Examining the Resettlement Experiences of Muslim Women: Implications for training psychologists and counselors

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ABSTRACT

In recent years there has been increased attention to the impact of migration on mental health. However, existing research uses an intra-individual lens, focuses on the poor mental health of refugees and asylum seekers, and fails to address the limits of traditional therapy. The aim of the present study was to address a gap in the literature on migration by focusing on the following question: how might a human rights approach help us to identify the policies, practices, and structural forces that impact mental health after migration?

Muslim women who migrated to the U.S. as refugees and/or seeking asylum were asked about their experiences of health and well-being. Qualitative data from 10 semi-structured interviews were analyzed and thematic methods were used to generate themes. Four main themes were identified: 1) critical to the definition of a meaningful life was having access to human rights to which Muslim women were entitled; 2) the pervasive impact of legal and financial issues, family separation, and citizenship-related challenges as structural causes of distress; 3) connection serves to enhance well-being; and 4) clinicians can help mitigate the emotional distress incurred by migration by identifying and responding to the health harming legal needs of their clients. This study highlights the importance of incorporating a structural competency framework when working with refugee and asylum-seeking Muslim women in order to challenge health-harming systems which restrict their human rights.

Keywords: *refugee, asylum, Muslim, human rights, capabilities approach*

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Introduction

Over the last decade, the world has witnessed countless major crises contributing to massive global displacement, and at the end of the year 2021, a record-high of 89.3 million people around the world had been forcibly displaced (United Nations High Commissioner for Refugee [UNHCR], 2022a; 2022b). Psychological research on the mental health experiences of migrants has largely focused on experiences and rates of psychopathology (Hess et al., 2022; Li et al., 2016; Nesterko et al., 2020). This focus is due in part to the failure to understand the traumatogenic conditions which migrants are forced to navigate prior to and during their migration journeys. There is a paucity of research examining how structural and systemic impediments to health and well-being disrupt the ability of refugees and asylum-seekers to pursue and achieve their vision of a meaningful life. The main aims of the present study were to develop a deeper understanding of the lived experiences of refugee and asylum-seeking Muslim women and to elucidate the structural barriers to their well-being. We begin with a clarification of terms, briefly describe the literature on migration and health, and then discuss the importance of using a human rights framework for understanding the experiences of refugees and asylum seekers.

Refugees and asylum-seekers

The terms 'refugee' and 'asylum-seeker' are both ways to describe individuals who have migrated away from their homes. Despite the fact that these terms are often used interchangeably, there are important differences. The term 'refugee' is defined by Article 1 of the United Nations *Convention Relating to the Status of Refugees* (1954, p. 2)., as "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it." An asylum seeker, on the other hand, is an individual who is seeking international protection but whose claim for refugee status has not yet been determined (Bradby et al., 2015). Refugees have a right to international protections, and seeking asylum is a human right.

Migration and its effects on health

Factors motivating migration vary for different communities depending on the sociopolitical context of their country of origin and personal circumstances. Reasons for migration may vary across and within diasporic groups, such as political instability in their countries of origin, being at risk of persecution based on their race, religion, nationality, political opinion, or membership in a particular social group, or fleeing war or ethnic, tribal, and religious violence (Akhtar, 1999; Fiddian-Qasmiyeh et al., 2014; Richmond, 1993). Despite the differences in reasons for migration, many displaced persons unfortunately share the experience of being vulnerable to psychological distress during pre-, peri-, and post-migration. For example, researchers have found that one in three forcibly displaced persons experiences depression and post-traumatic stress disorder (PTSD) (Steel et al., 2009). Furthermore, as exposure to stressful and traumatic events during and after the migration process increases, so do symptoms of depression, anxiety, and PTSD, which suggests a compounding effect of post-migration stressors on the associations between forced migration and mental health (Bogic et al., 2015).

While research has often emphasized the effects of pre- and peri-migration trauma, recent studies have focused on the ways in which post-migration stressors in receiving countries were also associated with negative mental health outcomes (see for example, Hynie, 2018; James et al., 2019; Li et al., 2016; Sangalang et al., 2019). Such stressors, which often violate fundamental human rights, have included, but are not limited to, discrimination, lack of access to resources and employment, restrictive immigration policies, and family separation (James, 2019; Li et al., 2016). Although these conditions have been found to be linked with adverse negative mental health effects

(Li et al., 2016), the research literature tends to take an intra-individual, rather than a systemic and structural approach to understanding migrant mental health and well-being. In so doing, the psy-disciplines (i.e., psychology, psychiatry, and related fields) miss an important opportunity to address "larger contextual forces affecting these individuals and communities, specifically through research" (Yakushko & Morgan Consoli, 2014, p. 98).

