation, please circle the "No or Maybe later."

I agree to participate in the study: [Yes | No or Maybe later]

Signature of Interviewer:_____

Date: _____

APPENDIX B. INTERVIEW GUIDE

Individual Interview Questions [Refugee]

Date: _____ Interviewer (Interpreter): _____

Place: _____

Time: start - _____ finish- _____

Informed Consent Form: ☐ Gift-Card receipt: ☐

Translation: English / Other Language [_____]

Interviewee Information

(Before starting)

Your responses to the questions that we will ask are very valuable for us to learn how housing impacts families and how we can improve the housing policy and resettlement services for refugee communities. This interview is to provide a policy advocacy tool to local agencies and Hennepin County as well as community-based organizations in Minnesota and other areas. Any vivid and detailed information that you will provide will be greatly appreciated and invaluable for other families in the community as well as service providers and local community. To understand family's situations and experiences in a broad context, we are going to ask you about your migration and resettlement experiences as well as housing experiences and the impact of housing on your family. Thank you again for your participation.

Family

1. Gender: __Female / Male_ ***(Do not ask, but just check yourself)***
2. Age: _____

3. Let me start with asking about your family. ***(Meaning and range of family depends on interviewee's perception)*** How many family members do you have?

   _____

4. Do they live together now? Otherwise, who lives separately and why? ***(Check family loss)***

(Only number of families and relationships)

5. Could you tell me about your family members? I'd like to know their relationship with you (i.e. daughter, son, etc.), their age, gender, their current job or school year, and any other peculiar things that they have.

Family Type: Single-Parent / Two-Parent / Polygomy / Extended Family **(*Please mark based on the information that the family provides. If unclear, please ask the interviewee.*)**

6. Do you have any other family members or relatives in Minnesota, other states, home country or refugee camps? What about others who you might think of as family in broad meaning (i.e. clan)? ***(Check how often they interact or support each other OR how well or not well they go along with them etc.)***

Migration and Resettlement

1. Now, I'd like to ask you about your migration and resettlement experiences. First, what was your immigration status when you came to the U.S.?

   _____

(ex. Asylee or Refugee. Among refugees, Free case, family reunification, UNHCR, etc.)

2. Where are you originally from? When did you leave your home country?

3. What happened to your family between your exile and arrival in the U.S. and Minnesota? Could you tell me about your migration experiences? (***Check: (1) Exposure to Traumatic events ex. war, witness or murder, torture, sexual***

violence, etc.; (2) Experiences in refugee camp, length of living in camps, family separation or loss, hardships, survival stories; and (3) Resettlement hardships ex. secondary migration)

3.1. How tough was your life during migration? How did the hardships you experienced during exile or in refugee camps affect you and your family?

3.2. How did these [***mention the events/hardships***] impact on you and/or your families?

3.3. How did you and your family cope with those issues and concerns? [***After initial answer***] Did others in the same situation help you or your family? ***(Check any social support)***

4. Could you tell me about your resettlement experiences? When you first came to the U.S., how did you feel? And how were your family (children etc)?

5. When you first came to the U.S., who did you live with (ex. Sponsor or anchor family, etc.)? Were you well supported?

6. What was most concerned when you came here (to the U.S.)?

7. How did you expect your life here in the U.S. before arrival in the U.S.? [*After initial answer*] Did it change after arrival? (***Check the gaps between expectation and reality***)

8. When you entered the U.S., did all of your family live together? How did your family handle all the situations when you first came to the U.S. and Minnesota? [After initial answer] Who helped most you and your family?

9. How do your personal and your family's life in your home country differ from those in the U.S.? How has your life been changed since then? ***(Check changes in social status, family well-being, quality of life)***

Housing Experiences

1. Now, I'd like to ask you about your housing experiences since you came to the U.S. What was your first place to live in the U.S. and how was it? (***If Minnesota is not the first state, check the first place in other states, too***)

2. Could you tell me briefly about your housing experiences after then (i.e. the second place and so forth until the shelter)? (***Check main reasons for moving and timelines of housing trajectory***)
3. What were the toughest issues or main difficulties in finding and managing stable or proper housing?

