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Living with the Choice: A Grounded Theory of Iraqi Refugee Resettlement to the U.S.

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I am submitting herewith a dissertation written by Lisa Ann Davenport entitled "Living with the Choice: A Grounded Theory of Iraqi Refugee Resettlement to the U.S.." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

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Living with the Choice: A Grounded Theory of Iraqi Refugee Resettlement to the U.S.

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Dedication

I dedicate this doctoral dissertation to the God of my life. Without Him, this work could not have been completed. I give Him honor, I give Him praise. I bless His name. It is my desire to glorify His name in all that I do. Through this research, I pray God will open many more doors for me to show His genuine love and compassion to all people, including the least of these.

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Abstract

Though the United States has become a place of increasing resettlement for refugees, particularly Iraqi refugees who have been forced to flee their homeland due to violence, persecution and civil unrest, little is known about Iraqi refugee resettlement in the United States, or the way in which resettlement impacts health and adjustment. A grounded theory study was conducted to develop a substantive theory of Iraqi refugee resettlement. Participants in the qualitative study included 29 Iraqi refugees and 2 community partners who participated in face-to face interviews. Data analysis and interpretation revealed fundamental concepts related to Iraqi refugee resettlement. Results of analysis showed that for Iraqis choosing to resettle here, the outcome is dichotomous: satisfaction or regret. The outcome is influenced by contextual factors as well as facilitating and hindering intervening conditions during the basic social process of resettlement transition. Each refugee's story is unique, yet all share common threads. This study allowed Iraqi refugees the opportunity to voice their personal experiences of resettling in America, and revealed life stories that inspire and illuminate a process that can guide health care delivery as they cope with the stresses of their journey. As a result, an in-depth storyline was established to explain the process of resettlement for Iraqi refugees. The development of this resettlement theory, grounded in Iraqi refugee experience, has the potential to guide nursing education, enhance the efficacy of practice, inform policy development and form the basis for research.

Keywords: adaptation, grounded theory, integration, nursing, refugee, resettlement, United States

Preface

Personal Reflection

For I was hungry, and you gave me food: I was thirsty and you gave me drink, I was a stranger and you welcomed me. Matthew 25:35 (English Standard Version)

As I walked into the Bridge Refugee Services (Bridge) office, I noticed a poster on the wall displaying the Biblical reference, Matthew 25:35. The benevolent acts of hospitality portrayed in this New Testament reference are an example of moral human compassion shown to newly arriving refugees. Refugees, who are typically strangers to us, often arrive in the United States with few belongings to call their own. Food, clothing, housing, and healthcare are basic essentials that must be acquired; but, how is our nation, as a whole, welcoming these strangers and meeting their needs? This question came to mind as I continued observing additional posters on the walls of Bridge depicting a photo montage of refugees worldwide.

These images became real to me as I participated in a World Refugee Day event on June 20, 2011. Initially unknown to me, the refugees present quickly became cordial acquaintances as I interacted with them – adults and children – all day. One could sense solidarity among them and their families as they conversed. These fellow human beings had thoughts, emotions, and concerns about their resettlement that I as a nurse knew little about; yet they deserved to be understood.

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Abbreviations

GULC: Georgetown University Law Center

NGO: Non-governmental organization

ORR: Office of Refugee Resettlement

PRM: Bureau of Population, Refugee and Migration

PTSD: Post-Traumatic Stress Disorder

TOR: Tennessee Office of Refugees

UNAMI: United Nations Assistance Mission for Iraq

USCIS: U.S. Citizenship and Immigration Services

USDHHS: U.S. Department of Health and Human Services

UNHCR: United Nations High Commissioner for Refugees

USRAP: U.S. Refugee Admissions Program

WHO: World Health Organization

Chapter 1

Introduction

"Give me your tired, your poor . . . yearning to be free". This poem, entitled 'The New Colossus', written by Emma Lazarus (1883), is inscribed on the pedestal of the Statue of Liberty, which stands prominently in New York Harbor. The Statue of Liberty has international significance for its symbolism of "freedom and democracy", offering a message of hope for those who come to America seeking security and protection for themselves and their families (U.S. Department of the Interior, 2012). In 2010, the numbers of refugees worldwide were reported to be 10.5 million, with women and children comprising 47% of this population (U.N. High Commissioner for Refugees, [UNHCR], 2010, p. 6-9). The United States (U.S.) is part of an international collaborative effort to provide assistance to refugees in need of resettlement. Over 300,000 refugees have resettled in the U.S. from at least 80 different countries since 2007 (U.S. Department of Health and Human Services [USDHHS], 2012). Out of 73,311 refugees resettling in the U.S. during the 2010 fiscal year, Iraqi refugees represented the largest resettling group, totaling 18,134 persons, (USDHHS, 2010). These seekers of sanctuary come to our nation and communities through legalized resettlement processes to seek refuge from the atrocities of war and violence that prevent them from returning to their native homeland or country of first asylum.

According to the Universal Declaration of Human Rights (1948), "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family" (Article 25). 'Health' is defined by the World Health Organization

([WHO], 1948) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Unfortunately, the human rights situation in Iraq is fragile due to on-going violent conflict, widespread poverty and lack of access to basic services to support the health of Iraqi citizens (United Nations Assistance Mission for Iraq, [UNAMI], 2011). These dire conditions prompt displacement of Iraqis within and across national borders as they pursue preservation of their basic human rights.

Beyond statistics about migration patterns, little is known about Iraqis' experience of resettlement to the U.S. as they interface with a new culture and way of life. Thus, a qualitative research study examining Iraqi refugee resettlement and the impact on their health and well-being was conducted. The purpose of this chapter is to describe the background and historical context of refugee resettlement, migration and the government's role in the process, discuss what is known about typical refugee profiles/experiences, and explain global and geopolitical conditions influencing increased Iraqi resettlement. This information will clarify the significance of conducting scholarly research examining the resettlement process of Iraqi refugees in the U.S.

Background

Dow (2011) notes that two types of migrating populations – immigrants and refugees – have entered the U.S. during the period beginning in the historical era of the mid-1900s and continuing until today. Therefore, a distinction between the two populations must be made in order to provide clarity for this study. Conflict-induced displacement is an important distinguishing factor that necessitates discussion as well.

Immigrants. *Immigrants* are described as those persons who "voluntarily leave their homeland to migrate to other countries with the hope of a new future filled with opportunities that may not have been available in their country of origin" (Dow, 2011, p. 211). Essentially, immigrants may choose to relocate to the U.S. for better employment, educational opportunities, or to join other family members already there. Immigrants fall into two subgroups: "legal" or documented immigrants and "illegal" or undocumented persons. The first subgroup, *documented émigrés*, are those who are not citizens or nationals of the U.S. but have been granted lawful entry based upon the legal statutes and codes defined in the Immigration and Nationality Act 1952 (PL 82-414) and Immigration Act of 1990 (PL 101-649). Many of these individuals wait years for legal entry and are admitted according to a quota system governed by U.S. Congress. The other subgroup identified by Passel (2005) is the population of *undocumented immigrants*, who have relocated to the U.S. but have not met the legal requirements for immigration. It is difficult to assess the number of undocumented immigrants that have relocated to the U.S. because these persons enter without documentation of approval.

Refugees. Dow (2011) defines *refugees* as those persons who are "unexpectedly forced to involuntarily leave their homes and flee for their lives often to unknown destinations" (p. 211). Forced migration can be instigated by many circumstances, such as natural or manmade disasters, or conflict-related events (Refugee Studies Centre, 2012). In 1951, the U.N. General Assembly recognize refugee as "any person, who has fled their country of origin and is unable or unwilling to return due to a 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". (U.N., 1951, p. 152). Forced migration for refugees, in this respect, is deemed "conflict induced displacement," where persons are coerced to flee across international borders in search of safety and protection from violent conflict (Refugee Studies Centre, 2012).

Conflict-Induced Displacement. Extreme violence, war, and societal upheaval in the Middle East continue to be critical conflicts of international significance that have forced millions of persons, particularly Iraqis, to migrate from their homes and communities in search of safety and protection (al-Khalidi & Tanner, 2007). The Republic of Iraq has been in a chronic state of conflict for the past three decades, beginning with the war between Iraq and Iran in 1980, a period of time when the two countries struggled for power and dominance in the Middle East (Parasiliti, 2003). War and tension between Iraq and Iran prompted conflict-induced displacement of Iraqi persons, circumstances which continue today as a result of subsequent conflict with both Kuwait and the U.S. Therefore, the historical context must be further understood in order to appreciate the totality of the forced migration experience of Iraqi refugees.

Historical Context of Iraqi Conflict

Throughout modern history, Iraq has been a place of prolonged civil unrest. Rebellious uprisings between political and religious regimes have created an environment of continual fighting and aggression and resulted in the deaths of many civilians and the displacement of Iraqi citizens (Ghareeb, Ranard, & Tutunji, 2008). The August 1990 Iraqi invasion of Kuwait, a bordering country south of Iraq, prompted the U.S. to use military force against Iraq. The Authorization for Use of Military Force Against Iraq Resolution of 1991 (PL 102-1) was made public law on January 12, 1991 and U.S. military forces began combat operations on January 16, 1991, aiming to enforce the withdrawal of Iraq from Kuwait (Elsea, & Grimmett, 2011). The end result of these operations was the liberation of Kuwait and devastation of the Iraqi military (Ghareeb, et al., 2008), all within a period of less than six weeks

Later, in the aftermath of the September 11, 2001 terrorist attacks on the U.S, America once again exerted military force in Iraq. On October 16, 2002, the U.S. Congress approved the Authorization for Use of Military Force Against Iraq Resolution of 2002 (PL 107-243). This resolution was driven largely by suspicions that forces in Iraq were harboring weapons of mass destruction, such as biological, chemical, and nuclear agents, for acts of terrorism (Dale, 2009). According the Resolution of 2002 (PL 107-243), members of al Quaida, a suspected organization allegedly associated with the terrorist attack on the U.S. September 11, 2001, were thought to be located in Iraq. Consequently, U.S. military operations began on March 23, 2003 as part of Operation Iraqi Freedom to dismantle suspected organizations promoting terrorist activity (Dale, 2009). The war

lasted almost nine years with the last convoy of troops leaving Iraq on December 18, 2011. Yet, while U.S. involvement may have officially concluded, peace in Iraq remains fragile, sectarian and political factions remain, and the projected need for Iraqi refugee resettlement remains high.

Recent Migratory Patterns of Iraqi Refugees

A serious consequence of the ungovernable duress in Iraq has been the forced migration of countless Iraqi civilians who have fled from their homes in search of safety and protection. According to the U.N. High Commissioner for Refugees [UNHCR], 80% or 8.4 million of the global refugee population resides in neighboring countries that are primarily developing nations themselves, and approximately 2.6 million refugees reside in humanitarian aid camps with living conditions that are sparse and often unsafe (UNHCR, 2012a p. 11 and 35). Among these people, Iraqi refugees are considered one of the largest refugee groups with nearly 1.4 million Iraqis migrating to nearby Syria, Lebanon, Jordan, and Egypt as of 2011 (UNHCR, 2012a p. 15).

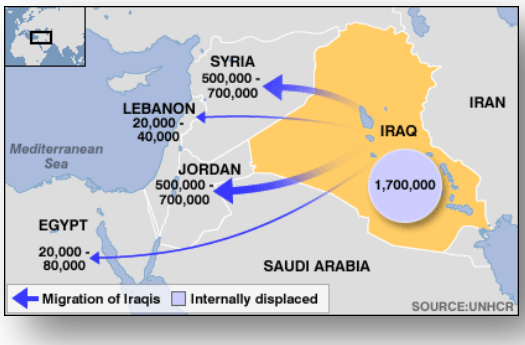

Figure 1: Migration Pattern of Iraqi Refugees 2003-2007 (UNHCR, 2007)

Most recently, refugee resettlement has been complicated by Middle East uprisings and violence associated with the "Arab Spring" phenomenon which began moving across the region in December 2010. "Arab Spring" is a protest movement sweeping across the Middle East that involves anti-government uprisings. The intent is to promote democracy and freedom from oppressive governments; however, the revolution is fraught with armed conflict and civil unrest. In 2011, Syria erupted into violent conflict itself and as a result its own population is fleeing to nearby Lebanon and Jordan. Thus, Syria is no longer a viable asylum option for anyone, especially Iraqis.

Statistics as of November, 2011 indicate that over one million Iraqi refugees continue to reside in Syria (UNHCR, 2011a). Those Iraqis who sought refuge in Syria months or years ago are now in a precarious situation because what was once "safe" has become a "danger zone" (Leenders, 2008). Yet, going home to Iraq is not necessarily an option for refugees in Syria or other host countries, since many of the personal threats that prompted the original migration persist. Therefore, Iraqi refugees may now be required to secondarily migrate to other host countries, such as the U.S., in order to receive necessary humanitarian support.

Additionally, Iraq must accommodate the nearly 1.3 million internally displaced persons that currently reside throughout Iraq (UNHCR, 2012b). As the country struggles with restoring social order in the aftermath of war, the projected outlook for Iraq is uncertain. Therefore, the need for further resettlement assistance for Iraqi refugees is expected to persist.

Three Solutions to Meet Refugee Needs

The UNHCR (2011b) advocates for three viable solutions to resolve the dilemma of finding permanent placement for refugees. These are rank-ordered based on the extent to which they minimize burden and stress on individuals and nations:

1. Voluntary repatriation or return to their country of origin. This is the preferred solution promoted by the UNHCR.
2. Integration within the country where refugees initially seek asylum.
3. Resettlement to a third country. This is often the only "durable solution" for refugees whose life, liberty, safety, and health are at risk and for whom there is no other alternative solution (UNHCR, 2011b). It is typically difficult to arrange permanent settlement to third countries. Only one percent of the global refugee population is accepted for resettlement by third countries (UNHCR, 2011b).

Defining who is at serious risk, and therefore eligible for resettlement to a third country as a person of "humanitarian concern," is under the purvue of the United Nations. The UNHCR's Handbook of Resettlement (2011b, p. 37) defines these individuals as:

- In need of legal and/or physical protection
- Survivors of torture or violence
- In need of life-saving medical treatment
- Women, girls, children, and adolescents at risk
- In need of family reunification
- Lacking viable alternative solutions

It is the UNHCR who identifies persons "at risk" and submits those cases for resettlement to a host country.

Role of the U.S. Government in Refugee Resettlement

The UNHCR (2010) processes approximately 80% of the submissions for refugee resettlement that the U.S. receives. According to information contained in the UNHCR Resettlement Handbook (2011b), the resettlement process for entry into the U.S. is described in Figure 2 as follows:

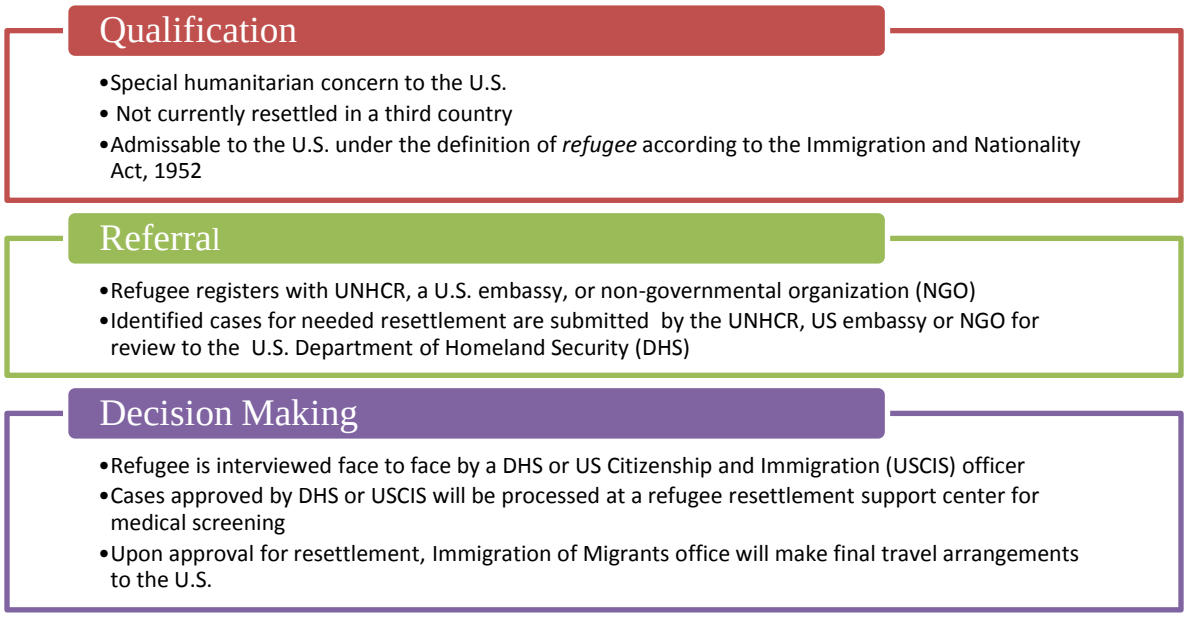

Figure 2: Resettlement Process

The U.S. has become one of the largest industrialized nations that shares in the international responsibility of working collaboratively with the UNHCR to resettle refugees. Resettlement to host countries such as the U.S., Canada, and other nations is considered by the UNHCR (2011b) as a "new beginning" for refugees who have been forced from their native homeland and are unable to return due to violence and

persecution endangering their basic human rights. In 2011, the UNHCR submitted 92,000 refugee cases for resettlement to over 22 countries (UNHCR, 2012a, p. 3). The U.S. is one of the largest countries that accepted 51,500 refugees representing over half the submitted cases by UNHCR that year alone (UNHCR, 2012a p. 3). Consequently, resettlement support for refugees entering the U.S. requires a commitment on a federal, state, and local level.

Federal Level. Historically, the policy of admitting refugees to the U.S. has been a reflection of a core value to provide a safe environment for oppressed persons fleeing from their countries of origin (USDHHS, 2010). The Displaced Persons Act of 1948 (PL 774), enacted by U.S. Congress in the aftermath of World War II, allowed admission of persons from regions of the world, including Germany, Austria, Hungary, Poland and Czechoslovakia, who qualified for eligibility under the auspices of U.S. immigration laws. The demand for refugee resettlement support continued to grow in subsequent years and the need for a formal resettlement process soon became apparent.