Why a human rights lens is important

Focusing predominantly on the experiences of psychopathology and distress among refugee and asylum seekers (see for example, Blackmore et al., 2020; Teodorescu et al., 2012) reinforces the psy-disciplines' guild interests. That is, understanding such migration experiences—which are inherently traumatizing as many displaced persons are fleeing from countries experiencing war and conflict—within a psychologized lens may lead to medicalized or manualized treatment approaches that fail to address the systemic obstacles that undermine well-being. As Summerfield (2003, p. 268) astutely noted, "claims that victims of war and atrocity typically have an unmet need for mental health services are overstated. Recovery from the effects of war may depend on re-establishing a sense of intelligibility, a task that must primarily go on in social space rather than mental space." Given that a psychologized lens locates trauma within an individual's psyche rather than within a sociopolitical context, it is not surprising that there have been few studies aimed at understanding refugee and asylum seeker health and resilience (see for example, Keles et al., 2018; Mitra & Hodes, 2019; Panter-Brick & Eggerman, 2012) and the socio-political obstacles that they encounter.

In contrast to the assumption that refugees and asylum seekers need more mental health services, a human rights-based approach (HRBA) shifts the focus from individual pathology and instead examines institutional forces, including what some have referred to as 'health-harming legal needs' (Matthew, 2017). As Porsdam Mann and colleagues (2016, p. 264) noted, a HRBA places "emphasis not only on avoiding human rights violations but making sure that human rights principles are at the center of a service-providing organization." As such, this approach provides an important challenge to medicalized and psychologized discourses.

Importantly, a HRBA facilitates a deeper understanding of the relationship between mental health, human rights, and the structural determinants of health, for we must consider the psychosocial context out of which 'symptoms' emerge (Cosgrove & Shaughnessy, 2020). Amartya Sen's capabilities approach (CA) is an excellent example of a HRBA (Sen, 1980). Capabilities are defined in terms of "a person's freedom to enjoy various functionings" (Deneulin & Shahani, 2009, p. 22), meaning that the individual has what they need to achieve what they value in life. That is, Sen (1980) evaluates well-being through what individuals are able to be and do, emphasizing that rights and capabilities must be seen as interdependent entities. In The Idea of Justice, Sen (2009, p. 232) highlighted that "the focus here is on the freedom that a person actually has to do this or be that–things that he or she may value doing or being." Rather than a focus on psychopathology, the CA shifts our attention toward the possibilities for well-being—and, most importantly, on the resources and rights needed to achieve well-being (Herrawi et al., 2021).

Therefore, in order for capabilities to be realized and for people to be able to bring their definition of what constitutes a meaningful life to fruition, governments need to provide actual opportunities and political entitlements (Chapman, 2015; Nussbaum, 2008). Chapman (2015) extended this idea by incorporating Daniels' (2007) theory of a moral right to health; by protecting both physical and mental health, "we contribute to the safeguarding of equality of opportunity" (Chapman, 2015, p. 13). Thus, the focus in CA is not simply on giving more people access to mental health treatment, but on removing structural barriers and enlarging the opportunities to which people have access (see for example, Shinn, 2014).

Methodology

Overview

Congruent with a CA approach, the main aims of this study were to develop a deeper understanding of the lived experiences of refugee and asylum-seeking Muslim women and elucidate the structural barriers to their well-being. In light of these goals, a constructivist epistemology (see for example, Ponterotto, 2005) and human rights approach informed this study. A constructivist epistemology recognizes the impossibility of any method as a guarantor of truth (Cosgrove, 2000; Gergen, 2001), and thus, the researcher does not position herself as an "omniscient narrator and summerizer" (Flyvbjerg 2001, p. 86) of participants' truths. Rather, the focus is on situating discourses within the historico-political context in which they are embedded.

A critical thematic analysis, an analytic approach that is often employed in qualitative research to bring social justice goals to fruition (Lawless & Chen, 2019), was used for data analysis. As described in more detail below and as Lawless and Chen (2019) noted, this is a method that allows researchers to code and interpret in-depth qualitative interviews like the ones we conducted and explicitly connect participants' narrative responses with larger social and cultural practices. Thus, critical thematic analysis, informed by a human rights approach, allowed us to better understand the socio-political grounding of the lived experiences of our participants who immigrated to the U.S. as refugees and/or asylum-seekers. Specifically, our interview questions were designed to a) allow participants to define well-being on their own terms, and b) identify the material and interpersonal challenges that they faced on a daily basis.

Researcher Positionality

The research team was composed of four individuals, holding both etic and emic perspectives related to the study's focus. The first two authors led participant recruitment efforts and conducted the interviews. The transcription and coding team included the first two authors and professional interpreters, including two persons fluent in Somali, one person fluent in both Somali and Arabic, and one person fluent in Arabic. The first and second authors led the analysis of the data, and the third and fourth authors provided guidance on the research process and consulted on the data analysis process, respectively. The first author is a second-generation Afghan American woman, cisgender, straight, doctoral candidate from a middle-class background. Her personal and professional experiences with BIPOC immigrant and refugee communities are critically informed through human rights and healing frameworks. The second author is a white, Italian American woman, cisgender, straight doctoral candidate from an upper middle-class background. Her research focuses on critical consciousness and bias prevention among white adolescents. The third author is a doctoral candidate, and a 1.5-generation Cuban immigrant from a working-class background, who is queer and trans. He brings experience in community crisis response and therapeutic work with first- and second-generation immigrants, primarily through experiences of interpersonal violence. Finally, the fourth author is a clinical psychologist, and is a cisgender straight woman from a middle-class background. She has conducted both quantitative and qualitative research aimed at addressing a range of bioethical issues informed by a human rights approach.