4. How did you come to this place (Mary's Place)? (***Check the first time to lose house and why, how many times or how long they have been homeless***)

5. How did you and your family deal with the housing crisis (ex. losing house)? How did you manage when the housing crisis occurred? What did you do to avoid homelessness?

6. Were they (your efforts or coping) successful or not? If not, why do you think they did not work?

Impact of losing house/housing difficulties

1. Could you tell me how much those housing issues made you worried? When you had housing problems (i.e. losing house), how did you feel and how was your family doing?

2. How do you think your housing difficulties affect your family?

3. Does anyone in your family have any health issues currently or previously? If then, what kind of health issues? Otherwise, do you have any health concerns with your children, family or yourself? (physically or psychologically) For example, do you worry about your children's health because of unstable housing? Do you get too much stress because of housing concerns? If then, could you tell me more?

4. When you lost your living place or had housing troubles, how stressful were you and your family? For instance, did you sleep bad, did you think too much, worry a lot, have a headache, feel angry or irritable, feel hopeless, etc? **(*If no description is provided, check each of the examples above*)**

5. Have you or your family made any effort to reduce the stress? What was it? (such as talking to staff here, talking to other friends, OR some people may take a medicine for better sleep or drink to forget..ect.) ***(Check medication, substance use, alcohol dependency, etc.)***

6. Do you think your migration experiences (ex. living in home country or in refugee camp) affect or relate to your housing issues in any way? If then, could you tell me why? For example, places to live in refugee camps might be very different from those in the U.S. Some families may say that life in refugee camp is more stable than here or that being homeless reminds them of life in refugee camp. How about you? Have your children talked about housing differences in the U.S.? (***Check residential environment and experiences in the home country or in refugee camp and differences between them and housing in the U.S.***)

7. Before coming to the U.S., have you expected or did you know that you have to pay a rent every month in advance to keep housing? If not, what was your expectation?

8. Do you think your housing problems affect your relationship with family? If then, how and why? (***Check relationships with spouse & children; both positive and negative***)

9. Do you think your housing problems affect your social life (such as making or managing friends, neighbors, getting a job, children's school and friends, group activity, engaging to neighborhood and community, religious activity, etc.) ? If then, how and why?

10. Have you found cultural differences between your cultural tradition and American culture? What are they?

11. What were the most challenging things to handle those cultural gaps? [*After answer*] How do you make a balance between your cultural tradition and American culture?

12. To adjust to the host society (U.S.), what efforts have you made? For example, learning English, making American friends, watching media, etc.? [A*fter answer*] What do you think would be helpful for your adjustment? (***Check acculturation strategies***)

13. Do you think these cultural differences and cultural challenges affect or relate to your housing situations? If then, how and why? ***(Check previous working experiences, employment history, education, English proficiency, gender role, parenting difficulties, and people's support)***

14. How have you been supported by social services, welfare benefits, or other community agencies in terms of managing housing, family health care, etc.? ***(Check MFIP, PA, Resettlement support, health care etc. And Specify timelines)***

15. Were they helpful or not very much helpful? How and why? [*after answer*] Do you think services and resources are accessible? How and why? (***Check any expectation for service agencies or policy and things to be fixed or improved****)*

16. How about people in your community? Are they supportive to your family? How and why? (***Check the amount/quality of social support systems by asking how many friends/groups they interact and how much they rely on each other***)

Resilience and Strengths of Family

1. What concerns do you currently have for the future of your family? [*after answer*] Any expectation for children?

2. What should be addressed for better life for your family?

3. How do you envision future life of your family? What is your hope and dream? For instance, in ten years, how do you hope your family members are doing?

NOTE: Please make a note on any special issues during interview.