As a result, the U.S. Congress passed the Refugee Act in 1980 (PL 96-212), standardizing the resettlement services provided to refugees entering the country. The Act defines refugees as "those persons who have fled their country of origin and are unable or unwilling to return to such country because of persecution or a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group" (PL 96-212). This legislation provides the basis for policies and procedures to assist refugees during the resettlement process and has become a defining standard for determining the eligibility of refugees to resettle in the U.S.

According to this law, a refugee can apply for permanent residence after one year and for citizenship after five years.

The U.S. Refugee Admission Program (USRAP) was officially established by the U.S. Congress through the 1980 Refugee Act to coordinate refugee admissions and assistance. Once a refugee receives approval to resettle in the U.S. and successfully arrives, he/she then becomes part of the USRAP, which is comprised of the following (U.S. Department of State, 2010):

- Bureau of Population, Refugees, and Migration (PRM) of Department of State
- U.S. Citizenship and Immigration Services (USCIS) of Department of Homeland Security
- Office of Refugee Resettlement (ORR) of Department of Health and Human Services
- Ten domestic Non-Governmental Organizations (NGO)

Church World Services, Episcopal Migration Ministries, and Bridge Refugee Services, Inc. are examples of non-governmental groups and faith-based organizations that partner with governmental organizations, such as the USRAP, to provide support and assistance to refugees. A unified approach is taken by all partners to facilitate the extending of welcome.

In order to accommodate the growing numbers of refugees resettling in this country, these organizations work to assist refugees with housing, employment and access to services in order to meet their needs for survival and self-sufficiency. The U.S.

Department of State allocates a one-time federal contribution of $1,800 per refugee to assist them during the initial weeks of resettlement (U.S. Department of State, 2010). The ORR works with state and NGO partners to establish longer-term refugee cash and medical assistance. The intent of coordinated assistance is to help the refugees adjust to their new way of life.

State Level. The State of Tennessee, like many other states, has seen an increase in refugee placement, with numbers increasing from 935 in 2006 to 1,793 in 2009 (USDHHS, 2009). The Tennessee Office of Refugees (TOR), part of Catholic Charities of Tennessee, Inc., is designated by the ORR to serve as a coordinating agency to manage cash and medical assistance for refugees in the state. Case-managed services assist refugees with meeting their resettlement needs, including housing, social services, employment, education, language acquisition, and health services. Refugee clients are eligible to enroll in state Medicaid programs, such as TennCare in the state of Tennessee, where recipients receive coordinated health services through the managed care program (State of TN, 2011).

Local Level. Bridge Refugee Services (Bridge) works in partnership with the TOR to provide case management services to refugees resettling in East Tennessee. It is a non-profit organization affiliated with Church World Services, Episcopal Migration Ministries, and Catholic Charities of Tennessee, Inc. Bridge aims to facilitate resettlement for refugees and to empower them to become self-sufficient. The following services are provided by the organization within the first 30 days of the refugee's arrival (Bridge Refugee Services, Inc., 2012):

- Organize airport reception to greet the family
- Provide initial supply of food
- Arrange housing
- Give personal safety orientation
- Help family members apply for social security cards
- Register families for cash/medical assistance/food stamps
- Offer employment services and ESL referral
- Make at least one home visit to each family
- Ensure that every refugee has a health assessment

The overall goal of refugee resettlement assistance is to help those who have fled to achieve, within a time frame of approximately eight months, empowerment and independence sufficient to sustain themselves and their families (USDHHS, 2011). Though organizations such as Bridge do much to facilitate resettlement, adaptation to the U.S. may not be a simple process for Iraqi refugees as they strive to balance their lives between two cultures – their cultures of origin and American way of life. Therefore, a description of Iraqi refugees is necessary in order to grasp the magnitude and scope of the adjustment required.

Iraqi Refugee Profile

Persistent turmoil in Iraq, escalating in 2003 with the U.S. invasion of Iraq, has resulted in the erosion of Iraqi society and disrupted the livelihood of Iraqis as a whole. All facets of life – religious, social, economic, personal and health – have been affected by the ongoing conflict. Prior to 2003, the population in Iraq was estimated to be 27,000,000 (World Bank, 2013). From the years 2003-2013 more than 100,000 Iraqi civilians have lost their lives due to violence and four to five million Iraqis have fled their homes and communities (Momani, 2013).

Religious profile. The primary religion of Iraq is Islam and is "practiced by 97% of the population with 60 – 65% Shii and 32-37% Sunni Arabs" and "approximately 3% of the Iraqi population is Christian" (Ghareeb et al., 2008 p. 5). . Those who are not Muslim may have experienced violent persecution (Maloof & Ross-Sheriff, 2003). Yet, acts of violence and repression are not limited to non-Muslims. Even those of the Islamic faith may have experienced persecution related to extreme political conflict. When it becomes impossible for Iraqis, both Muslim and non-Muslim, to resist the oppression of religious and political violence, then migration to other areas is becomes an alternative.

Social profile. Family is deeply valued and considered as the "center of life" for Iraqis (Ghareeb et al., 2008, p. 13). Early marriage is expected and encouraged. A traditional Iraqi household consists of a man who is the patriarch of the family, his wife and children. The average number of children per family is 4-6 (International Committee of the Red Cross in Iraq [ICRC], 2011). In Arab society, children are considered a heritage and are nurtured as they grow and develop. The children learn cultural values by observing and participating in family rituals and traditions. Extended family members such as the husband's mother and spouses of children will often live in the household as well.

Nonetheless, years of war and conflict has made an impact on Iraqi family dynamics. Close to one in ten Iraqi households is now female-led with 9 out of 10 women being widows (ICRC, 2011). The ICRC (2011) estimates over one million Iraqi women must head their household as a result of spousal death or disappearance. These women struggle to find employment and experience immense economic difficulty to provide

food and shelter for all members of the household. Unfortunately, only 14% of women in Iraq are working or actively seeking employment (Inter-Agency Information Analysis Unit, 2012).

Preservation of social bonds with relatives and friends is difficult during times of forced migration when kinfolk become separated during resettlement. It is difficult to estimate the number of families that are separated as Iraqis flee from conflict burdened environments. Family members lose contact in the haste to find refuge and safety; therefore, many Iraqis are uncertain about the fate of their loved ones. Al Ethawi (2013), who works with ICRC, indicates he receives an average of 20-30 requests per day from Iraqi families seeking to reunite with family members. Disconnection from the social support of family and friends may become a source of stress for refugees and impede their ability to successfully adapt (Maloof & Ross-Sheriff, 2003). An unfortunate outcome is social isolation that is detrimental to emotional well-being.

Alternatively, social isolation can become a means of self-preservation. After years of political and sectarian strife, a time when government surveillance of activities was common and neighbors spied upon neighbors, many Iraqis have learned that it is safer to keep to themselves and trust no one outside their immediate families (Ghareeb et al., 2008). Thus, when they migrate and settle in new homelands their natural instinct is to isolate themselves, not knowing whom to trust. This history of secrecy as a means of self-preservation complicates resettlement, impeding integration into their new communities.

Economic profile. Separation of family members during resettlement may also require refugees to alter their traditional roles. For instance, Iraqi men are traditionally

the sole income providers, and women typically do not work outside the home (Maloof & Ross-Sheriff, 2003). As Iraqi refugees resettle, women may be forced by circumstance to work to meet their own financial needs and those of their family. In some cases, a woman's spouse has been killed as a result of violent conflict, leaving her not only a bereft widow, but also as sole provider and holder of tremendous responsibility and financial burden, the sole provider for her children and family.

Iraqis also may have held prominent positions associated with distinguished careers prior to resettlement. Ihsanoglu (2007) explains that the professional working class, consisting of teachers, medical providers, lawyers, and business executives, was deemed the "social capital" of Iraqi society pre-war; however, 40% of this professional working class has been killed or migrated away from Iraq due to war. These same professionals may experience great difficulty in maintaining their professional credentials when they resettle to other countries due to loss of documentation or delayed credentialing processes (J.W. Cornwell, personal communication, May 27, 2011). Therefore, Iraqis who were previously highly respected professionals and leaders in their communities may be forced to settle for employment of much lower status and income during and post migration.

Health profile. Refugees often experience an unparalleled degree of trauma that may have critical long-term physical and mental health consequences (Beiser, 2009; Corvo & Peterson, 2005; Dow, 2011; Museru et al., 2010). Therefore, related health problems may ensue. One may also have pre-existing health issues that have never been addressed prior to coming to the U.S. Another may have had pre-existing health problems that were being addressed before migration, but have been ignored during the migration process.

Still another may have newly emerging health problems; yet, those needs go unmet due to inadequate access to care. Limited income and lower socio-economic status may lead to many health problems for Iraqi refugees as they resettle. Iraqi refugees may have certain health risks and diseases that are not being fully addressed, and their poor income may reduce their access to care (Maloof & Ross-Sheriff, 2003). Thus, exacerbation of healthcare disparities may be the unfortunate result.

Physical health. According to the U.N. Assistance Missions for Iraq (UNAMI, 2007), millions of Iraqis live in poor sanitary conditions with little access to food, water, and adequate shelter. Malnutrition is widespread, especially among children 6 months to five years of age (UNAMI, 2007). Lack of adequate nutrition creates a domino effect, causing a weakened immune response and vulnerability to infectious disease (Singer & Hodge, 2010). As Iraqis migrate to neighboring countries, limited access to healthcare and worsening living conditions can further exacerbate the risk for declining health. Vulnerable populations, such as women, children, and older adults, are especially vulnerable to conditions in refugee camps that are extremely overcrowded (Al-Khalidi & Tanner, 2007). By the end of October, 2011, 37.6% of the refugee population in Syria, 93% of which is comprised of Iraqi refugees, had critical medical conditions requiring extensive healthcare support. The unfortunate reality is that the need for health services far outweighs the availability of such services.

Mental health. Instability in living conditions caused by war and migration can exacerbate the intensity and duration of stress for Iraqi refugees, leading to serious physical and emotional consequences. Asylum-seekers struggle to adapt as they resettle

in unfamiliar cultures significantly different from their own, resulting in acculturative stress and anxiety (Keyes & Kane, 2004; Proctor, 2005). Miller and Rasmussen (2010) suggest that refugees may not only experience post-traumatic stress related to war and conflict but may also encounter unremitting tension from impoverished and overcrowded living conditions, and experience the burden of social isolation from family and friends that can negatively impact their psychological well-being. Depression, anxiety, and feelings of hopelessness can ensue. However, not all refugees experience negative mental health outcomes such as post-traumatic stress disorder (PTSD), depression, or anxiety. Bonnano (2004) suggests that some persons cope in a resilient manner despite exposure to violent conflict and the stressors of daily life. This positive dimension of coping often goes unrecognized or unacknowledged since it does not "fit" the typical assumption associated with refugees and negative mental health outcomes. Therefore, further research is needed to provide insight into how Iraqi refugees manage the stresses of their circumstances.

Refugees Living in the U.S.

One of the largest refugee groups resettling in the U.S. is comprised of Iraqis who have fled their country of origin due to the violent war-torn environment that has existed for more than two decades (USDHHS, 2011). According to U.S. Citizenship and Immigration Services, the U.S. has admitted 58,811 Iraqi refugees since the 2007 fiscal year (U.S. Department of Homeland Security, 2011). Statistics for fiscal year 2009 indicate that 18,709 Iraqi refugees resettled in the U.S. that fiscal year alone, with 348 Iraqi refugees resettling in the State of Tennessee (USDHHS, 2009).

According to an annual survey report produced by the ORR for fiscal year 2008 (USDHHS, 2011), the average number of persons living in a Iraqi refugee household was four with an estimated 80% younger than age 16. Only 24% of household members speak English fluently. Approximately 44% of refugees received medical assistance through Medicaid programs or refugee medical assistance programs. The same survey report indicates that approximately 23% of all adult refugees included in the survey lacked medical coverage in the 12 months prior to the survey.

Employment status is also a topic covered in the ORR annual survey. The 2008 survey (USDHHS, 2011) revealed a 35% employment rate among refugee respondents age 16 and over, which represents a significant decrease from the average employment rate of approximately 56% that was reported for the previous 5 years. Even more alarming, nearly 23% of refugees age 16 and over were not looking for work due to poor health. Reported outcomes for refugees in the State of Tennessee for fiscal year 2008 indicate that only 52% of Iraqi refugees who received case management assistance for employment had entered the work force, and the average wage was $7.92 per hour. Of those obtaining employment, only 79% had health benefits. Thus, the remaining percentage relied on public health insurance assistance or had no coverage at all.

Scope of the Problem

Refugee settlement to the U.S. often poses an extreme challenge, since migration often presents great changes in social and cultural environments. Forced migration can severely disrupt the livelihoods of refugees as they are driven from their homes and communities in order to escape violence and persecution. The harsh reality of

unavoidable migration often includes tragic losses of their homeland, way of life, families and friends, and dignity. Humanitarian assistance stems from empathy and has as its goal the provision of basic necessities for sustaining life. If done well, humanitarian relief addresses the root causes of despair, and can indeed offer a gateway to greater security.

The Georgetown University Law Center Report

A report from the Georgetown University Law Center (GULC), Human Rights Institute (2009) suggests that there is a refugee resettlement crisis in America today. According to the report, the U.S. is failing to meet the needs of refugees, particularly Iraqi refugees, due to inadequate resources, a declining U.S. economy and job market, and a deficient health care system. Based on research conducted by a group of students at GULC in Washington, D.C., the report examined the extent to which Iraqi refugees have been provided protection by the USRAP. Findings from the investigation revealed Iraqis with physical and mental needs have difficulty in securing access to care and treatment. The report also suggests that Iraqi refugees struggle to rebuild their lives in a healthy, integrative way when physical and mental health needs remain untreated.

In the present resettlement process, one such example comes out of difficulties securing permanent health insurance coverage. Medical coverage often expires eight months after refugees arrive in the U.S., leaving them without insurance. One refugee's experience is described in the GULC report as follows:

> Seema is a 56-year-old from northern Iraq who has grown to love Michigan. She has a heart problem, high cholesterol, rheumatism, and no medical coverage because her Refugee Medical Assistance (RMA)

> expired after eight months. Her elderly husband is also sick, and their adult son earns minimum wage. But still, Seema is lucky: hers is one of the few Iraqi refugee families with any wage at all
>
> . . . She only asks for her medical coverage to be restored. "We can handle everything else," said Seema. (GULC, 2009, p. 36)

Furthermore, even when it is available, medical coverage is often delayed due to administrative and bureaucratic barriers. Iraqi refugees may postpone evaluation and treatment of physical and mental health needs until public or private medical assistance can be acquired. As a result, they may suffer from further deterioration of health and well-being.

Aday (2001) describes refugees as persons who are vulnerable and subject to health disparities that could significantly affect the quality of their resettlement experience. Consider the following example cited by Downes and Graham (2011):

> A 65-year old woman forcibly deported from Bhutan to Nepal resettled in the United States four years ago. She neither reads nor writes in her first language (Nepal) nor in English. She has been attending English language classes since her arrival in the U.S. but has made little progress. The woman visits a health fair, bringing with her nine medications, including two bottles of insulin and three empty bottles for three different antihypertensive medications. Through an interpreter, you learn that the woman is not taking any of these medications regularly. She is also

> unaware that she should neither reuse needles nor share her medications with her son, who is also diabetic. She cannot afford to refill her prescriptions. (Downes & Graham, 2011, pp. 27)

The scenario described above represents the plight of only one refugee's distressing circumstance, but it underscores the need to gain a better understanding of the numerous complexities surrounding refugee resettlement, particularly in respect to the U.S. health care culture and infrastructure.

The ability to help refugees resettle becomes problematic as the number of refugees increases locally and nationally. The typical case load for a case manager at Bridge is 75:1, and the primary focus of assistance is on housing and employment, while the health needs of refugees are inadequately addressed due to time constraints, heavy case load, and lack of resources (J.W. Cornwell, personal communication, May 27, 2011).

As a result, refugees are often unaware of what resources are available and how to use those resources to find the care they need. Many refugees may be ineligible for available Medicaid programs, and accessibility to health care services may be limited. Refugees who are uninsured may seek alternative options for primary care, such as using the emergency departments (ED) for non-urgent needs, resulting in exacerbation of the overcrowded conditions that currently prevail in EDs across the nation (Davenport, 2007). Additionally, uninsured refugees may lack the monetary means to obtain needed prescriptions or to afford transportation to places of health care.

Research Problem

There is a paucity of published research in the resettlement process of Iraqi refugees as they relocate to the U.S. Multiple conditions, circumstances, and influences can affect refugee resettlement; yet, no theory exists to fully explain this process. Given nursing's moral imperative to help refugees achieve their highest potential for health throughout the resettlement transition, I conducted this qualitative research study. My intent was to focus on narrowing the gap in knowledge about the resettlement process, to examine the process of resettlement for Iraqi refugees who have resettled in the Southeast region of the U.S., and inductively develop a theory grounded in the Iraqi refugees' own spoken narrative.

Problem Significance

Nursing professionals have both moral and professional responsibilities to provide holistic care to all persons, even to the most impoverished. Dimensions of holistic care include physical, psychological, and social domains. According to Spiers (2000), nurses must seek an emic point of view of others to understand the whole of human experience. Nurses have a vital role in ensuring that human rights are preserved and respected. This respect "extends to all who require the services of the nurse for the promotion of health, the prevention of illness, the restoration of health and the alleviation of suffering" (American Nurses Association, 2010, pp. 3-4). Globally, nurses have a professional responsibility to "initiate and support action to meet the health and social needs of the

public, in particular those of vulnerable populations" (International Council of Nurses, 2006, p. 2).