As an iterative process, the researchers engaged in critical self-reflection on the ways their positionality, especially as a psychologist and psychologists-in-training, influenced their understanding of the data. For example, the first and second authors kept a shared document which served as a reflexive journal throughout the interviewing and coding process, to note any thoughts, feelings, reactions, or biases that emerged throughout the research process. These authors met frequently to discuss their journal entries. Additionally, the first author consulted with interpreters to discuss culture factors and to implement relevant ideas.

Participants

Participants were asked to verbally share demographic information during the beginning of the interviews, through a demographic survey (see Table 1). Participants included ten women from various backgrounds (one

Ethiopian, five Somali, two Guinean, and one Iraqi). All participants identified as Muslim. Three individuals entered the U.S. as asylees and seven entered as refugees. Participants spoke a range of languages and were encouraged to participate in the interview in their preferred language, with five interviews conducted in English, four in Somali, and one in Arabic. Participants were adults across the lifespan ranging from 23 to 70 years old (*M* = 44.9, *SD* = 13.95). At the time of the interview(s), their length of time living in the U.S. varied, ranging from 2.5 to 30 years (*M* =14.41 years, *SD* = 9.35).

Procedures

Permission was obtained from a local refugee resettlement agency, an organization founded by refugee women and serving immigrants in the greater Boston area, for recruitment and to carry out research procedures. A critical aspect of community-based research is collaborating with community stakeholders in a culturally appropriate and sensitive manner (Lyons et al. 2013; Woolf et al., 2016). The first and second authors have worked with the refugee resettlement agency for several years and had established and maintained a culture of trust with the staff and the larger community that the agency serves. These authors collaborated with the agency to contact two participants who had shown prior interest in the study, and snowball sampling methods were used to recruit the subsequent participants (Naderifar et al., 2017).

Potential participants were informed that the purpose of this study was to explore the experiences of health, well-being, and resilience in refugee and asylum seeker adults. They were informed that participation in the study would involve being asked to define a meaningful life, mental health, and well-being, as well as to share any challenges faced during resettlement and how they had overcome those challenges. Participants were informed that the outcomes of this study were aimed to provide support for improving health interventions for refugees and asylum seekers in the U.S. The incentive to participate in this study was a $20 retail gift card.

The interviewers, along with the interpreter(s), read consent forms out loud to participants, in addition to providing them with the consent document in their preferred language (i.e., English, Somali, or Arabic). Participants were asked to sign an informed consent form, which included information about the study (i.e., purpose of the study, risks and benefits, incentive to participate, IRB information and approval), in addition to providing verbal consent to participate. Following informed consent, participants were read aloud and provided a form with demographic questions, and were asked to verbally respond to the questionnaire, which included their age, race, religion, gender, sexual orientation, language(s) spoken, immigration status at time of arrival to the U.S., and length of time living in the U.S. Participants were not asked what immigration status they held at the time of the interview.

After demographic information was collected, the first and second authors conducted individual 40–60-minute semi-structured interviews in a private office space at the partner organization, separately. The semi-structured interview guide included questions that addressed the following domains: (a) participants' views on what constitutes a meaningful life, (b) barriers/challenges that negatively impact well-being, and (c) specific behaviors or resources that built resiliency through resettlement. All interviews were conducted either in English, Somali, or Arabic. Interpreters who collaborated with the research team consisted of four professional interpreters who had been working at the partner agency for over ten years, serving as interpreters for medical and mental health care, social services, case management services, and research.

The semi-structured interview procedures and questions were originally written in English and were translated to Somali and Arabic by one Somali interpreter and one Arabic interpreter, who did not serve as interpreters during the interviews. The translations were then checked by the interview interpreters to ensure the accuracy of translation from English to Somali and Arabic. They did not back-translate the interviews. An issue that arose during the process of translation included attempting to capture participants' descriptions of a 'meaningful' life through the interview questions. For example, there is no exact linguistic equivalent of the word 'meaningful' in Arabic and Somali, therefore, the first author and interpreters discussed methods to ask semi-

structured questions that would elicit a response from the participants about what factors made their life worth living in a culturally appropriate manner. In Arabic, the word used in the interviews معنى can also mean 'significant, 'essence,' or an 'intention' behind something. In Somali, several words could be used to describe 'meaningful,' and for the purpose of this interview, 'macno leh' was used because it has a broader application to daily life experiences. Due to the semi-structured nature of the interviews, the interviewers and interpreters had the opportunity to further explain and elaborate questions if and when participants needed clarification.