For instance, 1) Questions that the interviewee resisted or refused to answer to:

_____

_____

2) The questions that an interviewee reacted emotionally (i.e. crying, being upset, etc.):

_____

_____

3) The interviewee who, in your opinion, might have a mental health issues (Please add reason why you think so):

_____

_____

4) The questions that seem especially important or rarely relevant to the interviewee:

_____

_____

APPENDIX C. INVITATION LETTER FOR FOCUS GROUP WITH PROFESSIONALS

Invitation to Focus Group Meeting

When: Thursday, October 14th, 3:00 to 4:00 pm

Where: Lutheran Social Services, 2400 Park Avenue, Minneapolis, MN 55404

Dear refugee/immigrant community leaders and service providers:

I am writing to cordially invite you to a focus group meeting by the Refugee Consortium and the Heading Home Hennepin refugee housing work group. This focus group will be facilitated by Lisa Thornquist, the evaluator of Heading Home Hennepin, and Hyojin Im, a doctoral candidate at the University of Minnesota, and will bring together a group of professionals to discuss the causes and solutions associated with refugee and immigrant housing instability.

We are hoping to gain participation from a wide array of stakeholders for this event, including community leaders, service providers, and representatives of refugee resettlement agencies in Minnesota. As a prominent stakeholder in the refugee and immigrant service community, we would be honored if you could share your experiences and thoughts. We are particularly interested in the barriers that exist to prevent service access for immigrant and refugee families experiencing housing instability, as well as promising practices that may help to promote secure housing. We hope that this meeting will provide an opportunity for open exchange of ideas and professional networking among leaders who design and provide services to immigrants and refugees.

We sincerely hope that you will be able to make arrangements to be with us at Lutheran Social Services (2400 Park Avenue, Minneapolis, MN 55404) on October 14 from 3:00 to 4:00 for this one-time focus group. If you are able to attend, please contact Hyojin Im at hyojin@umn.edu so that we may plan for group facilitation. If you are not able to attend but would like to share your insights, we would greatly value your input, and encourage you to contact Ms. Im. We would also greatly appreciate it if you would help us spread this notice to your colleagues who may have interest in attending. All are welcome!

Should you have any questions about this focus group event, please do not hesitate to contact Hyojin Im at hyojin@umn.edu or by phone at (651)274-7157. We hope to see you on October 14!

Sincerely,
Heading Home Hennepin refugee housing work group and Refugee Consortium

APPENDIX D. FOCUS GROUP GUIDE WITH PROFESSIONALS

Focus group questions with resettlement service providers and refugee community leaders

Background of refugee homelessness project

- ☐ Increasing demand for understanding needs for successful resettlement and integration of refugees, and effective resettlement and social services
- ☐ Lack of research on role of housing insecurity and mental health in refugee families' integration to the host society
- ☐ Knowledge gap of interplay between housing and mental health in spite of high prevalence of both among refugees
- ☐ Needs for considering situational contexts to explore complex issues in the resettlement process: ex. Social capital, acculturation

Purposes of the focus group are:

- To explore concerns about housing instability and related issues in refugee community
- To identify risk and preventive factors of refugee resettlement and housing security in refugee community from a perspective of VolAgs, CBOs, and community leaders.
- To exchange information and share concerns of refugee communities regarding resettlement, housing and mental health, and social integration of refugee families.

Questions

1. Opening Questions
   - ❖ Tell us about yourself briefly
     (Name, Agency, Position/role in the organization)

2. Current issues in refugee resettlement and services to refugee communities

- ❖ What are current status of refugee resettlement?
- ❖ What are the challenging issues in providing early resettlement services? (i.e. policy gap, cultural barriers, etc.) What are the challenges from community leader's perspective?

3. Housing insecurity and mental health

- ❖ What are major issues related to housing in refugee community in Minnesota?
- ❖ How do service providers and community leaders perceive the issue of housing insecurity and how do refugee families cope with housing issues?
- ❖ How does your ethnic community respond people with mental health issues? What would be culturally preferred coping strategies for mental wellness? Tell us about traditional way and acculturated way of coping respectively.
- ❖ How does your ethnic community respond people with housing instability or homelessness? What would be culturally preferred coping strategies for housing stability? Tell us about traditional way and acculturated way of coping respectively.