Nursing research with a focus on refugee resettlement can have tremendous implications for individuals, families, organizations, communities, and global society as a whole. The process of emigration needs to be understood in order to identify areas of need where nurses can effect change. Since there is a dearth of research examining the relocation process of Iraqi refugees, scholarly qualitative and quantitative inquiry is needed to provide the groundwork for social action and change. Qualitative research is the place to begin when little is known on a topic or phenomenon of interest, such as Iraqi refugee adaptation. Ultimately, this type of study provides a venue for participants to voice their experiences about rebuilding or reorganizing their lives within a new contextual social world (Corbin & Strauss, 2008). As a result of knowledge gained through qualitative methods such as Grounded Theory, social justice can be promoted through awareness and advocacy efforts with a goal of reducing inequalities and disparities in healthcare access and delivery. Inequities confront refugees as they strive to resettle in the U.S. and are potential barriers that hinder fulfillment of their goals. Social justice is the "cornerstone" of holistic nursing practice and is a necessary advocacy role of the nursing profession (Barnes, 2005, p. 17).

Research Question

In order to generate a substantive theory, research questions are designed so as to provide the freedom and flexibility to explore the phenomenon in depth (Corbin & Strauss, 2008). For this study, the central research questions were as follows:

1. How do Iraqi refugees perceive the process of resettlement in the Southeast region of the United States?
2. What theory explains the process of resettlement for Iraqi refugees who have relocated to the Southeast region of the United States?

Philosophical Orientation

Nursing and healthcare exist in a social framework. Heightening the awareness of social philosophies and the arguments and ideas that transpire from these philosophies is critical for the continued development of knowledge for nursing science and research. As the scope of nursing extends beyond the bedside, awareness of philosophy and theory relevant to the social contexts of our work environments, populations, and society is essential to advancing the science of our profession in these areas. Meleis (2007) indicates that a robust philosophical and theoretical dialogue must continue in nursing in order to "drive the nature of evidence, the premises supporting pluralism in methods, the framework for interpretation, and the principles behind the selection of outcomes" (p. 102). The challenge is to apply skillful reasoning when inquiring about phenomenon related to nursing in order to advance the discipline of nursing within a social perspective. Essentially, one must recognize and understand the underlying social issues that may impact the health and well-being of persons, such as refugees. The impetus is to identify areas where social justice and change need to be supported. This is a "cornerstone" value of nursing as a whole (Barnes, 2005).

This research inquiry aimed to generate a substantive theory about the basic social process of resettlement for Iraqi refugees who now reside in the Southeast region of the United States. The philosophical support for this naturalistic inquiry came from pragmatism based on the work of Dewey (1929), which suggests two principles: a) knowledge can be generated by recognizing the adaptation of the human organism to its environment, and b) the subjective reality of that experience deserves to be understood. Essentially, the contextual nature of phenomena should not be ignored. The phenomenon of refugee resettlement can best be understood by acknowledging the experiences of the refugees themselves and grounding the theory in their actions, interactions, and social processes.

A social psychological theory of human action is symbolic interactionism, an extension of the philosophical thought of pragmatism, established by George Herbert Mead (1934) and advanced by Blumer (1969). The focal point of symbolic interactionism is that persons interpret and make meaning of events and then respond accordingly. Rodgers and Knafl (2000) describe the central tenets of symbolic interactionism as follows:

1. Reality is socially constructed;
2. Humans act based on constructed meanings;
3. Realities and meanings are constructed, maintained and changed through human interaction;
4. Meaning and reality are contextual; and

5. Interaction requires the ability to use symbols or language to communicate (pp. 287-288).

The process of social interaction is rooted in language, and communication is enhanced through the use of symbols. We use language to describe our worlds; therefore, language is a vital part of how we interpret, describe, represent, and construct our social realities (Allen, 2006; Gusfield, 2003). People create meaning within their contextual realities through human interaction, but they express that meaning and explain their perceptions through language. A researcher can gain an understanding of a particular phenomenon by exploring the reality of others' experiences through their spoken words. Grounded theory, based on the philosophical foundation of symbolic interactionism, was the systematic method used for this research about the resettlement social process.

Operational Definitions

Core concepts for the study are defined as follows:

Forced migration. "A general term that refers to relocation or movements under duress by refugees and internally displaced people. This includes those displaced by conflicts as well as by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects" (International Association for the Study of Forced Migration, 2011). Presence or absence of forced migration was determined by self-report of the participant.

Refugee. "Any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or

unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion" (USDHHS, 2011). Refugee status was determined by the participant's involvement with Bridge as part of the current or past caseload.

Resettlement. "The selection and transfer of refugees from a State in which they have sought protection to a third State which has agreed to admit them – as refugees – with permanent residence status. The status provided should ensure protection and provide a resettled refugee and his/her family or dependents with access to civil, political, economic, social and cultural rights similar to those enjoyed by nationals. It should also carry with it the opportunity to eventually become a naturalized citizen of the resettlement country" (U.N. High Commissioner for Refugees, 2004). Resettlement was determined by participants' involvement with Bridge as part of the current or past caseload.

Adaptation: "The process and outcome whereby the thinking and feeling person as individuals or groups use conscious awareness and choice to create human and environmental integration" (Roy, 2009). In this study, adaptation refers to a person's response to his/her changing environment, and was measured by interpreting the participants' own words explaining their perceptions of resettling in the U.S.

Health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization [WHO], 1948). In this study, health status was determined by the self-report of the participant.

Healthcare: "The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions" (American Heritage Medical Dictionary, 2007).

Health Disparity. "A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (USDHHS, 2010).

The core concepts of forced migration, refugees, and resettlement were operationalized by obtaining participants' self-reports as refugees who have been forced to migrate to the U.S. for permanent resettlement. Concepts of adaptation, health and health disparity were measured by interpreting participants' perceptions of resettling in the U.S. and their description of what health and accessibility to healthcare means to them as they create a new life in the U.S.

Assumptions

Recognizing one's own assumptions and biases enables a researcher to appreciably enter another's perceived world. This researcher's identified assumptions and biases are as follows:

1. Inductive qualitative inquiry can provide valuable insight into the basic social processes involved in the resettlement of Iraqi refugees to the Southeast region of the U.S.

2. The researcher's experience of working with the refugees increased theoretical sensitivity throughout the study

3. Not all of the concepts related to resettlement have been identified yet; and

relationships between the concepts already known are poorly understood and underdeveloped

4. Iraqi refugees face many challenges and barriers related to resettlement that have not yet been communicated

5. Iraqi refugees are able and willing to accurately describe their perceived experience of the resettlement process accurately

6. Through their narratives, Iraqi refugees can inform the researcher about the basic social process of resettlement as it is grounded in their own experience; and

7. It is possible to obtain clarity and accuracy in understanding refugee narratives by using the services of an interpreter.

Limitations

Limitations have been identified that may have affected the data analysis and results of this study, including the following:

1. Interviewees were of diverse ethnic origins and cultural practices;
2. Interviewees did have English as a second language;
3. There was potential for language-related miscommunication or misunderstanding. To address this concern, interpreter services were provided (both male and female options were available, to facilitate maximum comfort for the interviewee). However, the use of an interpreter will itself introduce some limitations: a)introducing a third person into every conversation/interview, and b) this third

person may potentially pose a threat to confidentiality and participant comfort; and

4. Interviewees may have given a response that they perceive to be socially desirable rather than what they actually think, feel, or do.

Delimitations

Delimitations for this study include the following:

1. Study sample was limited to only one geographical region of the Southeast U.S.
2. Study sample was limited to Iraqi refugees who have received federal assistance through a refugee resettlement agency in the Southeast United States;
3. Study sample was limited to only Iraqi refugees who are authorized under the Refugee Act of 1980 to be admitted to the U.S. on humanitarian grounds to live potentially permanently in the U.S.
4. Study sample was limited to only Iraqi refugees resettled to the U.S. within the last ten years.

Summary

Changing environments, cultures and social systems can have an impact on the resettlement capacity of refugees. There are diverse economic, social, and cultural norms that complicate the process, and differences in health-related beliefs, values, and practices lend additional layers of complexity to the resettlement progression for refugees as well. The basic psychosocial process of resettlement for Iraqi refugees has been largely unexplored; therefore, a grassroots inductive approach is needed to explore the contextual, conditional, interactional and consequential dimensions of this phenomenon.

In order to affect change, the issues surrounding the process of resettling Iraqi refugees must be understood. This study focused on discovering the process of resettlement. Gaining this understanding is a necessary prerequisite for nursing so that culturally appropriate care can be provided to support overall physical, mental, emotional, and spiritual well-being for the respective refugee client(s). According to Roy (1988), recognizing the subjective dimensions of refugee experience is a humanistic way of knowing for the nursing profession.

Research that facilitates a better understanding of the refugee perspective can be a catalyst for change. Findings from this study can clarify areas of need where interventional research is indicated. Most of all, this would allow refugees to have a voice. It also allows nursing to advocate for those refugees who are underserved, to speak to the need for improved healthcare that will support well-being and successful adaptation within their adopted country.

Chapter 2

Literature Review

Introduction

The literature of refugee resettlement spans nearly three decades, beginning with the inception of the Refugee Act in 1980, which created the Federal Refugee Resettlement Program as an amendment to the Immigration and Nationality Act of 1952. This chapter begins with a brief introduction to refugee populations that have been studied in the research literature. Secondly, theoretical frameworks that have guided refugee research will be discussed. A critical analysis of the current state of the science on refugee resettlement will follow. The chapter will conclude with a summary of what is known and not known in order to identify gaps in knowledge and thereby explain the need for the proposed research study.

Methodology

The literature search utilized the following electronic databases: CINAHL, Medline/PubMed, PsycINFO, Homeland Security Digital Library, Web of Science, Social Work Abstracts, and Google Scholar. References from related studies were inspected for additional literature relevant to the topic of refugee resettlement. Key terms in the literature search included adaptation, health, health care, integration, nursing, refugee, resettlement, and theory. Research studies or opinion articles examining refugee resettlement were included in this review if they met the following criteria:

1. Published in English during the timeframe of 2000 to 2011; and

2. Examined refugee health, healthcare, adaptation and/or integration.

The initial literature search produced 75 pertinent studies and articles. Twenty-three research studies were utilized for this review. These were performed in Australia (4), Canada (6), Netherlands (1), Sweden (1) and the United States (11). Study methods included mixed methods (4), quantitative (7), qualitative (9), case study (1), action research (1), and historical research (1). Five of the eleven studies in the U.S. were quantitative in design. Most of the quantitative studies were descriptive surveys or utilized a correlational research design. The qualitative works were case studies or phenomenological in nature.

Studies and articles comprising this review were found in professional journals in the fields of law, nursing, medicine, mental health, public health, and social work. Government documents relevant to refugee resettlement were also included. An additional search of the World Wide Web obtained information regarding past and current information pertaining to refugee resettlement programs, refugee data and resources.

Diversity of Refugee Groups Examined in the Literature

Refugees resettling in the U.S. during the late 1970s primarily originated from Vietnam, Cambodia, South Asia, and Afghanistan, and most research studies conducted between 1980 and 1999 focused on these populations (D'Avanzo, 1992; Erickson & Hoang, 1980; Fox, 1991; Lipson & Miller, 1994). Arrival data from USDHHS (2011) indicate that the largest numbers of refugees received in the U.S. since 2000 originated

from 70-80 different countries; the largest populations in the past five years have come from Bhutan, Burma, Burundi, Somalia, and Iraq.

The diversity of refugees received in the U.S. and other host countries is increasing; however, there is limited current research reflecting the expansion of refugees in the U.S. and minimal research has been conducted with Iraqi refugees in particular. A goal of the Center for Disease Control and Prevention (2011), a world leader in health promotion and disease prevention, is to promote the health of refugee persons in the U.S.; yet, little is known about Iraqi refugee health as part of their adaptive process in the U.S. Therefore, further research on Iraqi refugee adaption and their health is of paramount importance.

Application of Theory in Refugee Research

Research on the topic of refugee resettlement is most prevalent in the fields of psychology, sociology, nursing, and medicine; yet, the theoretical basis for existing research is seldom made explicit in the research reports. The body of research on refugee resettlement included multiple theoretical frameworks, such as adaptation (Keyes & Kane, 2004), acculturation adaptation (Oh, Koeske, & Sales, 2002), integration (Beiser, 2009), social support (Simich, Beiser & Mawani, 2003), self-efficacy (Kia-Keating & Ellis, 2007), self-sufficiency (Corvo & Peterson, 2005), ecosystem (Guruge & Knanlou, 2004), and family systems (Fox, Baldwin, Rossetti, Ploncynski, & Bandagi, 2008). Other frameworks included transcultural nursing care (Cooper, 1996), model of healthcare utilization (Drummond, Mizan, Brocx & Wright, 2011), and a socio-ecological model of health behavior (Pavlish, Noor, and Brandt, 2010; Wahoush, 2009).

From a mental health perspective, Kia-Keating and Ellis (2007) examined psychosocial adjustment and belonging based on the theory of self-efficacy with a sample of 76 Somali adolescents who had resettled in the Northeast region of the U.S. The Multidimensional Scale of Perceived Self-efficacy was one of the measurement instruments used in the quantitative study. It was hypothesized that exposure to adversities would result in increased levels of PTSD and depression as well as lower levels of self-efficacy. An important finding of the study was that adolescents had significantly lower self-efficacy, greater adjustment difficulties, and higher levels of stress and depression when they had experienced greater exposure to war, violence, and displacement adversity.

The desire to have a sense of belonging was also evident in the study by Keyes and Kane (2004). Supported by the theory of adaptation, the phenomenological study of seven female Bosnian refugees revealed that they simultaneously struggle with the loss of belonging in their old culture while striving to establish footing in their new cultural environment. Bosnian refugee participants in that study revealed that they find ways to adapt and cope, such as focusing on their past accomplishments and envisioning hope for the future, in order to survive in their new homes.

Refugees' survival in their new residence depends on a delicate balance between the old and new. Oh, Koeske, and Sales (2002) suggest that two modes of acculturative adaptation exist – assimilation and integration. According to the acculturative adaptation model, assimilation is the process of adopting greater elements of the host culture, whereas integration is a blending of host and native cultures (Oh, Koeske, & Sales,

2002). Their quantitative study of 157 Korean refugees revealed that those who try to adapt via an assimilative mode may have greater depressive symptoms due to loss of their own native culture; yet, adaptation via an integrative mode results in greater acculturative stress from trying to strike a balance between two cultures.

A mixed method study conducted by Beiser (2009) was guided by integration theory, which has its origins in behavioral science. The research was the largest and most comprehensive refugee study of Southeast Asian refugees resettling in Canada. Qualitative interviews of 1,348 participants complemented the quantitative survey questionnaire results. The lesson learned from the Canadian Refugee Resettlement Project was that individuals who retain their own cultural identity while integrating elements of the new culture by participating fully in the political, economic, social, and cultural life are more successful than those who primarily assimilate in the adaptation process. The results suggest that integration should be promoted to facilitate psychosocial adaptation to resettlement.

A conceptual framework for integration was developed by Ager and Strang (2008) through a comprehensive literature review, secondary data analysis, and inductive fieldwork. As a result of the conceptual analysis, key domains of integration were identified: employment, housing, education, health and strong social connections facilitated by language and cultural knowledge. Acquisition of rights and citizenship was considered the foundation domain of integration.

Refugees are expected to acclimatize themselves very quickly to the host country culture and to integrate themselves through language acquisition and employment as well

as seek care through health and social services. Unfortunately, successful integration within the domain of health for refugees is not well understood or defined. Refugees may encounter many challenges that impede successful health integration, yet indicators for health integration remain to be identified. Significant barriers to health care and resources have largely been unexamined. Therefore, qualitative exploration of refugee experiences regarding their health concerns and access to care deserve to be considered.

Social support was found to facilitate greater integration and to positively affect the refugees' mental and physical health and well-being in a study conducted by Simich, Beiser, and Mawani (2003). The study was guided by social support theory, which suggests that social ties with family and community strengthen one's ability to overcome the stressors encountered during life-changing experiences. Lack of social support was found to be one of the barriers to healthy integration in the study by Drummond et al. (2011), where participants revealed their preference to cope with psychological or physical health problems alone out of fear of what others may think about their cultural beliefs and values related to health care practices. According to Ryan, Benson, and Dooley (2008a), negative health outcomes may be an unfortunate result if social support for refugees is lost, constrained or devalued; therefore, the goal of healthcare professionals should be to identify resources lost and promote resource gain for refugee adaptation.

Conceptual Framework

According to Peterson and Bredow (2009), conceptual models are essential to the development of nursing theory. Conceptual models are abstract in nature, yet the defined

concepts identified in the models provide a foundation for furthering theory development on a phenomenon of interest. No studies related to refugee experiences have been guided by Roy's conceptual adaptation model for nursing, which originated in 1970 and was revised for the 21st century (Roy,1997; Roy, 2009; Roy & Andrews, 1999); however, Roy's (2009) conceptual model of adaptation has been identified as having significant relevance and value to the proposed research.

Roy Adaptation Model. The adaptation model described by Roy (2009) views persons as adaptive systems that are in constant interaction with the environment. Adaptive responses to environmental changes can be manifested as integrative, compensatory, or compromised processes. Andrews and Roy (1991) consider the two concepts, health and adaptation, as interrelated where "health is a state and a process of being and becoming integrated and a whole person" (p. 21). Integration, in this sense, is the level of adaptation where the whole interaction of person and environment is sufficient to meet human needs (Roy, 2009). As problems are encountered during refugee resettlement, the level of adaptation may become compromised or compensatory at best, resulting in potentially inadequate integration. According to Roy (2009), a "lack of integration represents lack of health" (p. 48). Adaptation problems that limit the health and well-being of individuals and groups in society are a concern to nursing.

The essence of nursing is to promote the health and well-being of individuals and groups so that overall quality of life can be enhanced. Roy (2009) suggests persons cannot reach their full human potential without health and well-being; therefore, nurses are accountable for understanding the adaptive processes of persons as they interact with

their environment and the resulting impact on their holistic health status. Andrews and Roy (1991) suggest "it is the changing environment [that] stimulates the person to make adaptive responses" (p. 18). As individuals and groups respond to focal, contextual and residual stimuli of changing environments, adaptation can be observed in four interrelated adaptive modes, including physical, self-concept, role function, and interdependence, as part of the coping process of human adaptive systems (Roy, 2009).