For the interview process, one interpreter who was fluent in Somali and Arabic was present for those interviewees who preferred to speak in Somali or Arabic. Since the research team was composed of individuals who were not native Somali or Arabic speakers, data was collected with the intention of coding it in the English language. The interpreter team that translated the interview questions assisted with the transcribing and translating of the interview data. After the data was translated from Somali and Arabic into English, the first and second author analyzed the qualitative data.

Analysis

Thematic analysis methods were used to analyze participants' interviews, as this method allows for flexible application across epistemologies and the subjectivity of the researchers are recognized as an integral part of the analysis process (Braun & Clarke, 2006; 2013; Clarke et al., 2019). The coding team consisted of the four authors who have been trained in qualitative analysis at their respective academic institutions by taking classes from faculty with expertise in this area. All four authors have published papers using qualitative research methods. The first author led the coding process and trained the second author in coding procedures. The first and second authors familiarized themselves with the data by listening to the recordings, by engaging in multiple readings of the transcripts, and by taking initial notes of all preliminary ideas. The first and second authors discussed thoughts, ideas, and preliminary codes with the third and fourth authors, as well as with staff from the partner organization. The first and second authors used an inductive approach to coding; themes were created from a bottom-up approach and drawing from the human rights' theoretical framework (Braun & Clarke, 2006; 2013; Cohen & Ezer, 2013; Terry, et al., 2017). The first and second authors created an initial set of open codes that aligned with the main study aims and assessed the usability of the initial codes by practicing coding one transcript through researcher triangulation. Both coders double coded 40% of the interviews (n = 4) and met for a total of six times to discuss coding strategy and reconcile disagreements. With coders in agreement with the coding procedures, the remaining interviews (n = 6) were single coded evenly between the first and second author (i.e., three each). All codes were sorted into categories, and through the process of specific grouping development, which involved identifying and organizing patterns across the data, resulting in the preliminary themes that were generated. These themes were refined by the first and second authors through discussion and were later reviewed, compared, and edited by the third and fourth authors. All authors discussed and compared themes to ensure that there was not significant conceptual overlap.

Analysis of the data led to four themes that captured the structural and systemic barriers that participants faced and the ways in which these obstacles impacted their health and well-being. The four main themes were: 1) critical to the definition of a meaningful life was having access to human rights to which Muslim women were entitled; 2) the pervasive impact of legal and financial issues, family separation, and citizenship-related challenges as structural causes of distress; 3) connection serves to enhance well-being; and 4) clinicians can help mitigate the emotional distress incurred by migration by identifying and responding to the health harming legal needs of their clients.

Theme #1: Critical to the definition of a meaningful life was having access to human rights to which Muslim women were entitled

Most participants emphasized that, for life to have genuine meaning, they needed access to greater material and psychosocial supports. Not surprisingly, conditions that foster good health, including access to education,

safe housing, employment, legal status, and connection to family, were frequently cited as imperative to leading a meaningful life. Hermala shared her thoughts on a meaningful life, which embodied sentiments across the sample: "My definition is being healthy, work in a safe place, and where I live, it's a safe place."

Education was central to the ways in which participants described a meaningful life in the U.S. Many expressed hopes of seeking educational opportunities through language acquisition, driving classes, and other resources. For some, the opportunity to receive a formal education was lost in the difficulties faced during pre- and post-migration. The inability to provide an education and other important resources for their children stood in opposition to living a meaningful life, as Francis discussed:

> I didn't go to school. And my children didn't have the opportunity to go... But I wish like they were coming earlier [to the U.S.], like when they was like, younger so they can go to school.

For those that did not have an opportunity themselves, they looked towards future generations to have a chance at a formal education, as Hawa shared, "what is meaningful to me is my kid's future and their education."

In addition to access to an education, the importance of good physical and mental health, and being reunited with family were central themes that emerged for Muslim women as they tried to engage in their life in a meaningful way. It is noteworthy that participants also emphasized the significance of peace and safety in their experiences in the U.S. As Maka emphasized, "The most important thing in [her] life is having a peaceful life," and Khadija echoed similar sentiments by stating," My expectation was to find peace here and I did find it." These reflections underscore the essentiality of peace and security as integral components of the right to health and overall well-being for participants in this study. Clearly, the critical importance of human rights for these Muslim women was intertwined with their definition of a meaningful life.

Theme #2: The pervasive impact of legal and financial issues, family separation, and citizenship-related challenges as structural causes of distress.

In post-migration, participants continued to experience negative mental health effects through their lengthy process of obtaining legal status and the subsequent consequences this imposed on their lives (Jordan, 2019; Monyak, 2022). The citizenship process for immigrants, which keeps families separated, was consistently described by this study's participants as creating and sustaining a profound negative emotional impact on refugees and asylum-seekers. Halima spoke of intense isolation, as she has been separated from her entire family throughout the time she has been in the U.S.:

> The loneliness. I don't have any family here. I just came by myself, and still, I am by myself. Everything I want to do is by myself. I wake up by myself, alone. It is hard to live alone . . . if you are living alone, you are always sad.