4. Early resettlement services and secondary migration

- ❖ What is current status of secondary migration in Minnesota and across the country? What forces refugee families to migration acorss states?
- ❖ How does secondary migration affect refugee resettlement services and refugee community in Minnesota?

5. Social Capital and Social Integration

- ❖ How do service providers and community leaders perceive social capital in refugee community in Minnesota?
- ❖ Are there any issues related to trust between local and refugee communities as well as service professionals and refugee clients?

6. Closing questions

- What should be addressed to better serve refugee families and communities during resettlement process?
- What efforts would be needed from VolAgs, CBOs, refugee communities, as well as mainstream service providers and local community?

APPENDIX E. A SUMMARY OF FOCUS GROUP WITH BILINGUAL MSW STUDENTS

MSW Student Focus Group

(HM: Hmong pstudnets; SO: Somali students; R: Researcher)

HM: we don't have a word for mental health- people think you crazy, it's a "dishonorment" stigma- needs to be addressed in HM community, younger generation is more open minded about it

HM: parents generation don't know how to deal with it, just know they have some "stress" or "anxiety" in their life so they keep it in and it builds and builds then one day they can't handle it anymore. There's no resources available to help. Will always say everything's fine if kids ask about depression or anxiety because they don't want to worry kids, so they usually never tell.

HM: Parents wait until they're going to burst and then it has a bad impact on kids. Don't know how to find resources- that could help refugees to show them where and how to access resources for mental health care.

HM: Resources- don't know how to finance care, but some families may not know how to access insurance and may not have money to pay out of pocket.

HM: There are't resources for the refugee cultures, only for the mainstream community.

SO: Stigma is great because all of the families know each other. Translator is likely to be someone you know or who knows others you know. Anxiety or stress is seen like you can't take care of yourself or you can't be independent. Will often deny… "in Somali community you're either crazy or you're sane, there's no in between." "If you go crazy, you're done for." Attitude that there's no way to help a person after they go crazy. Nobody will just go and sit and talk about their problems like to a therapist. May not talk about mental health, but people will talk about problems, just not identifying it as mental health or something that should be "treated". Younger generation is starting to understand, but even for many educated people there is embarrassment about mental health issues.

HM: Hmong community has a lot of doctors or chiropractors, but no mental health providers. It's because there's no market for people who will go and do therapy because stigma is so bad.

SO: Know of two people who are Somali and provide mental health services for Somalis because nobody will go.

HM: Wonder if there might be some people who would seek mental health intervention but there aren't any providers. Question about where the problem is: community won't seek help, or no professionals available to provide culturally relevant services.

SO: There needs to be more research on the subject- there is no research about the Somali community to guide practitioners. When I write a paper for class I always have to cite personal communication, personal communication, personal communication.

HM: For Hmong research is also limited. "There's no intervention or prevention, there's no culturally competent providers, there's no professional mental health clinicians who can speak the language and know the culture"

SO: Need community awareness about what mental health is. If someone explains that there are medications and there are these things that you can do they will maybe learn to do something about it. Story about a Somali girl who had mental illness and the family wouldn't let her take medications. Then she tried to commit suicide. She told her parents that she just fell down but told the clinician that she wanted to kill herself. Nobody knew what to do. In Somali community going to the hospital is acceptable, so maybe a good solution would be to meet the kid and family at the hospital. More respect for medical doctors.

HM: "People forget that it's not just about the parents' mental health anymore, it actually goes down to the child's mental health" Prevention for parents and interventions for the children would be useful.

R: Terms- do people talk about "stress" in the languages

HM: In Hmong the same term is used very broadly to indicate "distress" or "sadness". Parents might mention being sad or distressed, but they'll never show how deep it is, and will never share that with anyone besides a close relative.

R: What is the stigma or connotation behind the words used for mental health

SO: Sad is common term, but they will usually talk more about events that have been difficult for them. Often you have to read between the lines as they talk about events to understand the emotions and mental health behind what's going on.