Understanding the four adaptive modes in relation to refugee adaptation is essential. The stress of environmental change can stimulate the activation of certain physical responses to sustain life and maintain physiological-physical integrity. Refugees have a basic need to create meaning and purpose as they deal with the transition of resettlement. Therefore, preservation of psychological and spiritual integrity can strengthen the refugee's sense of self-concept and identity. Refugees may experience changes in role function as they resettle in a different culture and society. A person's occupational or social role in their society of origin may change as s/he resettles, so understanding of one's role in the new society is a basic need that is crucial to maintaining social integrity. As mentioned earlier, supportive relationships may be valuable to refugees as they struggle with the loss and separation of family and loved ones. Roy and Andrews (1999) suggest that the basic need of the interdependence mode is to give and receive love, respect, value, and nurturing in order to preserve relational integrity. Consistent with the conceptual adaptive modes in Roy's model, refugees may seek to preserve their physical, psychological, spiritual, social, and relational integrity in the adaptive process. Thus, the impetus for adaptation is to preserve "physiological, psychological, and social integrity"

so that a person can achieve "survival, growth . . . and transformation" (Phillips, 2006 pp. 362-363).

Roy's Adaptation Model (2009) provided the conceptual foundation for the proposed research; however, the premise of grounded theory research is to establish a theory based upon the "words of the participants" themselves (Brown et al., 2011, p. 2). A theory specific to Iraqi refugee adaptation emerged as stories of resettlement experiences in the U.S. unfolded, and it is this new theory that will be discussed in the chapters to come. This new grounded theory can prompt nursing action and intervention to meet their needs (Busby, Speraw, & Young, 2008).

Critical Analysis of Refugee Research

Four recurring themes emerged from the refugee resettlement literature – mental health, physical health, healthcare, and adaptation. Studies related to each identified theme will be critically analyzed to depict the current state of refugee resettlement research.

Mental Health. The majority of the refugee research literature is focused on mental health needs of refugees. As the amount of resettlement continues to rise in the U.S., the reality of mental health care needs of refugees can no longer be ignored. Much of the current literature on refugee mental health suggests that depression, anxiety, PTSD, substance abuse, fear, and even suicidal tendencies are prevalent within the refugee population. Yet, there is no theory grounded in Iraqi refugee experiences on which to guide interventional practice and research.

One of the largest comprehensive research studies investigating the risk and protective factors for refugee mental health was conducted in Canada. Beiser (2009) provides a report of lessons learned from the decade-long study titled 'The Ryerson University Refugee Resettlement Project' (RRP). The sample for the study consisted of 1348 Southeast Asian refugees who had come to Canada between 1979 and 1981. At that time, war and conflict were prevalent in Southeast Asia, and many persons had been displaced from their homes, resulting in a large-scale migration of refugees to various host countries. Funding was provided from the National Health Research Directorate Program to study the adaptation of Southeast Asian survivors of war, displacement, migration, and resettlement in Vancouver, British Columbia.

The sample consisted of three ethnic refugee groups – Chinese, Vietnamese, and Laotian (Beiser, 2006). Participants were selected based on a combination of snowball and probability sampling techniques. Questionnaires translated into the appropriate ethnic language were used to obtain demographic statistics, resettlement experiences, acculturation, health and mental health information. Surveys were taken in 1981, 1983, and 1991, and a 50% attrition rate was found by the time of the last survey, which is noted as a weakness of the study. In order to complement quantitative data, qualitative interviews were conducted with two similarly sized cohorts of refugees – those who seemed to be adapting well and those who were experiencing psychological distress.

The longitudinal design of the study provided valuable information that strengthened the knowledge base regarding resettlement and mental health well-being of refugees. Results of that study indicate that men have higher degrees of depression than

women during the early stages of resettlement, but that depression becomes more predominant in women refugees as time passes during the latter stages of resettlement and post-resettlement. Social support and language fluency positively impacted mental health well-being, whereas discrimination and disparities in equitable access to care negatively impacted mental health of refugees.

Current research suggests that refugees experience psychological distress due to lack of support. A literature review conducted by O'Mahony and Donnelly (2010) suggests that refugee women are susceptible to depression, specifically post-partum depression, due to social isolation and lack of social support. Social support from family members, community, and healthcare providers were suggested as being instrumental in promoting psychological well-being; however, research examining social support for refugees remains limited.

Simich, et al., (2003) conducted a qualitative study exploring the underlying reasons for secondary migration of refugees. Purposive sampling was used to recruit participants from refugee reception centers in Ontario, Canada. Refugees are often placed in certain geographic regions dispersed from members of their own ethnic culture; this separation exacerbates their feelings of anxiety and stress, and refugee participants in the study revealed a desire to seek ethnic and cultural similarities to their native heritage. Thus, refugees actively sought social support even if it meant relocating, in order to strengthen their ability to cope and adapt. The contribution of that study is the expansion of knowledge regarding the influence of social support on decision-making processes of

refugees. That research focused on newly arrived refugees but not on refugees who had been resettled for longer periods of time, which constitutes a weakness of the study.

During the resettlement process, refugees struggle with the fragile balance between two cultures – their native culture of origin and their new cultural home. Such cultural conflict may be experienced as refugees strive to learn the culture of their new society while at the same time striving to preserve cultural practices of their native homeland. Acculturative stress can result from cultural collision as refugees strive to cope with resettlement. Oh, et al., (2002) conducted a quantitative study examining acculturation, acculturation stress, and depression. The cross-sectional survey design consisted of a sample of 157 Korean immigrants residing in Pennsylvania, and a response rate of 90.8% was achieved. All questionnaires were translated into Korean language, and psychometric analysis was performed on study instruments revealing adequate reliability and validity, which is a strength of the study. Results of that study indicate that acculturative stress was positively related to depression. Also, results supported the theory that assimilation strategies to incorporate the host culture's language, values, and practices are more effective in reducing life stress and strengthening mental health than trying to integrate both cultures. A limitation of the study is a population-specific focus on Korean immigrants, making generalizability to other populations difficult. Also, the cross-sectional design limits the study as well.

When refugees arrive at their host country, refugee assistance programs strive to help the refugees become self- sufficient within a short time. Programs, such as Bridge, provide resources to refugees for approximately 6-8 months in areas such as housing,

employment acquisition, and language acquisition; however, the literature suggests that this focus on early acquisition of employment is intended to deter refugees from dealing with psychological distress that results from post-traumatic experiences prior to resettlement. Thus, resulting mental health problems, such as PTSD and major depressive disorder, may be left untreated. The study conducted by Corvo and Peterson (2005) examined post-traumatic stress symptoms, language acquisition, and self-sufficiency in a non-experimental quantitative study with 34 Bosnian refugees in Syracuse, New York. The small sample size was a weakness of this study; therefore, its results provided only weak empirical support that trauma-related problems interfered with self-sufficiency. Findings, however, indicated that there were issues of concern related to reported symptoms of sleep disturbance, loneliness, and hopelessness about the future for the Bosnian refugees.

In an effort to reveal the experiences of Bosnian refugees in the U.S., Keyes and Kane (2004) conducted a qualitative study of phenomenological design with seven adult female Bosnian refugees. Belonging and adapting were two major themes identified in the data analyses. It is often assumed that refugees are burdened with the negative realities of resettlement; however, both negative and positive aspects of their experiences were recognized in that study. Embedded in their experiences were "states of culture shock, loneliness, psychic numbness, grief, nostalgia, and feelings of dejection, humiliation, inferiority as well as feeling as if they belonged nowhere. Also, inherent in their experiences were feelings of "relief, safety, gratefulness, and a newfound freedom to

hope for a better life" (Keyes & Kane, 2004, p. 809). The study is one of the few studies reviewed that acknowledged both refugee grief and sense of hope for the future.

Grief was evident in the experiences of traumatized refugees hospitalized in a psychiatric facility in the Netherlands. A convenience sample was recruited to participate in the mixed-method study conducted by Strijk, van Meijel, and Gamel (2011) using a survey questionnaire and interview method. Results of that study revealed that 86.7% of respondents felt that their psychological needs were unmet at the time of the study. Displacement and the associated sense of loss were found to be directly related to expressions of grief, gloom, and loneliness.

One respondent remarked:

> When I look around me, I see so many people who feel happy and safe, and I think, "Why not me? Why can't I be that person, why can't I have what they have?" It makes me want to cry all the time. (Strijk, et al., 2011)

Participants in the study were in severe psychological distress that influenced their quality of life and well-being. The assessment-of-need questionnaire used in the study was not specifically designed for use with refugees; therefore, reliability and validity of the instrument for this population is uncertain.

Review of quantitative and qualitative literature on refugee mental health suggests that psychological distress is evident in refugee experiences. Social support has been recognized as being crucial to mitigating the effects of mental disorders associated with

stress and trauma. Refugee mental health research is limited; yet there is a growing body of research literature focused on stressors in the post-migration period (Miller, et al., 2002; Miller, Muzurovic et al., 2002; Miller & Rasmussen, 2010; Norris, Aroian, & Nickerson, 2011; Rasmussen et al., 2010).

A common finding of these studies is that persistent challenges or stressors from day to day within the post-migration period can have substantive effects on mental health outcomes. Stressors such as lack of social support, limited income, and unemployment have been shown to mediate psychological distress among refugees (Rasmussen et al., 2010). Although Rasmussen and colleagues included only Darfuri refugees, relevant implications for refugees of other ethnic origins may apply. One important implication for future research is to recognize that stressors in the everyday social world during the post-migration period can have significant mediating effects on refugee mental health; therefore, the social ecology of the post-migration experience needs to be considered in order to understand psychological distress from a broader perspective (Miller & Rasmussen, 2010).

How do challenges such as inability to access care, lack of health insurance (medical, dental, vision), minimal income (to afford prescriptive medications, co-pays, and healthy food), communication barriers, and minimal health literacy contribute to psychological distress during the post-migration period? These potential stressors related to the healthcare culture in the U.S. have been largely unexplored in relation to refugees. Therefore, this gap in knowledge needs to be addressed.

Physical Health. Refugees arrive to the United States with pre-existing physical health conditions and needs. According to Bruno (2011), circumstances of inadequate access to medical care, poor sanitation, and poor nutrition in refugee camp settings has left refugees with chronic untreated medical conditions that are often a threat to public health. Refugees are screened for communicable diseases in the early stage of the resettlement process. There is a dearth of research on the physical health needs of refugees resettling in the United States; only two studies could be located and are included in this review.

A retrospective quantitative descriptive study was conducted by Museru et al. (2010) that examined the prevalence of Hepatitis B virus infection among refugees who resettled in the State of Georgia over a 5-year period between the 2003 and 2007. The number of refugees testing positive for Hepatitis B surface antigen comprised an overall prevalence of 10.7% of the refugee population resettling in Georgia during the five-year period. Those who tested positive were referred for follow-up care, but there was no formal mechanism to ensure that the refugees received access to the recommended medical care. Although the research was retrospective descriptive design, the results provided valuable information regarding the extent of Hepatitis B in the Georgia refugee population.

An additional retrospective descriptive study design was also conducted by Barnes and Harrison (2004) to examine reproductive health practices of refugee women. Medical charts were reviewed from 1996 to 2000, and the frequency of reproductive health problems and breast and cervical screening rates were

measured. Twenty-five percent of the women in the sample had reproductive health problems, and 86% of women over the age of 40 had never had a mammogram, while only 24% reported having had a Pap smear test within the previous 3 years. Fifteen percent of the women were pregnant but had not received prenatal care. Although that study was of a retrospective descriptive design, results of the study provide much insight to the reproductive health care and screening practices of refugee women.

A community-based participatory qualitative research study conducted by Doyle, Rager, Bates, and Cooper (2006) revealed behavioral, psychological, access/treatment, environmental, and social/economic factors that affected the health of migrant workers. Although migrant workers are different from refugees by definition, factors identified are implications of what refugees may experience when resettling in the U.S., such as poor diet/nutrition, low resource awareness, lack of insurance, illiteracy, stress, language difficulties, and limited income to afford medications or treatments.

Despite the documented threat of communicable diseases, such as tuberculosis, intestinal parasites, Hepatitis B, HIV and potential chronic health conditions associated with poor living condition and lack of care, there has been little research exploring the impact of such threat to health and the process of healthcare access for refugees. Also, no studies were found that examined the physiologic impact of chronic stress on refugees, particularly allostatic load (McEwen, 2002; McEwen & Stellar, 1993).

Healthcare. In a healthcare system already burdened with complex problems and in need of reform, the addition of growing numbers of refugees can challenge the ability of the public healthcare system to provide equitable access to healthcare. Thus, many health

disparities may prevail due to lack of insurance and inadequate access to primary care and needed resources for preventative care. Refugee medical assistance is provided during the first 6-8 months of resettlement while the refugee seeks employment. If no employment is acquired by the end of the covered medical assistance time period, then the refugee is left with no insurance, thereby limiting access to healthcare.

Focus groups and semi-structured interviews were conducted with refugees in New York City as well as healthcare providers over a 30-month period by Asgary and Segar (2011) to examine perceived barriers to healthcare access. Results of the study identify several barriers, including (a) mistrust and perceived discrimination of Western medicine, (b) affordability, (c) lack of knowledge regarding healthcare resources, (d) the fact that healthcare is for urgent care only and not preventative care, (e) linguistic differences, (f) resettlement stressors and other priorities, and (g) lack of community social support. A limitation to the study is that 30 of the 34 participants in the study were male; therefore, the gender imbalance suggests perceived barriers to healthcare access by women were not adequately addressed.

Healthcare barriers for refugees were also examined by Morris et al. (2009) in a qualitative study examining the healthcare access experiences of 40 participants. Additional barriers were identified in the study, including 1) transportation issues, 2) financial hardship and lack of insurance, 3) acculturation difficulties, 4) communication barriers, and 5) cultural differences in health care practices and beliefs. Findings of that study were consistent with existing literature regarding challenges to healthcare access for refugees.

An additional qualitative study conducted by Pavlish, et al., (2010) examined the experiences of Somali refugee women and their healthcare interactions as they sought care for their health needs. Questions regarding health concerns, utilization of healthcare resources, and barriers to health care access were posed during focus group interviews, and the researchers report that the participants were eager to share their experiences. Results of the study revealed that the Somali women's experiences consisted of unmet expectations regarding holistic healthcare as American healthcare providers concentrated primarily on their physical needs while disregarding their social and mental well-being. Deficiencies in culturally appropriate care were also identified. Additionally, the Somali refugees expressed frustration with trying to communicate their healthcare concerns to U.S. healthcare providers who did not seem to take the time to listen or explain details to them.

A strength of the studies examining barriers to care is that both refugees and healthcare providers were recruited to provide their perspectives of healthcare access for refugees. Convenience sampling was a limitation to the studies, but overall, the information gained is valuable to understanding obstacles that may prevent adequate healthcare for refugees in the U.S. Inadequacy of healthcare for mental and physical health needs of refugees as revealed in the analyzed studies thus far can impede the ability of refugees to successfully adapt in an integrative way.

Adaptation. Few research studies were identified that focused specifically on refugee adaptation. Psycho-social family adaptation of Vietnamese women was examined by Fox et al. (2008). The study was qualitative in design and ascertained the experiences of

Vietnamese refugee women. The findings of that study revealed that Vietnamese women mourned their loss and separation from family members, and the resulting psycho-social impact on their mental health influenced the length of time and resources needed for adaptation. Strengths of the work are that it investigated family, and that it was conducted in the U.S. Conversely, the research was limited to the extent that it investigated only the experiences of women in the age range of 45-68 years, and focused exclusively on Vietnamese refugees. Valuable insight into refugee perspectives on family and how family influences adaptation is obtained from this study.

Adapting was a major theme recognized in the study conducted by Keyes and Kane (2004). In response to the loss of family and friends, refugees sought to establish and strengthen new social networks as a way of promoting adaptation to their new way of life. A strength of this study is its exploratory approach in examining both positive and negative elements associated with refugee adaptation. Therefore, a broader view of refugee adaptation experiences is evident in the research. The phenomenological method used for the study provides much needed insight into the lived experiences of refugees and reinforces the need to better understand a broader array of factors influencing refugee adaptation.

Cultural adaptation and refugee social interactions were examined by Jorden, Matheson, and Anisman (2009) in a mixed-method study with Somali refugees in Canada. Findings from that study indicate that refugees who had experienced traumatic life events pre-resettlement had greater stress sensitivity and reduced social relations that negatively impacted cultural adaptation. Social support was found to mitigate an increase

of symptoms related to psychological distress. The sample population included 169 participants for the quantitative component and 23 participants for the qualitative aspect of the study. An additional strength is that both men and women were included as study participants. The examination of the correlational effect of social support on cultural adaptation is a strength of this study.

Physical and mental well-being is predominantly discussed in the refugee literature; however, social well-being is minimally addressed. Only two studies were located that specifically focused on social support and the impact on adaptive patterns for refugees (Schweitzer, Melville, Steel & Lacherez, 2006; Simich, et al., 2003). Results of both qualitative studies indicate that social support had a significant influence on adaptive outcomes, such as positive mental health and well-being when social support was strong; however, neither study was performed in the U.S. Little is known about refugee social and relational well-being for those who have resettled in America.

Summary

It is known that refugees have unique mental health and physical health needs that deserve attention from healthcare providers. Culturally sensitive care is needed, but little is known about the healthcare needs of Iraqi refugees. The atrocities of war, violence, displacement, and uncertainty precipitate the deterioration of mental health and well-being of Iraqi refugees. Depression, stress, anxiety, fear, and psychological distress are often the mental health consequences. Chronic health conditions and communicable diseases are physical health needs prevalent among refugees; yet, barriers to healthcare prohibit the ability to fully address both mental and physical health needs.

Iraqi refugees may not have the level of knowledge and support needed to help compensate for the challenges they may face. Therefore, the physical, psychological, spiritual, social and relational integrity of Iraqi refugees may be compromised. As a consequence, ineffective resettlement experiences could be one result. After critical review, identified gaps in the literature are recognized as follows:

1. Much of the research conducted in the U.S. has been quantitative and qualitative in nature, yet only descriptive in design;
2. Few studies have examined the conceptual interrelation of health and adaptation;
3. No studies have examined the basic social process of resettlement for refugees, particularly Iraqi refugees;
4. No studies have been conducted to elucidate a theory grounded in the Iraqi refugees' resettlement experiences;
5. Few studies have included adolescents or older adults in the sample;
6. Few studies have included both men and women in the sample;
7. No interventional research could be located for Iraqi refugee populations in the U.S.;
8. Few studies have been done with the largest growing refugee populations in the U.S., Bhutan, Burma, Iraq, and Somalia;
9. No studies have been conducted to examine adaptation in a holistic way to ascertain the relational, social and spiritual integrity of Iraqi refugees; and
10. No studies could be located investigating the resettlement process of Iraqi refugees in the State of Tennessee.