Despite living in the U.S. for 9 years, Halima continues to experience family separation and limited social support due to legal and socioeconomic barriers surrounding travel restrictions. Gigi spoke of a similar difficulty:

> It's difficult because I don't have family while I am here. All of my family are in Africa…It's hard to live here if you don't have papers, and if you don't have papers, you can't go back home to see your family and come back. So, if you go back, you can't come back here.

For Gigi, the lengthy process for asylum and protected legal status has kept her separated from her family members, due to strict travel restrictions for noncitizens. Since refugees and asylees who travel back to the country from which they sought protection may endanger their legal status, individuals and families are kept separate until they can obtain U.S. citizenship, a process which takes a minimum of 5 years (Immigration Equality, n.d.; United States Citizenship and Immigration Services (USCIS), n.d.). Gigi was left to rebuild a social support system, all while under the stress of navigating the legal documentation process in the U.S. Participants collectively described the harmful psychological sequalae of family separation, primarily due to restrictions imposed upon them while

attempting to live in accordance with U.S. laws, all of which negatively contributed to their ability to pursue a meaningful life. Sara concisely summarized this experience, expressing, "When you have legal status in the United States you have a good life, if you don't, then you live without any meaning to life."

Not surprisingly, the legal challenges paved the way for a host of negative sequalae, which included financial barriers that exacerbate the effects of structural violence. Insecurity and uncertainty around one's financial status created serious barriers to adjusting during resettlement. Participants discussed at length the overwhelming stress of navigating their new circumstances in the U.S. with limited financial resources. Francis spoke of the barriers that led to experiences of economic marginalization upon arrival to the U.S.:

> At that time, I didn't have a job, and it was tough for me, and I didn't know about how to apply for help, like food stamps or something. I didn't know. Yeah, it was tough for me.

Francis had to navigate the complex process of obtaining unemployment benefits, in addition to limited knowledge and resources to apply for financial support, providing a clear example of how structural support remains inaccessible thus limiting individuals' ability to improve their lives. Participants shared a range of concerns related to financial instability during resettlement, including, but not limited to, fears around food insecurity, the inability to afford rent, homelessness, the inability to obtain legal permission to work, navigating applying for aid, and an inability to send money back home to their family members.

Although a strong desire to either learn or improve their English proficiency was a central theme, language programs were difficult to find and/or attend. This was of particular importance to participants because the U.S. naturalization process is contingent upon passing both an English and civics test (USCIS, n.d.). Therefore, the lack of English proficiency compounded various other difficulties, such as accessing health care services, social services, legal services, and so on. In turn, this resulted in an inability to access vital resources and diminished participants' ability to support their children. Asha poignantly spoke of the struggle to navigate medical care without access to the English language:

> Mostly, when I go to the hospital, I am unable to speak in English and I feel like the interpreter does not do a good job at translating…the most stressful thing is you don't know the language. I feel like all doors are closed on me because I do not know the language.

Despite having access to medical care, Asha was still faced with navigating a hospital system while tolerating inadequate interpretation services during her medical appointments—barriers that potentially impacted the quality of healthcare she was receiving. Language barriers created a general sense of entrapment. As Asha described, "all doors are closed," sharing a sense that she did not have a place to go for support due to a lack of English proficiency. Maka shared similar sentiments, explaining how being dependent on a translator gave rise to feelings of "not [having] the freedom to speak for [herself] in the hospital." These experiences demonstrate the significant impact of language barriers on participants' ability to communicate their health needs and concerns and access appropriate healthcare services. In sum, participants' descriptions of the countless structural barriers that were at the root of their distress highlights the ways in which systemic inequities perpetuated and exacerbated their challenges and hindered their rights to essential resources.

Theme #3: Connection serves to enhance well-being.

Participants were asked to share the ways in which they were able to overcome the challenges they had experienced upon arrival to the U.S. and beyond. Religious beliefs and access to necessary resources through the partner organization served to support their well-being and buffer the negative impacts of structural and systemic impediments. Religious beliefs served as a positive coping practice to overcome barriers and challenges experienced during post-migration. All participants in this study identified as Muslim, and the majority looked to their Islamic faith and religious practices as a source of healing and support to overcome the stressors of their daily lives. Religious practices specified by participants included going to the local masjid (mosque), reading the

Quran, praying, and fasting. The connection to religion and religious practices are inherently embedded within a relationship rather than an individual act, as the intention is to seek a connection with God through engaging in these religious practices (Henry, 2015; Williamson, 2018). Hawa shared how incorporating religious practices into her daily schedule allowed her to overcome stressful experiences:

> I take a shower, I pray, and I read the Quran, and then I feel better. I also fast Monday and Thursdays.

Living in accordance with Islamic beliefs allowed Hawa to overcome the stressors she was facing in the U.S. as a refugee. Other participants shared the benefits of prayer on their mental health, such as Halima who explained, "I pray, and I talk to God. That is how I do. And after that I cry, and then I pray and pray again. And then after that I go out." Additionally, participants provided narratives of gratitude for their well-being, grounded in their Islamic beliefs. These findings suggest that religious beliefs and practices, as well as the ways in which Islam plays a central role in the lives of the participants, helped them to understand and cope with their negative life events and stressors.