HM: Same for Hmong. No definition that can be translated… usually expressed as sadness

R: shares Korean perspective

HM: it's really more about the symptoms

Mix of Everyone talking: stomach hurts, headache, body pains, want to sleep all the time

SO: PTSD- story about a woman with PTSD- Fatima didn't know about PTSD and the woman always just talked about headaches or being tired. One day the woman broke down in her office and Fatima put it together, but it was hard to go through the process.

R: Using symptom checklist can be helpful and describes the symptoms

SO: sometimes if a client talks too much it can be a sign that something's wrong

HM: sometimes they have a story, but they feel like nobody's going to listen or acknowledge what they're experiencing. Nobody can ever verify the feeling.

SO: come from refugee camps and everything is new here, and all of a sudden there's a rift with their children, so that adds to the stress. The mothers might come together to support each other and talk about it. Had a neighbor who came from Kenya- couldn't communicate to her kids anymore. She would come to my mom all the time and she would cry and she would say this is what's going on, my son said this today, he can't even speak Somali. But Fatima's mom doesn't know what to do to help since she is not trained as a practitioner. All she can do is just listen. If you're not a practitioner it can be really hard to deal with that if you're the listener, so Fatima's mom sometimes complained of symptoms like headaches after hearing the stories of others. That happens a lot. Communities transfer the problems around a lot by talking to each other.

R: Listeners transfer the pain by telling stories, but it also transfers to kids because they see their parents being sad or upset. Attachment can be affected by that.

HM: people don't think about the fact that kids are as affected as adults. There needs to be some intervention and prevention with kids as well. That's overlooked a lot.

SO: At the schools especially. Since kids grow up here and speak English people don't expect them to have some kind of trauma- they don't understand that parents transfer all of that to the kids. Then the kids act out and they're not getting school work done and they don't get the intervention they need.

HM: Kid are often obedient and quiet and they don't see the suffering inside.

SO: They don't understand that the obedience is part of the culture. "I remember when I came here in jr. high and I had a biology class and I came to class late and I was standing outside I was waiting for his permission to come into the classroom because that's how I was raised." The teacher felt so bad. I was brought up that the teacher is like a second parent. So, a kid being quiet and polite in school does not mean they're okay

HM: In our cultures we're very resilient people. We're trained that if we're good, good things will come out of it. If we do good, we'll have a prosperous life and that's really been ingrained in us. So, when we see our parents having mental health issues we don't ask because we're polite and we're not supposed to mess with other people's business. We never really go out and say "you have an issue and you need to go get help".

SO: Parents already experiences all this stress back home and they're resilient and we don't want to stress them out more. They're in a country that makes them feel so small: the education does not come and their hard work, their intelligence, their kids have to do everything for them. If we add on and say "we think you're stressed and why don't you get help that would add more…" When my mom says something wrong, won't correct her… don't want her to think that she doesn't know anything. Young adults are more in charge of the family sometimes.

R: families have gone through so many things in America and before in the camps

SO: If people were at home they'd probably know what to do with mental health issues, but here they don't know where to go. And then when they go get resources, they want to see some one who'd culturally competent. Completely new problems come up when they get to the US and the problems are just adding and adding.

HM: I think that's where social capital comes in. Coming to the US there needs to be some sort of social capital. Like in our community we need to find someone to help us to communicate and to "be there" so you have support.

SO: There's only so much they can do for you, though. Resettlement agencies aren't the same as they used to be. Now is like "welcome to the United States, see you later." There was a family this winter that didn't know how to turn on the heat so they were freezing. Informal support network had to take care of it through a series of phone calls. In terms of mental health, though, there's nothing to be done for them.

R: My assumption is that nobody even thinks of mental health practitioners because they don't attribute struggles to mental health. If there's a housing situation they just think about getting housing, maybe not thinking about the mental health issues that may prevent getting stable housing.

HM: that's the last thing they want to worry about: mental health stuff, but it's there.

SO: that's where that education piece comes in. Pride is a big thing. If my father can't get up and go to work and provide for his children, then he's nobody, and that alone adds stress. With the bad economy it's even worse. And people don't make the connection with mental health.

HM: that happens as well in our community. That's why they get really stress out if they can't find a job.

R: that's just depression, actually

SO: but without education people don't really make that connection.