In view of the identified gaps, this dissertation research sought to advance nursing knowledge and science regarding the process of resettlement for both men and women Iraqi refugees who reside in the Southeast region of the U.S. The intent was to take a holistic approach to examine all influences and conditions that may affect Iraqi refugee resettlement. The substantive grounded theory that was generated will be discussed in the remaining chapters.

Chapter 3

Methods

The nursing profession lacks a solid theoretical base for understanding the phenomenon of Iraqi refugee resettlement in the U.S., a critical deficit since nurses are increasingly encountering an expanded diversity of clients in health care settings and communities. A greater understanding of Iraqi refugee resettlement in the U.S. is needed for two major reasons: to provide a foundation of conceptual knowledge for theory development, and to inform evidence-based nursing practice. Thus, a plausible conceptual framework is needed to guide culturally appropriate care for refugees. This chapter is organized into 4 major sections. First, the philosophical underpinning of grounded theory; second, the researcher's role; third, study procedures; and finally, equipment used for the study will be identified.

The goals for theory development in the nursing discipline are to describe phenomena of interest, explain conceptual relations, and provide a conceptual understanding of phenomenon to guide further research and practice (Meleis, 2007). At the outset of this research, it was presumed that all the concepts related to Iraqi refugee resettlement had not yet been identified and relationships between the concepts already known were poorly understood and underdeveloped. An underlying assumption of grounded theory is that concepts and their relationships are not well defined, yet can be inductively discovered as phenomena are explored (Strauss & Corbin, 1990). Therefore, grounded theory was the chosen methodological approach

for this study so that a greater theoretical understanding of Iraqi refugee resettlement could be ascertained.

Grounded Theory: Philosophical Underpinning

One must understand the philosophical foundation of the method in order to logically rationalize its use. Two philosophical assumptions of grounded theory relevant to the proposed research are the ontological stance and the epistemological stance.

Grounded Theory: Ontological Stance. It is vitally important to understand the ontological stance of a research method to ensure congruence with the research purpose and proposed research questions. Ontology, or the metaphysical, "deals with questions about the nature of reality" (Godfey-Smith, 2003, p. 5). Insight to another's reality is obtained by seeking to understand the perspective of one's experience. The search for a single reality limits the human science of nursing and is inadequate for understanding the complex phenomena of human behaviors, cognitions, and perceptions (Meleis, 2007). Therefore, consideration for multiple realities provides a broader perspective of phenomena and facilitates a greater understanding for advancing nursing science and knowledge of refugee adaptive experiences to resettlement in the U.S.

The constructivist paradigm of grounded theory encompasses the assumption that no absolute single reality or truth exists and knowledge comes from careful study of the world where phenomena can be better understood in pluralistic ways (Mallon, 2008). No single reality of refugee adaptation can explain the complexity of the multiple influencing factors and conditions that may affect the action, interaction and emotional responses

during the refugee adaptive process. Thus, incorporating multiple realities is necessary to develop a thorough conceptual understanding for substantive theory development.

As refugees construct stories to explain and make sense of their resettlement experiences, researchers can analyze the refugee stories to constructively categorize emerging concepts in a systematic way to generate a theory that captures as much of the complexity of refugee resettlement process experience as possible (Corbin & Strauss, 2008). The construction of stories by the research participant and the construction of a conceptual framework by the researcher is part of the co-construction of knowledge that is a unique feature of the constructivist paradigm.

Grounded theory, as a progressive extension of symbolic interactionism, is designed to facilitate co-construction of meaning through the shared expression of one's experiences. For Mead (1934), the reality that humans experience is primarily socially constructed. Symbolic meaning can be applied to objects of interest and expression of that meaning through interaction facilitated by verbal and non-verbal modes of communication. Three fundamental tenets of symbolic interactionism are identified by Blumer (1969):

1. Human beings act toward things on the basis of meanings that the things have for them
2. The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows
3. These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters. (p. 2)

Learning the meanings and values of symbols that refugees apply to their experiences is essential to understanding the subjective reality of their adaptation to resettlement in the U.S. Language is a vital part of how we communicate the symbols that represent our ideas, thoughts, and experiences. It is the contexts, the meanings and the expressions of thoughts and ideas which constitute language. Thus, language plays an important role in expressing the realities of experiences.

Dialogue provides the space for language to take on a form of life. Expression and reflection of experiences and ideas can lead to concept identification and clarification of thought and meaning given to the particular concept(s). Analysis of concepts is optimally performed through collaboration with others (Rodgers & Knafl, 2000). Through collaboration and dialogue, concepts can be better understood and conceptual meaning can be ascertained. A combination of external and internal dialogue gives rise to creative ideas (Meleis, 2007).

Thus, it is through the collaboration of thoughts and perceptions that a collective understanding of the whole can be made. Qualitative inquiry can facilitate increased dialogue with refugees to gain insight into the realities of their experiences and the meanings applied to them. An appropriate method to explore the meaning of refugee adaptation from multiple perspectives is grounded theory.

Grounded Theory: Epistemological Stance. In order to expand the philosophical understanding of grounded theory, the epistemological stance needs to be acknowledged as well. Godfrey-Smith (2003) defines epistemology as the "side of

philosophy concerned with knowledge, evidence, and rationality" (p. 5). Essentially, epistemology is a branch of philosophy concerned with how knowledge can be ascertained.

Glaser and Strauss (1967) challenged traditional approaches to knowledge development at a time when conventional positivist epistemology embraced the idea that science consists of universal and absolute truths based upon description and explanation of empirical facts (Mautner, 2005). The discovery of grounded theory methodology by Glaser and Strauss (1967) prompted an epistemological shift from a purely positivist view of how knowledge is generated to an expanded postmodern constructivist paradigm. A shared premise of grounded theory and constructivism is that objective observation, prediction, measurement, and control are not the only central ways to understand the world (Strauss & Corbin, 1998).

Bryant and Charmaz (2007) suggest that the development of grounded theory provides credence that qualitative inquiry has "equal significance" in providing a foundation of knowledge to advance science (p. 33). The intent of post-modern constructivist philosophy is not to negate the value of quantitative research tradition, but rather to imply that qualitative research traditions can broaden the depth and breadth of knowledge and understanding as well. Qualitative researchers seek to interpret and understand meaning of phenomena as it is perceived and experienced in its natural setting as a variety of interpretive approaches are used with the intent to make the "world visible in a different way" (Denzin & Lincoln, 2003, p. 5).

Constructive interpretation requires an active role of the researcher in the research process. According to Rodgers (2005), "knowledge has a strong human element in that it is primarily a social construction" of collectively shared meaning grounded upon multiple realities (p. 154). Shared meaning can be acquired through mutual interaction of the researcher and the research participant. Thus, the primary goal of a qualitative approach, such as grounded theory, is to minimize the distance between the researcher and the participant in order to promote collaborative knowledge construction (Creswell, 2007). The researcher is not a mere spectator in the research process, but rather, a valuable contributor to knowledge development as a whole.

Role of the Researcher

I have served as the principal investigator for this study to fulfill the requirements of a doctoral dissertation. I have received a master's degree in nursing with a concentration in homeland security nursing, now known as global disaster nursing, from the University of Tennessee. Additionally, I have 23 years of nursing experience and have gained extensive education and knowledge in global health and social issues such as displacement, and migration.

Reflexivity. I approached the proposed study as a self-reflective being during the data collection and analysis process. As an active participant in the co-construction of meaning with the research participants, the researcher's feelings and emotional responses cannot be negated. According to Corbin and Strauss (2008), *reflexivity* is an important component in qualitative research (p. 31). A considerable amount of emotional work is involved in nursing research, particularly qualitative research, which is often not

discussed or explicitly known (Davenport & Hall, 2011). As the stories of research participants unfolded, I had emotional responses that needed to be acknowledged and recognized. Therefore, I kept a journal to record my thoughts and feelings throughout the research process to use as a valuable tool for the purposes described below:

- Examine the impact of the position, perspective, and presence of the researcher;
- Promote rich insight through examining personal responses and interpersonal dynamics;
- Empower others by opening up a more radical consciousness;
- Evaluate the research process, method, and outcomes; and
- Enable public scrutiny of the integrity of the research through offering a methodological log of research decisions (Finlay, 2002, p. 532)

As the interviews were conducted and the data analyzed, I did experience some "compassion stress" (Rager, 2005). Therefore, I identified a peer mentor who allowed me to debrief after particularly difficult interview sessions. I kept a journal of my thoughts and feelings throughout the study as well as used careful judgment about interview scheduling, striving to conduct no more than one or two interviews per day. I did strive to maintain a balance between research, work and personal life as a self-care strategy to manage the stressors associated with qualitative research.

Sensitivity. Qualitative researchers approach research studies with certain aspects of themselves such a professional experience, education, and knowledge about certain

phenomena that should not be ignored. Prior knowledge and experience with phenomena of interest enables the researcher to have valuable insight to what the data is revealing (Glaser & Strauss, 1967, Strauss, 1987, Corbin and Strauss, 2008). Sensitivity to what is emerging from the data is what Glaser (1978) recognizes as *theoretical sensitivity*. According to Corbin and Strauss (2008), it is the knowledge and experience of the researcher that allows them to understand more completely what theoretical concepts are emerging from the data and the relationships among them. A personal reflection was written as a preface to this study to disclose preconceived ideas, assumptions and biases in an effort to promote transparency throughout the research process.

Training that I have received at the University of Tennessee has prepared me for conducting this qualitative grounded theory inquiry. A doctoral level qualitative research course provided a foundation of knowledge that was used to guide this qualitative research. I have also participated in a grounded theory group that allowed me to gain experience with observing the reading of transcripts, as well as identifying emerging concepts, and constructing relationships among the concepts. Therefore, the experience gained from participating in the grounded theory group prior to conducting this research has increased my sensitivity to theory development and proven valuable for this research.

In addition to the active role of reflexivity and sensitivity, I was, also, responsible for actively recruiting the study sample as well as collecting and analyzing the study data for developing a substantive theory regarding refugee resettlement. As principal investigator, I completed the data analysis and interpretation in conjunction with a grounded theory research group led by Dr. Janet Witucki-Brown. The interpreters for

this study were active participants in the grounded theory research group during the data analysis process as well. Throughout the data analysis process, I was able to journal field notes and memo impressions of the developing concepts throughout the data collection and analysis process. The collaborative analysis process facilitated development of a theoretical scheme that illustrates and explains the concepts and their relationships of Iraqi refugee resettlement.

Study Procedures

Grounded theory was the chosen methodological approach for this study. As the experiences of Iraqi refugees were explored, the method of Corbin and Strauss (2008) guided the approach. A theoretical understanding of refugee adaptation was ascertained by discovering the processes by which Iraqi refugee resettlement happens as portrayed by the perspective of Iraqi refugees themselves. The procedural method was as follows.

Ethical Considerations. Endorsement to recruit study participants was demonstrated by obtaining a letter of support from Bridge Refugee Services, Inc. (See Appendix A). An application for the research study (Form B) was submitted to the Institutional Review Board at the University of Tennessee for review. Approval was obtained after requested revisions to the original submission were made. During the course of the study, two modifications to the original IRB were submitted using the required IRB Form D documentation to request allowance for interviewing small groups of 1-4 individuals if that was the only way participants would agree to an interview and to expand the research participant population to include community partners. Both modifications were reviewed and approved.

Prior to participant recruitment, a male and female interpreter were identified to assist me with translating study documents, serving as interpreters for the research interviews and participating in the data analysis process. Use of an interpreter is a possible threat to maintenance of confidentiality. The use of an interpreter/translator may pose a risk for loss of confidentiality because someone other than the interviewer will be present for all interviews. To reduce this threat, the chosen interpreter or translator was requested to sign a pledge of confidentiality agreement (Appendix B) prior to data collection stating that he/she would not discuss information revealed in the interview with anyone other than the principal investigator.

Informed consent was requested from all participants and all potential participants were allowed to ask questions or discuss study participation with the investigator prior to consent (See Appendix C). The informed consent form was translated into Arabic (Appendix C). Back translation of the informed consent forms was conducted to verify the quality of the translations (Appendix C). If the participant could not speak or read English, informed consent forms were provided in Arabic, the primary language of the refugee participant. The interpreter/translator read the informed consent form to the participant to obtain permission if the participant was unable to read the document in his/her own language.

Privacy and confidentiality were maintained throughout the entirety of the study. Records for the study were kept confidential. All transcripts were identified by code numbers known only to primary investigator. No individual identities have been used in any research reports, presentations or publications regarding the study. All informed

consents, tapes, transcripts and research information have been kept in a locked file and will now be kept in the office of Dr. Susan Speraw, chairperson for the researcher's doctoral committee. All electronic information has been kept on a password-protected computer owned by the principal investigator. Research information has only been available to research personnel and will not be revealed except as requested by the Institutional Review Board or required by law.

Participation in the study was voluntary, and participants were given a choice to have either a female or male interpreter. Participants were free to decline a response to questions that they preferred not to answer. Additionally, participants were allowed to withdraw from the study at any time without penalty. None did so. Participants received a $10 gift card to WalMart after each interview to thank them for their time, regardless of how long the interview lasted.

Reflecting on experiences could have elicited painful memories and emotions; therefore, the researcher was cognizant of crisis intervention debriefing and counseling resources to offer to each participant. I monitored for signs and symptoms of stress related to the expressions of each refugee participant's experiences and Iwas prepared to offer referral for follow-up if needed. In some of the interviews, the participants became anxious or emotionally distressed. The interview was paused to allow the participants to regain composure. The participants were allowed to express emotions, such as crying, and the interviewer offered reassurance. When the interview resumed, the focus of the discussion was changed to a less stressful topic with the intent to return to the difficult topic later if deemed appropriate by the interviewer. The interviewer was prepared to ask

the participant if he/she would like to stop the interview if the distress continued or increased, but none of the interviews progressed to that point. If the participant wished to have stopped the interview, he/she may have done so without penalty. I was prepared to offer the contact information for Helen Ross McNabb outpatient mental health support for follow-up if needed. I did recognize loss of confidentiality would have been a risk if the participant required mental health crisis intervention.

As the study findings are disseminated, I will avoid language that could imply or suggest bias according to age, gender, racial, sexual orientation, or ethnic origin. Pseudonyms are used to protect the identities of all research participants in this dissertation, and will be used in articles submitted for publication.

Study Sample. A purposeful sampling strategy was used to enroll a homogenous sample of participants for the study. Initial recruitment of study participants was conducted at Bridge Refugee Services, Inc. Permission to recruit study participants was obtained from the Bridge Refugee Services, Inc. (See Appendix A).

Upon IRB approval, the study purpose, design, method and intended report of study findings was communicated to all case managers who work at Bridge Refugee Services, Inc. so they could inform their Iraqi refugee client population about the study to support study recruitment. I requested that an informational flyer about the study be posted at the Bridge Refugee Services, Inc. office. Advertisement for the study was in English and translated into Arabic as well (See Appendix D). I also had the opportunity to communicate the study purpose, design, method, and intended use of study findings to

refugees who attended an English as a second language class at Bridge Refugee Services, Inc.

Persons who were interested in participating in the study contacted me in person or through one of the chosen interpreters, by phone at 1-865-309-0968 (password protected voicemail) or by password protected email at ldavenp1@utk.edu. Persons who chose to leave a phone voicemail were greeted with instructions in Arabic and English to leave a phone number and/or email where they could be contacted by the researcher to establish a date/time to meet in person for the informed consent. When a person notified the researcher that he/she would like to volunteer for the study, the researcher requested interpreter/translator to contact the potential participant to set up a date/time for an interview at a location of their choice.

Inclusion criteria for the study sample were as follows:

1. An Iraqi person (male or female) who had resettled in the U.S. as a refugee
2. An Iraqi refugee who had resettled to the U.S. under the auspices of the Refugee Act 1980
3. An Iraqi refugee who had resettled to the U.S. within the last 10 years
4. An Iraqi refugee who could speak English, or Arabic

Selective sampling in this manner was the "theoretical jumping off point from which to begin theory development" (Thompson, 1999). As significant concepts emerged and the developing theory needed further refinement, additional study participants were recruited by asking study participants to recommend persons who could help the researcher learn more about the research questions pertaining to refugee resettlement.

This was consistent with the recommendations of Creswell (2007) who stated that additional participants can be recruited to further contribute to the developing theory. This allowed follow-up on recurring patterns and categories that were central to the emerging theory, and were deemed theoretical sampling and, ultimately, the hallmark of grounded theory (Corbin & Strauss, 2008). Sample recruitment in this manner continued until data saturation was achieved and no additional information was needed to understand a given category. Saturation is defined by Creswell (2007) as the point where one "no longer finds new information that adds to the understanding of a category"; therefore, a point of data saturation has been obtained (p. 240).

Data Collection. Individual semi-structured interviews were conducted face-to-face with recruited study participants in a private naturalistic setting. An Arabic speaking interpreter was present for each interview. Participants were allowed to choose the location for the interview, such as their home, local mosque or local library. The researcher informed all participants that interviewing in public places could pose an additional risk to confidentiality; however, efforts were made to conduct the interviews in a private room at the chosen location.

The informed consent (Appendix C) was provided in both English and Arabic language. If the participant was unable to read, the informed consent document was read in its entirety by the interpreter/translator. Persons who acknowledged agreement to the informed consent were requested to sign the document using their legal names. If a person objected to signing his/her legal name, then he/she was given an option to give verbal consent prior to an interview in lieu of providing written consent. The verbal

consent was audio recorded separately at the beginning of a recorded interview and kept confidential with all research documents.