In addition to religious practices, being connected with the local refugee agency served as a critical source of social support for participants. These connections also enabled them to access the rights to which they were entitled, such as social and/or health services, and assistance with citizenship processes, housing, employment, and education. Salaam emphasized how the assistance she received from the agency paved the way for her to achieve substantive freedoms:

> They showed me where to shop, they showed me where I go to the hospital, they teach me how to pay my bills, they teach me how I ride the transportation, they buy me a car and get me to the driving school. They helped me a lot.

With the organization's support, Salaam was able to access the resources she needed to take care of herself and her family. The agency helped participants feel an enhanced sense of belonging and connection to their life in a new country.

It is the combination of religious beliefs, a connection to the agency, and the larger connection to the community, through which participants described overcoming and navigating challenges they faced post-migration.

Theme #4: Clinicians can help mitigate the emotional distress incurred by migration by identifying and responding to the health harming legal needs of their clients.

When asked to share their thoughts on how psychologists and other mental health professionals can best support refugees and asylum-seekers, participants emphasized the importance of providers serving as a bridge of support—connecting them to important needs as a way to support their transition to life in the U.S. Importantly, the agency that participants were connected to employed a wide range of mental health professionals, including case managers, social workers, mental health counselors, psychologists, and psychiatric nurse practitioners, in order to meet the needs of the communities they served. For those participants that did engage with mental health services, it was evident that the support they received from providers served as an integral part of their experiences. As Sara described:

> They listened to me, and understood me, and they directed me. They could tell when I was not doing well from my voice, and they would call back the next week to check up on me, I felt relieved.

Francis shared the feeling of being connected to mental health services as a positive factor on her life, explaining, "you know you have support...that makes you healthy too, makes you happy." Khadija added that it is important to bring an awareness of available resources and services, as the lack of information and stigma surrounding mental illness can serve as a barrier to help-seeking:

You learn the struggle that refugees have been through. It is very difficult to help thembecause they are afraid to ask for help.

Maka also explained, "In our culture, mental health is a taboo. It is looked down upon, that is why I never even thought about it."

In addition to participants emphasizing the benefit of access to a community of mental health professionals, they were clear that they wanted and needed more than intra-individual interventions. Participants highlighted that given how profoundly material barriers affected their well-being, mental health professionals should serve as agents in accessing fundamental rights and resources. Such behaviors could include, as Maka noted, "help[ing] us find tutors for the English language" and "informing [refugees] about the services they can get that are related to mental health."

Discussion and Recommendations

Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. (United Nations, 2000, p. 1)

The four main themes and barriers to well-being (e.g., difficulty obtaining citizenship and not having access to the human rights to which they are entitled) that emerged from the analysis are not ones that psychologists and counselors typically believe fall under their purview. Yet there is a burgeoning body of research that highlights the ways in which systemic issues play a critical role in the distress experienced by immigrant communities (see for example, Asif & Kienzler, 2022; Atari et al., 2021; Marquez et al., 2021). For example, the results of the present study are congruent with and extend Haas's (2021, p. 193) anthropological research which found that the protracted asylum system was the primary locus of the distress experienced by asylum seekers: "[The] perceived therapeutic interventions were limited in their ability to assuage their suffering. In this context, legal status was often understood as the most effective form of healing." As transcultural psychiatrist Derek Summerfield (2001; 2003) also pointed out, recovery from the traumatogenic effects of migration and asylum-seeking means re-establishing a sense of meaning and intelligibility, a task that cannot be achieved in a predominately mental space. Some participants shared that because their therapist connected them to various resources, such as English tutors, employment opportunities, access to public transportation, and so forth, this resulted in substantial changes in their life—which in turn, served to alleviate their stress and enhance their well-being. Relatedly, participants discussed the importance of social connection in the healing process and emphasized that such connection can manifest in various ways: it can involve reestablishing one's relationship with God or actively engaging with the community, the refugee agency, and other supportive networks. This stands in contrast to neoliberal tenets of health and healing, which prioritizes individual responsibility as the primary path to achieving health and overlooks the significance of social connection in the process (Esposito & Perez, 2014; Zeira, 2022). Participants highlighted how connections served as essential components of fostering resilience, support, and holistic well-being in their experiences living in the U.S.

Similarly, Bemak and Chung (2021, p. 137) reported that if therapists want to bring their social justice goals to fruition and support the human rights of refugees and asylum seekers, they need at times "to assume a case manager role to provide information and support for refugee clients." Thus, mental health professionals could be more effective in supporting refugees and asylum-seekers by facilitating their access to critical resources and by helping their clients find pathways to citizenship. In so doing clinicians are embodying the actions of psychiatrist Frantz Fanon, and what liberation psychologists refer to as the principle of "accompaniment" (Fanon, 1968; Watkins, 2015). If we as clinicians can become accompagnateurs, we will be taking an important first step in developing a decolonial politics of mental health care (see for example, Reinhart, 2021).