R: Social capital- in Korea I have friends and family and we can talk about things. In refugee camps you still have great community. There are self-help systems. In the US, sometimes they cannot come with good resources, especially in some states. Define social capital. Tell me more about how social capital changes.

HM: we have some Hmong doctors now so people go there because they feel more comfortable. "Sometimes American doctors don't understand. When an elder is sick sometimes they really don't want the American doctor to inject anything, they'll

want to speak to a Hmong person or a family member to see if they can find another solution."

R: So maybe soc cap is very limited within the community- in group and out group.

HM: maybe younger generation would prefer not to go to a Hmong doctor." I don't know why but because I grew up here I feel like there's so much more than what our parents' perceptions are and I believe more in a white doctor, maybe because he has more credentials…" She would rather go to non-Hmong doctor, but parents would rather see a Hmong doctor. And they don't make appointments, they just walk in because of that system in our community they feel more at ease.

SO: about credentials- Somali doctors may have same credentials, but I would sill not be comfortable with the small community here if I go to the doctor he may know someone I know- so she would rather go to a white doctor, even though there is confidentiality, still fear of seeing him outside and some other community event. Parents both go to a Somali doctor and the only thing Fatima likes about it is that she doesn't have to translate. All I have to do is drive them there. It's such a relief. I'll never let anyone else translate except for me, my sister or my brother (for medical stuff). A somali doctor shows up and then my dad tells him every little thing, even things I don't understand, so I totally see the benefit of having the Somali doctor especially for our parents. It gives them pride if I don't have to translate and do all the work. He feels confident and he gets his pride back. For the younger generation maybe they don't care, but for the older generation they care.

R: Is it also a trust issue too?

ALL: yes.

SO: the trust is a big thing is the guy is from your community

HM: For us my parents believe the Hmong doctor knows what they've been through- the cultural context, so it builds the trust there.

SO: Alcohol is not allowed in Somali culture. With a white doctor they might ask if you've been drinking. The specialist (who's Somali) didn't ask that question because he's familiar with the culture.

HM: White doctors have to ask that questions because it's what they know.

HM: for doctors it's one thing, but for mental health it's different because Hmong people gossip so much and they don't want others to think they're crazy.

HM: It also goes to they (older Hmong) don't understand the system of confidentiality.

HM: and sometimes they might understand but they don't believe it.

HM: Sometimes they'll tell you so much that you just have to summarize (when translating)

SO: when I was a case manager they'll tell me so much stuff and give me all this information that I'm like… um, what do I do. So I wish they could trust that other person other than me who can do more for them than I can, but it's hard to break from the cultural comfort. Other professionals need to listen to them and question them. The county just gives a form for them to fill out, and because they don't know how to anser they may not fill out the form right. "We get information through stories, from talking, and that comes with trust. But if you give them a form. Uh uh, that's going to be in my file so I'm not going to fill that out." You get trust by being patient and listening. Somali culture has a big oral culture.

R: Perception that white doctor may have more skills, so you may feel more confident

SO: students feel most comfortable with other international students and that builds trust because you're going through the same thing.

R: Social capital bonding and bridging explanation. Have different frame of reference for mental health since coming to US. Americans talk a lot about mental health. Seems to be drawing something. Why is bridging so difficult.

SO: we're scared of what we don't know. It's hard to talk about that if you don't have training with it. There are limited opportunities for many people to make friends outside the community. People tend to bond over common issues (example of parents of kids with DD). People don't know how to advocate. They hide from the community and they fight with their doctors. The only thing that makes their stress less is having a

network of other similar families. If someone educates them they could be the voice in the community.

HM: They're unfamiliar and they're afraid of the "different". Everything in US is already different, so the community gives them something familiar. Sometimes if they branch out they may feel guilty. If a parent goes outside the community to make a friend that may mean that they spend less time within the community and they may feel guilty about that. Maybe they're afraid that they may lose themselves or their identity, or their culture. My dad talks to neighbor, but only because he's been here for 20 years and he feels better. They're afraid that the white person might think of them differently.