In order to protect privacy, the researcher requested the participant to provide a pseudonym (nickname or alternate name) that he/she would like to use for identification purposes. This approach was intended to protect the real names of the participants. This is necessary since many refugees have fears regarding their safety. They would not want their real identities known. Even though their identities would be protected, early selection of a pseudonym helped to increase their comfort level. The pseudonym was used for audio recording purposes only. A master list was kept by the researcher that matched the consent name with the recorded pseudonym name and kept confidential with all research documents. To further protect the identity, each Iraqi participant was given a number that will be used in reporting the findings of this research (P1 . . . P29).

During the analysis process, it was determined that recruiting community partners as participants would be valuable to understanding Iraqi refugee resettlement in a broader way. Approval was granted by the University of Tennessee IRB to recruit community partners as participants as well. Additional participants that were included in the study were persons from the community who have a vital role in helping Iraqi refugees transition to resettlement in the U.S. These persons are actively involved as an employee of the refugee agency or serve as a volunteer with community organizations. Support provided by the refugee agency and community partners is a vital component of the refugee resettlement process. Therefore, interviewing employees of the refugee agency

and/or members of the community helped the researcher broaden theoretical understanding of the Iraqi refugee resettlement process.

***Role of interpreters*.** All interviews were interpreted/translated with the assistance of an Arabic speaking interpreter. Participants were given a choice of having a female or male interpreter for their interview. A female and male interpreter was chosen for the study. Both interpreters resettled to the U.S. as refugees themselves and spoke Arabic fluently. They contributed to this research by translating documents, interpreting interviews, and actively participating in the grounded theory research group during data analysis. Their personal experience of refugee resettlement was valuable to data analysis and interpretation. Sensitivity to what the data was revealing was strengthened by having the interpreters present at the grounded theory research group. I learned a great deal of information about Iraqi culture and the refugee resettlement process from the interpreters as they helped to clarify interpretations of the refugee participants' interview data.

The researcher provided training in qualitative interviewing for both interpreters by discussing and reviewing the document, *Interpreting in a refugee context* (UNHCR, 2009) with them. This module included ethical components of interpreting, language issues, role of the interpreter, and strategies for interpreter self-care. It also included training in special aspects of legal requirements, such as mandated reporting of intent to self-harm or harm of others.

The interpreters had a vital role in facilitating communication with the refugee participant. A primary responsibility of interpreters is to remain objective and neutral during the interview process; nonetheless, listening to the stories of the refugee

participants elicited some memories and emotional responses within the interpreters. It was important for me to be cognizant of this when it was occurring. Therefore, I would initiate a debriefing conversation after the interviews and throughout data analysis. The intent was to allow the interpreters to discuss their thoughts and feelings about what they heard, observed and witnessed during the interviews. I also encouraged them to journal their thoughts and feelings as the research study progressed. Self-care is very important for not only the researcher, but the interpreters as well. The interpreters would often express that the stories of the participants were very similar to their own resettlement experience. I had a tremendous responsibility to demonstrate respect and support of the interpreters during these times.

Interview process. The original intent for all interviews was to be individual and face to face. However, as the study progressed this was not always possible. Family and social support is important during the transition of resettlement for Iraqis, and some volunteers requested couple or "family" interviews, and were unwilling to agree unless spouse or other family support was present. Allowing participants to interview in small groups provided them a better sense of emotional safety and security. Therefore, there were three possible forms of interviews:

- **Individual:** This was the preferred format mode, and the one that was encouraged. However, if a volunteer indicated a strong desire to participate, but felt it important to have support person present, the following alternative approaches were allowed:
- **Couple's Interview with spouse or partner**

- **Small "Family" Group** comprised of 2-4 persons. These "family" members could include any combination of grandparent, mother, father, daughter, son, brother, sister, and/or close friend who is considered to be "family"

Whether Individual, Couple or Small Group, only persons who met the inclusion criteria for the study (adult refugees who have arrived within the past ten years and speak Arabic or English) were allowed to participate. A total of 17 interviews (See Table 1) were conducted, with a total participant N of 29 refugees and 2 community partners (Total N=31). Thirteen of the interviews were conducted in the Iraqi refugees' own home and two were conducted in an alternate setting at the participants' request. Interviews with the community partners were conducted at their work place.

Table 1. Interview composition

Type of Interview	Number of Interviews	Number of Participants
Individual	4	4
Couple Interview with spouse or partner	8	16
Small "family" group (2-4 participants)	3	9
Community Partner	2	2
Total	17	31

In allowing for couple or group interviews, there was a possibility that the interviews could have been dominated by a spouse or family member. The researcher was sensitive to this risk throughout the interview process and the issue of dominance was considered during data analysis. Observations of non-verbal language, vocal intonations, physical expressions and gestures, were made during the interview process, and recorded in field notes. The researcher's thoughts and impressions were documented after each interview session.

A demographic profile (Appendix E) was completed for each Iraqi participant. Table 2 and Table 3 provide a synthesis of this data. Iraqis may differ from other ethnic refugee groups in the following domains: English fluency, education and occupation.

First of all, English is taught in the Iraqi educational system and many Iraqis arrive to America with some English fluency. Twenty two of the twenty nine Iraqi participants had some fluency and proficiency in the English language. Refugees from other countries of origin may not have had the educational foundation of English pre-migration; therefore, English fluency may be vastly different than those who migrate from Iraq.

Secondly, Iraqis often have high levels of education prior to resettlement. Fourteen of the 29 Iraqi participants had completed secondary and post-secondary education. In contrast, refugees from other countries may not have this education pre-migration.

The third differing characteristic may be the occupational or career stature. Iraqis hold professional positions in law, engineering, business or commerce; whereas other refugee groups may not hold such positions prior to the migration journey.

Table 2. Demographic Profile of Iraqi Participants

Participant	Gender	Age	Marital status	English Fluency	Level of Education	Length of time in U.S.	Occupation in Iraq	Occupation in U.S.	Employment status	Health insurance	Total number of persons living in household	Total number of children	Total number of adults
1	Female	52	Married	No English	Middle School	4 years	Commerce	None	Unemployed	Medicare	2	1	1
2	Male	44	Married	Some English	Military	2 months	Airplane mechanic	None	Unemployed	Public	5	3	2
3	Female	40	Married	Some English	High school	4 years	None	None	Unemployed	Public	6	4	2
4	Female	28	Married	Some English	2yr college	20 months	None	None	Unemployed	Public	4	2	2
5	Male	30	Married	Fluent English	Bachelor Degree	20 months	Electical Engineer	None	Part-Time	Public	4	2	2
6	Male	54	Married	Some English	High school	3 yrs 3 mths	Tailor	Tailor	Part-Time	Public	5	3	2
7	Female	47	Married	No English	9th grade	3yrs 3 mths	Seamstress	None	Unemployed	Medicare	5	3	2
8	Female	44	Widowed	Some English	6th grade	2 years	Custodial	Custodial	Part-Time	Uninsured	3	2	1
9	Male	25	Divorced	Fluent English	5th grade	2.5 years	None	None	Unemployed	Uninsured	3	0	3
10	Female	25	Married	Fluent English	Nursing school	2 yrs 7 mths	Nurse Assistant	Food Service	Part-Time	Public	6	4	2
11	Female	40	Married	Some English	Middle School	2 yrs 20 days	None	None	Unemployed	Public	5	3	2
12	Male	43	Married	Some English	Middle School	2yrs 20 days	Business Owner	None	Unemployed	Public	5	3	2
13	Male	26	Single	Some English	2yr college	1 month	Social Worker	None	Unemployed	Public	1	0	1
14	Male	28	Single	No English	9th grade	7 weeks	Business Partner	None	Unemployed	Public	1	0	1
15	Male	26	Single	No English	High school	22 days	Blacksmith	None	Unemployed	Public	1	0	1
16	Male	28	Single	No English	8 th grade	1.5 month	Automobile glass repar	None	Unemployed	Public	1	0	1
17	Male	34	Married	Some English	9th grade	1 year	Mechanic	Mechanic	Part-Time	Private	3	1	2
18	Female	26	Married	Some English	3 yrs college	1 year	None	None	Unemployed	Public	3	1	2
19	Female	35	Married	No English	8th grade	3 months	None	None	Unemployed	Public	4	2	2
20	Male	38	Married	Some English	High school	3 months	Interpreter	None	Unemployed	Public	4	2	2
21	Male	37	Married	Some English	College	4 years	Lawyer	Factory worker	Unemployed	Public	6	4	2
22	Female	28	Married	Some English	College	4 years	None	None	Unemployed	Public	6	4	2
23	Male	42	Married	Some English	1 year of college	2 months	Police officer	None	Unemployed	Public	4	2	2
24	Female	33	Married	Some English	9th grade	2 months	Cosmetology	None	Unemployed	Public	4	2	2
25	Female	40	Married	Some English	High school	1 yr 5 month	None	Cleaning	Full-time	Public	3	2	1
26	Male	41	Single	No English	5th grade	3 years	Clothing retail	None	Unemployed	Public	1	0	1
27	Male	38	Married	Some English	8th grade	3 years	Wood factory	Wood factory	Full-time	Uninsured	5	3	2
28	Female	24	Married	Some English	7 th grade	3 years	None	None	Unemployed	Uninsured	5	3	2
29	Female	21	Single	Some English	Middle School	4 years	None	Fast Food	Part-Time	Uninsured	2	0	2

Table 3: Demographic Profile Summary (Iraqi refugees, N=29)

Average Age	35 years	
Gender	14 Female	15 Male
Marital Status	1 Divorced 6 Single 1 Widow 21 Married	
English Fluency	3 Fluent English 19 Some English 7 No English	
Length of Time in U.S. (range)	1 month – 4 years	
Employment Status	2 Full-Time 6 Part-Time 21 Unemployed	
Health Insurance Status	2 Medicare 1 Private 5 Uninsured 21 Public Insurance	
Average Number persons per household	4	
Average Number of Children per household	2	

The researcher informed participants that no child care would be provided. If children accompanied their parent(s) to an interview session, supervision of them was the responsibility of the parent(s). However, there was a private safe play area at Bridge where the parent could easily view the child as he/she played during the interview. If an alternate interview location was chosen, then child care was the responsibility of the parent(s). The researcher provided the children age appropriate coloring tools (crayons, or markers) and paper for their entertainment. Children were free to keep the crayons at the end of the session. Many children were present during interviews conducted in the participant's homes. They quietly played in another room or occupied themselves with the crayons and coloring books provided. If the child entered the room where the interview was taking place, the interview was paused to allow for parent-child interaction and then resumed when the child returned to other activities.

As I entered the participant's homes, I was made to feel very welcome. The Iraqis demonstrated genuine hospitality by offering water, tea or juice to drink and oftentimes a spread of fruit, vegetables and/or sweet treats prior to or during the interviews. I was a stranger and they welcomed me into their environment with a kind spirit.

Participants were informed that the interview would last approximately one hour. Three of the interviews lasted between 30 minutes to 1 hour, twelve of the interviews lasted 1-2 hours and two interviews lasted greater than two hours. As the study progressed and based upon the study findings, the investigator requested an additional interview with one small "family" group that included three individuals and lasted

approximately one hour. The follow-up interview was needed with the group participants to clarify conceptual understanding and interpretation.

Open-ended questions were provided to encourage participants to elaborate on their experiences of refugee resettlement and adaptation. As discussion progressed in the interviews, further questions were posed to explore emerging concepts that arose through the participants' descriptions of their adaptive experiences. The interview with Iraqi refugees began with the following introduction:

> Tell me, as much as you are comfortable sharing with me, your experience of resettlement in the United States.

Additional questions were posed to ask participants to clarify their expressions and to further explore concepts that emerge in the interview process. The preliminary interview protocol that was used to guide the interview process is described in Appendix F. The interview with community partners were conducted in English and began with the following introduction:

> Tell me your experience of working with Iraqi refugees as they resettle in the United States.

During the process of all interviews, observations were made of details such as participant non-verbal language, vocal intonations, physical expressions and gestures, and recorded in field notes. Thoughts and impressions were documented after each interview session. The amount of time required for data collection was determined by data saturation and theoretical sampling.

All interviews with the Iraqi refugees were digitally audio voice recorded. The interviews with community partners were conducted face-to-face lasting 1 to 1 ½ hour each. Community partner interviews were not recorded due to technology failure, but extensive notes were taken with participant permission.

All refugee interviews were transcribed verbatim. The transcription of the interviews was performed by a hired transcriptionist or myself. An Arabic speaking translator interpreted the interviews. Therefore, a confidentiality statement was obtained from both the hired translator/interpreter and transcriptionist to ensure all matters related to the research interviews were kept confidential and private (See Appendix G). Transcripts, audiotapes, informed consents, and confidentiality statements are to be kept in the office of Dr. Speraw for 3 years and then will be destroyed by shredding all paper documents as well as deleting all digital recordings. Electronic computer files related to the research study are to be kept on a password protected computer owned by the principal investigator until the study is completed. At that time, all electronic computer files will be placed on a data storage device that will be given to Dr. Susan Speraw to keep in her office.

Data Analysis. Once individual interviews were transcribed, an inductive process was used for analysis. The central process for analyzing the interview data followed the recommendations of the Corbin and Strauss (2008) model of analysis to deconstruct, conceptualize and re-construct the data in order to thereby develop a core category that captures the story and all the categorical complexity within the data. Data analysis began after the first interview so that beginning emerging concepts could be identified in order

to guide subsequent data collection for theoretical sampling consistent with grounded theory methodology.

As the researcher, I immersed myself in the data to search beyond the surface to gain a deeper understanding of Iraqi refugee resettlement in the U.S. Transcripts of the interviews were taken to a grounded theory research interpretive group at the University of Tennessee College Of Nursing to assist with concept and thematic identification. All participants in the group were required to sign a confidentiality statement.

Transcribed interview data, field notes, and memos were sources of evidence that were analyzed. Memo-ing is an essential part of the analytic process as it is a way to record thoughts and ideas that transpire as data are explored (Corbin & Strauss, 2008). The researcher considered the language that participants used to tell their stories, the metaphors that they used, emotions that were expressed, as well as words that reflected temporal or spatial influences. Also, contextual factors expressed in the data such as social, political, cultural, and environmental influences that either facilitate or hinder actions and interactions were considered in the analytic process. The researcher memo-ed her impressions of the various dimensions that could be considered in the data in order to establish a progressive audit trail of how the concepts, categories, and the thematic story line were developed.

A qualitative data management software system, QSR N-Vivo 9, was used to manage and organize the data into coded categories as well as to document memos of the researcher's impressions of the emerging concepts and patterned relationships among them. Memos were recorded after each analytic session and each memo was labeled with

a concept code. The conceptual labels applied to the memos were reflective of the researcher's interpretation of the data (Corbin & Strauss, 2008). Memos are conceptual in nature and the researcher compared memos for similarities and differences as further analysis continued.

During the analysis process, three types of coding were used simultaneously – open coding, axial coding and selective coding – as the researcher interpreted and constantly compared the emerging concepts, relationships and hypotheses derived from the data. Open coding of the data was performed as interview transcripts were read to distinguish an overall impression of the interview data as a whole; detailed line-by-line readings were performed to identify significant categories, often called "in vivo" codes, that were derived from the words and phrases of the informants themselves (Strauss, 1987, p. 33); and axial coding was performed as provisional categories were identified to recognize and establish relationships and patterns among the identified categories.

At this point, constant comparisons were made to determine similarities and differences of conceptual codes. Conceptual similarities were ordered as one category or theme. As emerging categories were formed, theoretical comparisons and sampling facilitated the further refinement and development of multiple categories. Additional perspectives of community partners were explored to yield rich and relevant information to broaden the expanse of theoretical understanding. Eventually, a core central category emerged that ultimately became the explanatory or theoretical scheme of Iraqi refugee resettlement. All other categories were related to this core category to fully explain the process.

The complexity of Iraqi refugee resettlement was explored to discover the antecedents, contexts, intervening conditions, action/interactional strategies, and the consequences of these strategies in the process (Strauss & Corbin, 1990). Selective coding identified a core central category to explicate the story line, and the derived theory were illustrated in a theoretical model and narratively conveyed to provide an overall impression of the theoretical essence grounded in the research data. As final interpretations were made, the theory was validated against the data, and propositional statements were made.

Credibility.

To strengthen the authenticity of the study findings, steps were taken to ensure the accuracy of the research study findings as follows:

- The researcher's personal assumptions, values and *biases* were made explicit in a personal reflection. The role of the researcher has been clearly explained, and the researcher's interest in the phenomenon has been described as well.
- After prolonged time in the field, the researcher has made an effort to provide *rich, thick description* to convey the study findings. Interpretations of the conceptual categories has been supported by the richness of the data itself
- Variations from the emerging theory were investigated and acknowledged in the theory presentation as a *discriminant finding*.
- A grounded theory expert, Dr. Janet Witucki-Brown, participated in data analysis and interpretation to guide and validate fidelity to the grounded theory method.

- Fidelity to the method of grounded theory was maintained to ensure that theoretical sampling and data saturation was used to determine when the conceptual categories are fully explicated.
- Theoretical conclusions have been shared with the interpreters who are Iraqi refugees for *member checking* to give them an opportunity to comment on the study findings as a way to validate that the conclusions are accurate.

Dependability

According to Creswell (2009), steps must be taken to demonstrate consistency in the analytic approach. Strategies that were used for this research are as follows:

- Transcribed interviews were reviewed by the researcher to ensure that no mistakes were made in the transcribing process.
- The researcher wrote memos after each analytic session to identify codes that could be constantly compared to the data in order to define and redefine the codes accordingly.
- The grounded theory methods and analytic procedures have been explicitly detailed in the study report to allow evaluators and consumers of research to have a clear audit trail of how the theoretical conclusions were reached. The *audit trail* has been illustrated in a descriptive, comprehensive diagram to clearly elucidate the theoretical development.

Equipment

The equipment needed for this study were as follows:

1. Digital recording device
2. N-Vivo 9 data management software
3. Computer (Laptop)

Conclusion

This study provides a foundation of knowledge on Iraqi refugee resettlement upon which a substantive theory has been derived. As a result, future implications for nursing research, education, practice, and policy advocacy can be ascertained. The realities of Iraqi refugees who resettle in the U.S. shed light on the ways in which the process of Iraqi refugee resettlement occurs and how it can be improved for Iraqi refugees who relocate to the U.S. in the future.