Our findings also highlight the ways in which a HRBA can facilitate the development of a decolonial politics of care. As articulated in the World Health Organization's (WHO) Constitution (1946, p. 1315), a fundamental right of every human being is "the right to the enjoyment of the highest attainable standard of physical and mental health." Sen's (1980) CA as previously discussed, is an example of a HRBA that can inform psychological practice and enhance the field's social justice efforts. But the question remains: how do we bring the CA approach to fruition in the clinic? To address the socio-political grounding of emotional distress and apply the CA framework in the therapy room and beyond, we offer two suggestions: (1) train psychologists to be "structurally competent" (Metzl & Hansen, 2014), and (2) develop medical-legal partnerships. Both of these suggestions can help inform clinical practice.

What is the structural competency movement and how is it relevant to psychological practice?

Bergkamp (2022, p. 39) discussed how, traditionally, psychological services "have been conducted behind closed doors, in private, and usually one-on-one," emphasizing how this is not enough to "alleviate the suffering of oppression from historical and institutionalized oppression." In contrast, the structurally competent clinician is one who understands *and addresses* the relationships among race, class, and symptoms and who acts on systemic causes of health inequalities (see for example, https://structuralcompetency.org/structural-competency/).

The structural competency movement was developed in the field of psychiatry, and as Neff and colleagues (2020, p. 2) discussed, this framework entails training health professionals "to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures." This means that clinicians must be willing to leave their disciplinary comfort zones and develop a robust understanding of the ways in which neoliberal policies and practices codified in the U.S. healthcare and legal systems, such as increasingly restrictive immigration policies and the relentless attacks on the U.S. asylum system (see for example, https://immigrantjustice.org/issues/asylum-seekers-refugees), contribute to poor health outcomes. Thus, training in structural competence equips students with the skill set to not only understand but also respond to the sociopolitical and structural factors that affect individual and population health (Neff et al., 2020). As such, it is being implemented as part of the core curricula in medical education. Our findings demonstrate the ways in which structural barriers (e.g., legal, socioeconomic, etc.) can impact the health and well-being of migrant communities in the U.S. Therefore, our findings lend support for the inclusion of structural competency training in graduate psychology and counseling programs.

Beyond graduate school, licensed psychologists could provide psychological evaluations and summaries of findings into a medicolegal report which can be used by attorneys to assist individuals seeking asylum (Ferdowsian et al., 2019; Scrugss et al., 2016). They could also provide neuropsychological and diagnostic evaluations for individuals who demonstrate cognitive difficulties and/or impairment to determine if these issues prevent them from completing the naturalization process in order to obtain legal status. Additionally, they could gather and provide data to legislators at the local level to inform, amend, and/or develop laws and policies that will provide better protections for immigrant communities.

It is important to acknowledge that even these actions are limited in their ability to challenge health-harming legal systems. In other words, a psychologist supporting an individual's asylum claim by providing a psychological evaluation is still working within a system that requires individuals to prove that they deserve to live in safety, rather than return to persecution.

Medical legal partnerships: A transdisciplinary model that identifies and addresses the health-harming legal needs of refugees and asylum-seekers.

The health-harming legal needs of refugees and asylum-seekers are embedded within complex political and legal systems, which necessitates an interdisciplinary approach that can address the holistic needs of migrant communities. The medical-legal partnership (MLP) model integrates lawyers into health care teams "to detect and address health-harming legal needs to improve health outcomes at the patient, institutional, and population

levels" (Paul et al., 2017, p. 292; see also, Tobin-Tyler & Teitelbaum, 2016). As immigration laws, policies, and practices are ever-changing, the integration of lawyers into health center care teams can allow for the promotion of community health and well-being by giving individuals access to services in a trusted environment (Marple et al., 2020). Having an on-site attorney is critical for individuals who may not seek out legal assistance, who do not have access to legal assistance, and/or for those who have had negative experiences with the justice system (Marple et al., 2020). Health harming legal needs include, but are not limited to, experiences of discrimination, poor/unsafe housing conditions, threats of eviction, denial of food benefits, and other forms of precarity (Berg et al., 2022; Krishnamurthy et al., 2015). For example, a major challenge experienced by both refugee and asylum-seekers are the restrictions on their lives due to the lack of citizenship. Yet even if refugees and asylum seekers have access to legal support, psychologists are probably not aware of the fact that traditional legal aid offices cannot represent clients in immigration hearings—but the MLP attorney can "represent clients and help resolve immigration status, clear criminal, or credit histories, and assist with asylum applications" (Matthew, 2017, p. 362). Access to citizenship opens the doors for immigrants to access important health resources, such as food and insurance benefits, as well as alleviate their distress related to not being a U.S. citizen (e.g., being separated from family members, strict travel restrictions, limited employment opportunities, etc.). Various screening tools have been created to identify and address the social determinants of health in health care settings (see for example, Billioux et al., 2017; National Association of Community Health Centers, n.d.), providing an opportunity for psychologists to screen and work to address the health-harming legal needs of immigrants, refugees, and asylum-seekers.