HM: Media portrays minority communities differently- makes fear. Then if there's one incident where a Hmong person gets robbed by a black man, the whole community will know about it and it will be like "you better not go around black people." Kids get pressure to stay within the community to enrich the community rather than going outside.

SO: if you start hanging out with non-Somali there's a fear of losing your culture and community might look at you like "he's a sell-out" hanging out with all white people. She's all educated now so she just wants to hang out with the mainstream.

R: social relationship is more collective level than individual

ALL: agree

R: mainstream organizations trying to do outreach

SO: new generation has big gap- more individualistic, more I, I, I. Then you go, and it all aobut us, us us.

HM: both agree

R: Korean example "our house" "our mom"

ALL: agree

ALL: see collective relationships as a good thing, but see newer generations going away from it.

SO: But the reason for the resilience is the collective culture.

HM: the only reason why we're so resilient is because we have the well connected community.

HM: that's why there's so many Hmong in MN and CA. People migrate to be together.

SO: Every Somali who comes to the US wants to go to MN because there's community. Everyone chips in for everything to support each other. If you were individualistic, you have to start saving, because you have nobody to turn to.

HM: and that's where the bridging comes into play- it's community bridging.

R: talk about confidentiality

SO: Community chips in when something happens and everyone trusts that that will happen. With mental health if they had education about mental health collectively, they may be able to solve collectively. Problem solve collectively and be able to figure things out and buffer against stressors.

HM: Older generations need to understand that everyone's going through similar things, so if a few people started to go and get help, maybe others might follow along and see what it's about. This could help to normalize it.

SO: if it can normalize, next thing you know if will be alright.

R: Will acculturation help to normalize mental health

SO: I wish we could have a campaign for destigmatizing mental health. There's no stigma to disability because they talk about physical disability. But anything beyond that it's just like mental health… it's like that person' retarded and there's no help for them.

R: coping strategies traditionally

HM: Women will come together and talk and gossip and reach out to each other. It's the times like healing ceremonies when people get together and talk.

HM: Like how's marriage, how's kids, how's life, how's everything

HM: they know they've all been through the same thing- trust. Also how they cope with it.

SO: And they're transferring problems to each other too

R: Confidentiality too

ALL: Men don't talk about it.

HM: Men just boast. I have the best job, I have a best wife, this is how you should get a girlfriend, my son is a doctor, telling stories to make each other look good

R: How can we approach the men about mental health?

HM: You should still do it, but it might take longer

SO: might depend on how you define mental health. It might be that men talk about their struggles and how that makes them stronger.

ALL: conversation gets a bit scattered with people talking real fast and changing topics, so it was hard to follow. I don't think it was anything really important.

SO: Men talk about strengths, women talk about weaknesses

HM: might be more beneficial to talk to husband and wife together about mental health. Might open up the men and build understanding between them. But wife might not want to contradict the husband.

SO: a lot of it depends on how you ask the questions.

HM: spend some time building rapport first then gradually get into questions

R: talk about community- what do you mean by that

HM: extended family- everyone is your family and everyone knows everyone

HM: when I talk about community I'm talking about the Hmong People- mostly where I'm living, so maybe not the ones in California. We're very different in Minnesota than California, so when I talk about community it's really about Hmong people in MN

SO: when I say community I'm talking about family. Community is family. I trust them, speack same language, smile, eat, dance, share. I'm also thinking about Somali community- I will still feel at home with the Somali community in Ohio- same language, same culture, etc. Go to Somali restaurant, community dance, etc. Even in Kenya, I felt like I was with community.

R: So it's like cultural background.

ALL: agree

R: Maybe it's related to language? Like what "community" means in our language.

R: People go through conflicts in the camps, now conflicts with clans. Does that affect community?

HM: I’m sure there’s some conflict, but I feel like it’s more generational conflict now. Especially the men butt heads a lot. The 18 clan council talks through a lot of stuff. The women often get blamed, especially in the older generation. Younger generation more likely to talk it out.

HM: talked about intergenerational conflict but the overall desire to make things work in respect to elders.