Chapter 4

Results

In order to generate a substantive theory, this grounded theory research study was designed to explore Iraqi refugees' perspectives of their resettlement process to the U.S. The primary research questions were designed to provide the freedom and flexibility to explore the phenomenon in depth (Corbin & Strauss, 2008). For this study, the central research questions were as follows:

1. How do Iraqi refugees perceive the process of resettlement in the Southeast region of the United States?
2. What theory explains the process of resettlement for Iraqi refugees who have relocated to the Southeast region of the United States?

The basic social process of Iraqi refugee resettlement was discovered by using a grounded theory and a constant comparative method during data collection, analysis, coding and memo-ing. Open coding was used during line-by-line reading of transcripts to identify "in-vivo" codes derived from the words of the participants themselves. A total of 220 codes were identified throughout data analysis. As interpretation progressed with axial coding and constant comparison, relationships among the codes were further derived from the data. Emerging patterns were recognized and provisional categories were identified as similarities and differences among the codes were considered. Theoretical sampling facilitated further refinement and development of multiple categories. As a result, six distinct categories were discovered from the data including fifteen sub-categories.

Eventually, a core central category emerged that ultimately became the explanatory or theoretical scheme of Iraqi refugee resettlement. A point of data saturation was reached upon analysis of the twelfth interview. A total of 17 interviews were conducted, with a total participant N of 29 refugees and 2 community partners (Total N=31). Analysis of three additional interviews with Iraqi participants was performed, but yielded no new or distinctly different codes. Perspectives of community partners were additionally explored to yield rich and relevant information to broaden the expanse of theoretical understanding.

Theory of Living with the Choice

The substantive theory of *Living with the Choice: A grounded theory of Iraqi refugee resettlement to the U.S.* reflects the complex story line of the process of resettlement for Iraqi refugees. The story begins with the antecedent category of *making the choice to seek a new life*. Upon resettlement to the U.S., the basic social process of *Living with the Choice* involves three stages, *arriving to America* (early agency support), *adjusting to a new culture* (intensive agency support), *seeking self-sufficiency* (agency support withdrawal). As refugees progress through each stage, there are contextual factors, intervening conditions (both facilitating and hindering) as well as fundamental patterns of behavior impacting the outcomes of Iraqi resettlement to the U.S. The consequential outcomes are recognized as either *satisfied with the choice* or *regret the choice*. An inherent condition throughout the basic social process is refugee physical, mental, emotional and spiritual health. Essentially, refugees are living with health concerns as they transition through the process of resettlement.

Each categorical stage explaining the theory of *Living with the Choice* will now be discussed. The encompassing condition of *coping with health concerns* will be addressed as well. Additionally, perspectives from community partners were explored to broaden theoretical understanding and will be discussed. To conclude the chapter, the theory of *Living with the choice* will be compared to extant literature and works of research regarding Iraqi refugee resettlement.

Making the choice to seek a new life

Making the choice to seek a new life is determined to be the antecedent in the theory of *Living with the Choice*. Due to civil unrest and violence that continue to persist, Iraqis make choices to protect themselves and their families. The "choice" is comprised of three parts, *fleeing Iraq* is the first choice that prompts the choice of *seeking sanctuary in neighboring countries* and, finally, Iraqi refugees are *choosing to resettle to America* for a durable solution to meet their resettlement needs.

Fleeing Iraq: The initial choice. The sociopolitical upheaval and conflict that has been transpiring in Iraq for over two decades has provoked many Iraqis to flee in search of safety and security. Living with fear and personal or witnessed accounts of violence, and a desire to escape danger are the common stimuli for *fleeing Iraq*.

Leaving behind unsafe conditions. An Iraqi refugee describes the situation in Iraq as, "It is unsafe and most of the Iraqis want to get out of Iraq . . . It is so messy there (P13). Another reflects upon the situation as, "We faced death every day in Iraq . . . we were fearful because of the morning we might find a dead body across the street or in front of

our home" (P17). An Iraqi refugee remember the intense violence and suggests, "We want to start a new life . . . I hate to see people die . . . and starving in the streets" (P8).

Living with fear. The hostile environment instilled an element of fear in the Iraqis living under such duress. Many were "afraid to walk in the streets and walk freely . . . and I must be careful with each step that I take" (P17). Others expressed worry about the safety of their family and loved ones. Consider the recall of a female Iraqi refugee:

> In Iraq, sometimes a student or child would go to school and he/she would not get back home . . . Some children in Iraq would go to school and maybe they would kidnap them or ask money from their parents (P17)

Another Iraqi described his fear by stating, "Before I could not sleep in my own home in Iraq. Too scared. Someone may take my sons" (P2). The same perspective was expressed by one more Iraqi participant as "Back home (Iraq), we would be concerned when we sleep that someone would break into our home or kidnap our children" (P 11). Additionally, anxiety related to fear is made explicit in this Iraqi woman's personal recollection:

> I was lonely and stayed in the house most of the time . . . I was afraid of the militia that they would kidnap me and my daughters. I noticed some rockets shot at the airport and I was afraid he (husband) would get hurt. I was afraid of the bombs . . . We have lived in Iraq with fear and worry even at holidays we did not have the opportunity to celebrate with our family and friends. This made me very stressed (P19)

Unfortunately, fear became a common source of stress for Iraqis that manifested itself in not only adults, but children as well. One Iraqi mother's account reveals the impact of fear on her child:

> I can't forget those times in Iraq. Our child feels fear all the time. He will not sleep by himself. Even a balloon, he is afraid of that especially if he bumps it and it pops. During his birthday, we wanted to get the balloons and balloon pump, but he was afraid of that. Once when he was little, a bomb exploded. All the glasses in our home broke. Since that time, he has been afraid of everything (P18).

Fear was often the stimulus to consider fleeing Iraq as a result of day to day acts of violence. Protection of themselves and their families became a priority initiative of Iraqis during these tumultuous times.

Personal or witnessed accounts of violence. Kidnapping was frequently discussed in the interviews and was often experienced personally or witnessed. One Iraqi recalls his unique story:

> They kidnapped me for 18 days. They wanted $100,000 from my parents. We did not have that kind of money. The kidnappers burned my parent's car to punish them and they kidnapped me. After 18 days with the kidnappers, they covered up my eyes so I could not see anything. They hit me with the weapons and they shot me . . . a stranger found me in the street and took me to the hospital because I was bleeding. They did some emergency stitches at the hospital (P14).

A male Iraqi refugee, detailed his eyewitness account of kidnapping as:

> One of my experiences is, they tried to kidnap as many people as they could . . . they even went to a place of higher education and took a couple of employees. Nobody knows where it ended with them. I mean the employees that they took, they never got back . . . we found places to hide . . . maybe there are more than thousands of such situations . . . so unsafe. It made me ready and willing to leave (P5).

For this reason, Iraqi refugees "want to start a new life". Not, "the hard life" they left in Iraq. To start a new life, the deliberate choice to flee Iraq had to be made. It was not an easy choice for Iraqis because "it was hard to walk in our way without knowing the end of it" (P5). Uncertainty prevailed as the choice to flee was made. "90% of our people went separate ways without knowing the end of it. So, it was hard" (P5).

Seeking sanctuary in neighboring countries: The second choice. One option for Iraqis who made the decision to flee Iraq was migration to neighboring countries. *Seeking sanctuary in neighboring countries* was the process that many Iraqis took to escape further violence and persecution. Twenty seven of the twenty nine Iraqi participants in this study chose to migrate initially to Jordan, Lebanon, Syria or Turkey. The decision to leave Iraq was often sudden with very little time to gather belongings, collect the documents they needed or say "goodbye" to their families and loved ones. Family separation was common. An Iraqi refugee couple spoke of their circumstance as,

> When we had to leave Iraq . . . both of us fled, but to different places . . . We had to change our address three times because someone threatened us .

> . . It was hard. It was hard. I (wife) was crying all the time . . . because I want to join my family again who were in danger. I wanted to join them again . . . I just wanted to join them (P5).

Internal struggles with family separation began even as early as upon deciding to leave their homes. Yet, the choice to escape to neighboring countries was articulated by an Iraqi gentleman to be the first of many steps to "start our life from zero" (P21).

Starting a new life. All Iraqi refugee participants indicated that they fled to neighboring countries, such as Jordan, Lebanon, Syria or Turkey. No participants reported that they resided in camps while transitioning from Iraq to the neighboring country. Home in the new country was commonly described as an "apartment" or "rented house".

This new start was a welcome reprieve from some of the oppression experienced in Iraq. Consider the following circumstance of an Iraqi couple,

> When we were in Iraq, my wife is Shiite and I am Sunni. We could not live with either community because we would be threatened. They would force us to get a divorce. We flew to Jordan to escape the oppression. (P23)

Preserving the integrity of their union as a couple was a priority; therefore, seeking asylum to a neighboring country was thought to be a viable option. Exploitation of this nature in the second country was not discussed in the interviews; however, two participants disclosed that bribes were often solicited by government officials or employees to "make it easy for you . . . if not, we will make it harder for you" (P15).

Experiencing adversity. Soon after relocating to a bordering country, Iraqis began to experience struggles. Turkey and Lebanon had restrictions on employment, particularly since the Iraqis had not established residency status. The following perspective is an example of difficulties Iraqis encountered:

> We flew from Iraq to Turkey . . . the healthcare in Turkey is so expensive and there are many refugees there . . . it is so expensive and the refugees cannot afford much. It is so cold there. Winter is so cold in Turkey and we have to pay for coal or wood for heat and it was so expensive. The services from the U.N. were very little and did not cover everything, even the rent. Turkey tries to help, but it is very few that get help . . . there is a law in Turkey that foreign refugees cannot work at all. So, we could not get a job there (P6).

Iraqi refugees had many recollections about the complexity of establishing residency and gaining employment in bordering countries: "It is illegal to get a job there if you do not have residency" (P27). As a result, some jobs were obtained in "secrecy to have money for food and housing" (P27). Another describes his experience:

> I flew to Turkey. I stayed in Turkey for two years. So, I lived some good and bad days in Turkey. The good days in Turkey are because Turkey is very beautiful. I don't speak Turkish; therefore, the bad days were due to that. I worked very bad jobs there. (P16)

Obstacles, in this respect, created discontent among the Iraqis who were hoping for a better future and needing physical/mental relief from stress. A memory of this time was mentioned in an Iraqi's verbal reflection as:

> When we lived in Jordan, we feel very afraid because we had no legal residency and the police would follow us sometimes. They kinda controlled us and we could not get a job because we had no legal residency. It was very stressful for me because I could not get a job and it was forbidden there. (P17)

For this participant, life was never easy despite the hope that things would be better. "During our stay in Jordan, the Jordan people kinda hate the Iraqis because they caused problems there. I felt uncomfortable because of that in Jordan" (P17). In the midst of adversity, Iraqis began making additional choices to facilitate resolution to their plight.

Choosing to resettle to America: The third choice. In order to address the problems they were facing, the Iraqi refugees sought to pursue resettlement to a third country as a durable solution. Iraqis made careful decisions to resettle to a third country despite the stress of uprooting their families and themselves yet again. Determination to seek a better life was the impetus driving the choices made by the refugees.

I began this research with an assumption that refugees were not allowed to express a preference for a resettlement country. However, this assumption was challenged during one of the grounded theory research group sessions. The outcome category of *regret the choice* was emerging from the data and it was determined during data analysis as relationships among the categories were explored that refugees actually do have an

opportunity to make a choice to resettle to the U.S. The interpreters reiterated that a choice was permissible.

Individuals seeking resettlement must complete an application for resettlement to a third country as required by the UNHCR and have an appropriate assessment performed to verify refugee status and confirm resettlement need. I researched the application process for refugee resettlement and confirmed that indeed considerations of the refugees' preferences for resettlement country are taken into account (UNHCR, 2011b). Choices are not guaranteed, but refugee input is permitted and preference is documented on the refugee registration form (RRF). Once the interviews are conducted by UNHCR personnel and the need for resettlement is confirmed, referral for resettlement is made to a suitable resettlement country.

Why America? Along with the United States, there are twenty-six countries worldwide that have developed refugee resettlement programs (UNHCR, 2012b). During the interview process, I began to ask, "Why America?" Iraqi refugees in this study expressed certain ideals and expectations for choosing to resettle in America. A single Iraqi mother of two children replied, "In Syria, they told us we would have a better life in America and get help" (P25). Furthermore, the Iraqi refugees talked about the U.S. as the "land of the dream" or the "land of opportunity . . . we came to work, to build, to get a better future for us and our children" (P23). "To get a job" was an overarching response in most interviews.

The Iraqi refugees talked openly about their dreams about America. "It was a dream to come here . . . I dreamed about making friends and meeting new people to make a better life". Consider one participant's response:

> It was my dream to get here to America to have a good life, a better life to make my dreams come true . . . it was my dream to come to America so that I could rest and relax (P13).

To get "physical and mental relief" was one Iraqi's explicit expectation and "the hope was that help could be received upon resettling" (P1).

Enduring the time. The processing time required to review resettlement applications can be very lengthy. Responses from the Iraqi participants reveal the wait time extended from at least one year to six years to receive approval for resettlement. According to UNHCR (2012b), the approval process depends upon the quota set by the receiving country. Unfortunately, the number of refugees needing resettlement far outweighs the number of available places. Waiting was described as "stressful" for the Iraqi refugees who were struggling to provide basic needs for their families and themselves. One Iraqi stated, "We live in this day and unsure if there would be a tomorrow" (P5). Once approval had been obtained, Iraqi refugees typically waited an additional one to two years before a plan was in place for actual travel to the approved resettlement country.

Going to America. When Iraqi refugees were notified of the concrete arrangements and itineraries for coming to America, several participants described candid emotions they felt at that moment. "We were so happy (laughing). We started throwing clothes in the suitcases because we are happy and left half our belongings there. We were

surprised" (P23). Additionally, one Iraqi male revealed his thoughts and feelings about the news, "My very first feeling, I have been very happy. I will not lie to you. When they first tell me you are leaving in the morning to America, I danced in the streets. That was in Syria" (P9). Likewise, another Iraqi participant suggested:

> I was so happy. I slaughtered a lamb when I got my visa to come to the U.S. It is our culture when we receive something so good. I cooked the meat and shared it with the people around us (P19).

News of *going to America* was a celebratory time and a season of joy for the Iraqi refugees.

Uncertainty still prevailed, but hope remained that life would indeed become better. The Iraqis were expecting physical and mental relief, a healthy environment where they could feel safe and secure, to make new friends, and to ultimately have a better future for them and their families. Figure 2 illustrates the conceptual relationships associated with the antecedent category, *making a choice to seek a new life*.

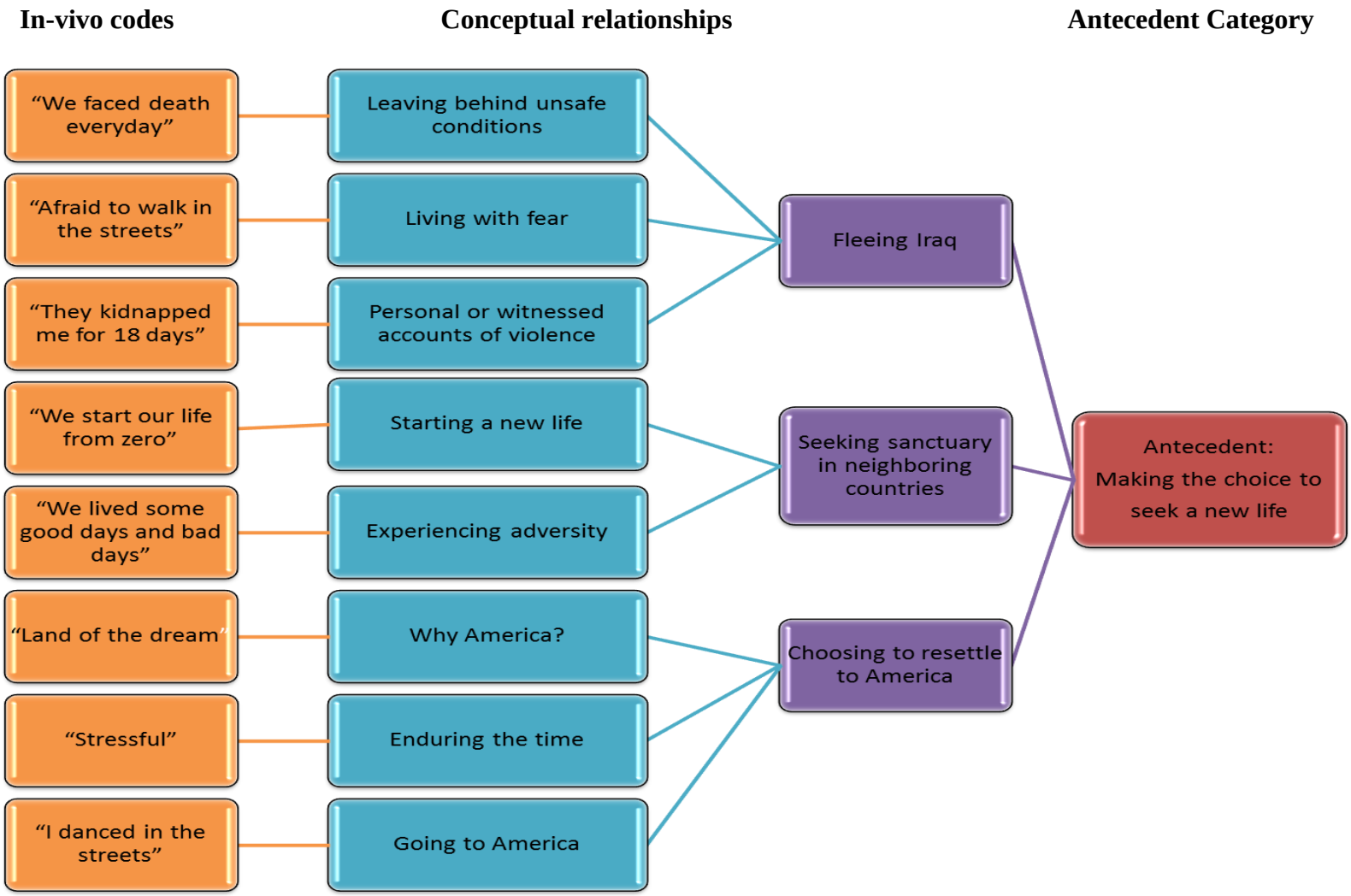

Figure 2: Antecedent category illustration

Living with the Choice

Resettlement to America was methodically chosen by the Iraqi refugees as a means of achieving a new life. During data analysis and interpretation it was determined that *living with the choice* was the core category in the basic social process of Iraqi refugee resettlement to the U.S. Three stages of *living with the choice* include, *arriving to America* where early contact with the refugee agency began, *adjusting to a new culture* where intensive agency support is expected and *seeking self-sufficiency* as support from the refugee agency is withdrawing. Iraqi refugees encountered contextual and intervening conditions that impacted their progress during each transition and affected the overall outcome of resettlement satisfaction. Additionally, Iraqi refugees used strategies to helped them persevere during the process. *Living with health problems* was a categorical pattern that refugees faced throughout the resettlement transition. The resulting outcomes of the entire process were categorized as either *satisfaction with the choice*, or *regret the choice*.