Limitations and Implications for Future Research

It is important to acknowledge the limitations of this study. Regarding the sample, limitations include the small sample size and sampling methods (Gabriel et al., 2017; Hanza et al., 2016). These challenges were exacerbated by the COVID-19 pandemic and constrained our recruitment efforts. This study also did not ask participants to share their immigration status at the time of the interview, though eligibility in this study included both individuals who entered the U.S. as either refugee(s) and/or asylum-seeker(s). This limitation impacts the findings, as these groups, by nature of their entry into the U.S., have varying experiences of displacement, access to resources, and levels of vulnerability. Given that these differences were not explicitly explored during the interview process, it is essential to interpret the study's findings with caution.

Additionally, snowball sampling methods were used to recruit participants, therefore, the sample was limited to the initial participants nominations. This process effected the representation of individuals of various backgrounds and identities (e.g., gender identity, sexual orientation, etc.) in the participant sample (Jacobson & Landau, 2003). The agency from which we recruited participants primarily serves a large Muslim community, therefore access to individuals of different religious backgrounds was limited, creating a more homogeneous sample. Furthermore, the length of time living in the U.S. substantially varied (e.g., from 2.6 to 30 years), as well as the fact that all participants were living in one state. In the U.S., differences in immigration laws and policies, amount and allocation of resources, and demographics across States are just a few factors that affect the context in which refugees and asylum-seekers may find themselves upon arrival. Thus, cities and states differ in terms of the resettlement resources that are available to refugees and asylum-seekers (e.g., housing, healthcare, employment, etc.). Future studies can focus on specific subpopulations (e.g., race, ethnicity, citizenship status, length of time in the U.S., etc.) to gain a more nuanced and/or specific understanding of resettlement experiences of refugees and asylum-seekers.

There also were limitations with the translation of the interview procedures and data transcription. Although the interview questions were translated into the Arabic and Somali language by professional interpreters outside of the agency, and later reviewed by the interpreter team, these questions were not back translated into English. This also was the case with the interview transcripts, which were transcribed in the original language

spoken by the participants and then translated into English, but not back translated into the original languages due to limited resources. These limitations have the potential to introduce inaccuracies in the translated protocols and transcripts. Moreover, there may have been a loss of linguistic complexity and nuance when simplifying the content in English. Additionally, participants were not involved in reviewing and providing feedback on their interview transcripts. All of these limitations should be taken into consideration when interpreting the findings.

Conclusion

In order to address the grossly unmet need for rights-based mental health care and support, it is imperative to do an assessment of the global burden of obstacles that has maintained the status quo. Addressing the burden of these obstacles is a more effective strategy than the current approach dominating mental health policies and services which focuses on the global burden of disorders neglecting the importance of context, relationships, and other important social and underlying determinants of mental health. (Pūras, 2017)

Acknowledging and upholding the fundamental human rights that refugees and asylum seekers are entitled to serves as a cornerstone for their overall well-being. By ensuring their access to human rights, this creates an experience that fosters their pursuit of a purposeful existence. Participants were clear that structural barriers led to human rights violations and contributed to their root causes of distress. Our results also point to the importance of social connection—to one's religious and local community, the refugee resettlement agency—for enhancing well-being.

The challenges associated with migration, which resulted in the experiences of family separation, lack of healthcare, lack of education, and employment opportunities, created and sustained both physical and mental health problems for our participants. Participants identified major obstacles that hindered their pursuit of valued opportunities and a meaningful life, including structural violence, barriers to accessing crucial resources like language programs, the freedom to travel to see their families, and finding employment. Therefore, this research suggests that psychologists may be able to mitigate the emotional distress incurred by migration by identifying and responding to the health harming legal needs of individuals that migrated to the U.S. These efforts can take the shape of incorporating MLP's into healthcare teams, and training psychologists and counselors in a structural competency approach. With enhanced efforts to address institutional factors that adversely impact refugees and asylum-seekers, psychologists and allied mental health professionals can serve as a bridge for refugees, asylum-seekers, and other immigrants towards living self-determined definitions of a meaningful life.

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Declaration of Conflicting Interests:

The authors report no conflicts of interests.

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Table 1. Demographic Characteristics of Participants

Pseudonym	Age	Race	Ethnicity	Spoken Language(s)	Years in the U.S.
Hermala	31	Black	Ethiopian	Amharic/English	2.5 years
Halima	32	Black	Somali	Somali/Arabic/English	9 years
Salaam	70	Black	Somali	Somali/English	30 years
Gigi	23	Black	Guinean	Fulani/English	2.6 years
Francis	50	Black	Guinean	Fulani/English	18 years
Maka	46	Black	Somali	Somali	25 years
Sara	49	Arab	Iraqi	Arabic	17 years
Khadija	60	Black	Somali	Somali	20 years
Hawa	42	Black	Somali	Somali	14 years
Asha	46	Black	Somali	Somali	6 years

Note. All participants identified their gender as "female" and their sexual orientation as "heterosexual" when asked during the interview. Participants are listed in the order of being interviewed for the study.