Arriving to America (Early agency support). New York, New York or Chicago, Illinois were the common ports of entry to the U.S. for the Iraqi refugees. When I asked the questions, "What has helped you as you have resettled", many Iraqi participants began to talk about their course of arrival. Both positive and negative encounters were conveyed; therefore, I began to ask, "What is the meaning of arrival to Iraqi refugees"? I then asked more specific questions, such as "how were you greeted upon arrival" to explore the conceptual properties of *arriving to America*. Two conceptual categories interpreted to be dimensionally related to Iraqi refugee arrival are *landing at the airport* and *reaching their new home*. Early agency support transpires during this transition stage; therefore, time is a contextual factor that frames the process of

resettlement for Iraqi refugees. The Iraqi participants often used words, such as "when", "after" and "before" that Corbin and Strauss (2008) consider as conditionally related to context and process.

Typically, new arrivals were greeted by a representative from the International Organization for Migration (IOM) who completed additional paperwork. Perceptions that they were different and, perhaps, devalued began soon after arrival to the U.S. The Iraqi refugees indicated that they were "afraid" and "scared" as they initially arrived to the U.S. because "I look different than everybody else", "I did not know anybody" and "I could not speak English". An Iraqi participant remembers explicitly the process of his first arrival, "The IOM person met us when we arrived in Chicago. She yelled at me because I had not completed the paperwork . . . she did not speak Arabic. She seemed very nervous and upset" (P19). Another Iraqi voiced a different experience: "the IOM employee met me when I arrived and treated me so nice . . . he gave me food, something to drink and helped me a little with my paperwork" (P14). Being a stranger to America, Iraqis are very sensitive to how they are greeted and welcomed.

Landing at the airport. After an overnight stay in the portal entry city, the Iraqi refugees are then flown to their resettlement destination. The Iraqi refugees spoke openly about the welcome they received at the airport in the resettlement city. An Iraqi refugee distinctly remembers his arrival as, "When the case worker from the refugee agency met me at the Knoxville airport, it was so good . . . he helped me with my luggage and gave me some cash money to get some food" (P19). He also described his arrival as,

> It was almost unbelievable for us. Do you know the difference between hell and paradise? That is what it felt like when we arrived. We had come from hell to

> paradise . . . our sponsor met us at the airport and brought us a flower and a basket of fruit . . . it was so nice (P19).

The welcome they received seemed to provide a first impression of what America or the resettlement city would be like. Greetings from a case worker, refugee agency employee, sponsor or community partner was received positively in the interviews where Iraqi refugees spoke in detail about their arrival. One female Iraqi participant expressed unequivocal feelings about the process of her welcome,

> I was seven months pregnant when I arrived. At the beginning, I was very afraid because I was pregnant. I had nobody to take care of me. When we got to the airport, one of the churches welcomed us and they brought more than 30 persons with them to welcome us. They took good care of us. That made me very happy and comfortable. Half my fears were gone because so many people welcomed us (P22).

As the interview with her and her husband progressed, they showed me a photo album with pictures of them and all the persons who welcomed them. They were excitedly showing me all the photos. I observed them laughing and smiling as the pictures were shared. It was evident that the reception they received was very meaningful to them. They now refer to those who welcomed them as "friends . . . our American friends". While reminiscing about the photos, he remembered,

> They had an interpreter and they said they would help my wife . . . the first day we arrived was my birthday and they celebrated my birthday. It was so nice. It made me feel very happy and very comfortable (P21).

Typically, the case worker from the refugee agency greeted the refugees' upon their arrival. Those who were greeted as well by the hospitality of sponsors or community partners appeared to remember it as positive feature of the arrival process. Early contact with the refugee agency personnel and members of the community is a facilitating condition that sets the stage for how the succeeding resettlement process unfolds.

Reaching their new home. Iraqi refugees came to America with the expectation to find a home where they could feel safe and live comfortably. Upon arrival, the case worker or designated personnel from the refugee agency accompany the refugees to their new home. An apartment is chosen by the refugee agency for the refugees prior to their arrival. Early interviews were conducted with Iraqi refugees who had been in the U.S. greater than one year. Participants of this nature spoke of reaching their new home in a positive manner. One Iraqi woman indicated, "I like the place that I live in" (P3). Another Iraqi couple remembers,

> When we first came to the U.S., we found an apartment with simple furniture. It was better than nothing . . . we thought we would be in a camp. But, we got here and had an apartment with furniture. I was so surprised. I thought I would get nothing and would be homeless. This apartment with simple furniture was wonderful. (P4 and P5)

Reaching their new home for these participants exceeded their expectations.

Nine of the "new arrival" Iraqi participants, who had resettled to the U.S. less than one year prior to the interviews, were particularly vocal about *reaching their new home.* During data analysis, it was interpreted to be a source of stress for them. Therefore, I began to explore their alternative perceptions more in-depth.

Safety was a conceptual code identified in an interview with an Iraqi gentleman who had been in the U.S. for 2 months. He stated, "Before I could not sleep in my own home in Iraq . . . Now, for the first time in a long time it is safe . . . Here it is safe" (P2). His reference to "before" and "now" also signifies the contextual nature of time for the Iraqi refugees. He had welcomed the interpreter and me into his home and he referred to his home as "safe". However, I observed him locking the door as soon as we entered his home and he checked the sliding patio door to make sure it was locked prior to beginning discussion with us. I reflected upon this as I made journal notes after the interview and I noted the question, "Does he really feel safe?" Also, I questioned, "How did reaching his new home make him feel safe"? Safety, as interpreted, is a contextual dimension that Iraqi refugees used to portray meaning to their arrival.

In order to expand my understanding, I explored what safety was like for the other "new arrivals" when reaching their new home. Not all Iraqi refugees felt safe in their new homes. An Iraqi mother claims,

> I stay with the children and play with them. We can't take them out because there are not safe places for them to go. Here there are no nice places or parks. We don't know the way. We feel like we are the lower class of society. (P24)

Another Iraqi woman, who is a single mother of two children, advised,

> We came here looking for safety and security, but we did not find it . . . I had taken pictures of the apartment showing how unhealthy it was. Also, it was not in a safe area. It seemed like a compound where lots of criminals lived . . . We do not get out of the house. I have trouble sleeping or feeling comfortable. (P25)

Living in neighborhoods that were perceived to be unsafe became a source of stress for the "new arrivals". In contrast, some Iraqis reported feeling safe in the U.S. A male Iraqi participant reports, "It is very safe for us here" (P19) and another indicates, "The U.S. is safe for us to live . . . the situation over there (Iraq) was so dangerous" (P 4).

Additionally, the interior aspects of their new home were profoundly influential on the perceptions of Iraqi "new arrival" refugees. Concerns about the interior of their apartment were discussed openly during the interviews. Consider one Iraqi male's perspective,

> When I got here, they rented me an apartment . . . The carpet was burned. The drain of the shower was not working. It is not a good place to be. There are lots of insects and pests. (P13)

Another Iraqi offers his view as, "I was so excited about this welcome and then I lived in one of the apartments that they gave me. The apartment was not too good. There were a lot of insects and pests" (P14).

Living conditions, both interior and exterior, were interpreted to be a contextual dimension of *living the choice* of resettlement to the U.S for Iraqi refugees. How the living conditions are perceived influences the contentment of resettlement for the Iraqi refugees. After reflecting on her experience, an Iraqi woman states,

> This place that we live in is bad, but there are worse places. We don't want a castle, but just a better place than this. They said we must live here and follow the system. Why do we have to do that? . . . I was oppressed in my country and came here for a better life. We escaped that country and now are in the United States. Still we are oppressed. (P24)

Oppressive living conditions can exacerbate further stress, fear and anxiety for Iraqi refugees. As a result, feelings of distrust and discrimination can develop.

The "new arrivals" began comparing their "new home" experience to oppression confronted in the country of Iraq. An Iraqi male suggests,

> I feel I am oppressed. I feel they are discriminating. They put Christians in a different place than the Muslims. They try to make it sectarian basis . . . They live in the West and we live in the East. Sunnis are given different accommodations than the Shiites. They try to segregate us. We are here to get rid of that discrimination. The U.S. is to be the country of freedom. Why do they do that? Our dreams are all going away. There is no dream that we expected come true . . . We have found discrimination and this has astonished us. (P23)

The inability to choose their home location was a source of frustration communicated in the interviews with the "new arrivals". To this point, Iraqi refugees were allowed to express their preference to resettle to the United States; however, they now perceived their preferential choice for residence was no longer considered valuable upon their arrival. Consider one Iraqi male's perspective,

> I feel like they fool me. I am smart and can manage my life. When I get here, I feel like they fool me and they have control not me. I feel like I am lost because I have no control and cannot manage my life . . . I hope I can get back to Iraq soon. I feel like I made a bad decision to come here. I feel I made a wrong decision by coming here. (P19)

Another Iraqi participant stated,

> I flew from Iraq to the U.S. I came through Jordan then France and then to the U.S. At that time, I did not know if the apartment would be good for me. (P14)

Federal, state and local agency policies may not allow the Iraqi refugees to choose their housing; therefore, this is an intervening condition that impedes the Iraqis' resettlement satisfaction. A more positive outcome may result if the Iraqis are allowed to participate in mutual goal setting for their new home.

Rather than just complain, an Iraqi refugee offered a solution by suggesting,

> Put the refugees in a special place like a hotel or something like that to give them an opportunity for a specific time so they can get a better place that they can find. Not just rent a place that they don't want to live in. (P15)

Another suggests, "I suggest renting an emergency or temporary place until I can decide what would be a good place to rent. It is not appropriate to put a refugee somewhere that he or she would not like" (P14).

Reaching their new home and the appraisal of that home's living condition is interpreted to have a primary conceptual relationship with the early phase of *living with the choice* that, in turn, has an overall beginning influence on the evolving process and the consequential outcome. Allowing the Iraqi refugee an opportunity to express their preference or select a place of residence from certain options can alter their perceptions of accommodations as a hindering condition, turning this into a strategy they can use to manage their life circumstances. The resulting outcome may be a renewed sense of purpose to control their own destiny when starting their new life.

Adjusting to a new culture (Intensive Agency Support). Contextually, the next phase of the process of *living with the choice* involves intensive agency support that typically begins 2-3 days after arrival to their new home. Iraqi refugees begin to take part in the services the refugee agency offers, including case management services, job club for employment assistance and English as second language (ESL) training. Support services are provided at the agency and the Iraqi refugees are provided a certain amount of bus passes to help with transportation to gain access to the services they need. Two concepts that were mentioned in every interview with the Iraqis and that are relevant to this dimensional stage are *learning the language* and *seeking employment*.

Learning the language. At this point in the process, learning the language is a critical component of adjusting to the American culture. Iraqi refugees primarily communicate using the Arabic language; therefore, learning the English language can facilitate better communication as they adjust to the new American culture. Although learning the language is a critical component of their resettlement process, it is challenging at best. Of the 29 Iraqi refugees interviewed, 7 did not speak English, 19 spoke some English and 3 spoke English fluently. Those who did not speak English included two persons who were age 47 and 52, four new arrivals who had only been in the U.S. less than 3 months and one Iraqi refugee who was somewhat illiterate in the Arabic language as well.

I had the opportunity to attend an ESL class at the refugee agency prior to beginning the interviews with the Iraqi refugees. There are two types of classes that are offered. One for the beginning student and one for the more advanced student who has had some English language training prior to resettlement. I attended the advanced class that included five Iraqi men. Word

recognition, sentence structuring and reading comprehension was covered in the ESL content that day. Although I did not specifically ask questions of the Iraqi class attendees that day, the observation experience sparked my curiosity for how the Iraqis perceive learning the English language. I began to ask more directed questions during the interviews about learning the English language and how the process was for them.

Struggles with learning the English language were a paramount concern. One Iraqi woman who had been in the U.S. 4 years states, "I speak very little to no English and am older" (P1). Another older gentleman admitted,

> I don't read and write . . . I am illiterate in both Arabic and English . . . I went to the ESL classes but I did not understand anything. I am not even literate in the Arabic language and I did not even know the basics. I really need to learn basic knowledge. I have been here three years and still do not know any English. It would be good to have a native speaker to help the refugees' transition to the English language. (P26)

Additional hindering conditions were described as,

> They try to teach the full sentences, they must start with A, B, C, and D because I can't speak English. Ninety percent of refugees are from Iraq so they have to bring them an Iraqi teacher to teach them the language. I could not understand anything in the ESL classes. How could I understand the words if I cannot understand the A, B, C or D? (P14)

Problems associated with learning the English language are considered conditions that impede their resettlement transition. Not knowing the language is deemed by one Iraqi woman as an

encumbrance to her ability to communicate particularly when seeking healthcare in the U.S. Consider her perspective,

> The language is the hardest thing to be here. It is very difficult to communicate with people. This is the major barrier that we faced. I used to visit a special doctor for my pregnancy. I had no interpreter. One of my friends tried to help me by going with me to my appointment. She then quit because she did not have time for that. I tried to get an interpreter, but it is very hard. The doctor has no interpreter in her office so I tried to communicate with the doctor myself . . . I know some English and can understand her. Not completely, though. I cry a lot because of that. I have a problem with my thyroid and the doctor gave me a prescription. I did not know that I had to take a pill every day in the morning. It was for one month that I did not get my pills. I did not know that I had to take the medicine immediately . . . she got the nurse to call my friend. She asked my friend to tell me that I need to take the pills. (P18)

Learning the language has many challenges; however, Iraqi refugees identified strategies to help them despite the complications they encountered. The question, "who helped you?" and "what resources helped you learn the English language?" allowed the Iraqi participants to reveal specifically who and what source of help was used to overcome the many barriers. One Iraqi woman indicated, "I met a lot of friends at church . . . they help me know how to read and write and learn English" (P10). Another Iraqi woman stated,

> I have many friends. Some American and some Iraqis. Many American friends have helped me . . . They send me teachers to help me learn English. One of the

> Americans has a daughter that teaches English and she helped me during the school year. The American women help me learn English. I am old so it does not come easy for me. Sooner or later, I will get it. I try to learn words from my daughters and son. They speak English very well. They help me understand what everyone is saying. (P3)

Iraqi participants used technological resources, such as Google ® translate, to help them understand forms of communication, such as information sent home from their children's schools. Interaction with their own significant others, also, provided a source of support. An Iraqi woman discusses the support her husband who spoke fluent English provided to her,

> I cannot speak English and it was very stressful for me. I feel like I could not communicate with people and it was very stressful for me. My husband was very supportive and encouraged me. He told me we are here to have a better life for our children and it helped me. I used to get some school to learn English and some of the teachers tried to help the ESL students and I felt better. During this time, I found a job and was very happy. (P4)

Action and interaction strategies were used frequently by Iraqi refugees to learn the English language. Competency is not often formally measured, but it is interpreted that Iraqis consider job attainment as a measurable outcome attributed to their English proficiency. Therefore, learning the language is vitally important to gain employment and acquire other opportunities to create a better life for themselves. "We came here to work, to build, to get a better future for us and our children" (P23).

Seeking employment. Finding a job is a priority for Iraqi refugees. Intensive agency support is offered for a limited period of six to eight months. During this time, the refugee agency offers a job club where employment opportunities are communicated and pre-employment training is acquired. In an effort to prepare the refugees for entering the workforce, the refugee agency offers training in basic interviewing techniques, job etiquette, how to apply for a job and job safety. Assistance in completing job applications is offered as well for those who cannot read or write English.

Finding employment in an already burdened U.S. economy is very difficult for Iraqi refugees; therefore, securing a job requires continual persistence until a job is obtained. Of the 29 Iraqi participants interviewed, 21 were unemployed, 6 had acquired part-time employment and 2 were employed full-time. The refugees' occupations in Iraq were typically professional in nature, such as engineering, business, law and social work. Trade-oriented occupations were held as well, such as blacksmithing and mechanics. However, general employment obtained in the U.S. was factory, custodial or food service related.

During the period of intensive agency support, Iraqi refugees are actively seeking employment. An Iraqi male who had been in the U.S. for two months stated, "My only burden now is to find a job" (P2). Although finding a job was burdensome, at least one job per household was typically acquired during the six to eight month time frame where agency support was greatest. Three concepts, *poor working conditions*, *discrimination* and *employment stability* were commonly discussed during the interviews and determined to have conceptual significance to the category, *seeking employment.*

Poor working conditions. Iraqi refugees had expectations of finding a job when resettling to the U.S.; however, the working conditions of available employment were a surprise to them. An Iraqi gentleman offered his perspective,

> The surprise is when I worked for the factory. In every place there are negative and positive points. The negative was when I worked in the factory itself . . . as soon as they approve your application they just tell you there is your job and go do it . . . It is unhealthy and unsafe . . . So I am surprised the health institutions are not watching over these people. I am sure if someone would come to observe, they would shut it down . . . They sell drugs everywhere there inside the factory. Illegal drugs primarily. The "weeds" and other illegal drugs. Marijuana and others. They use them while they work. The forklift person . . . I can't imagine why he would be high and still be working. (P12)

Behaviors observed in the American workforce took this Iraqi male by surprise. For this person, no safety training was offered prior to starting the job and safety equipment was not available, such as ear protection and masks to protect from dust particles. I explored this issue with other Iraqi participants who confirmed their circumstances were very similar.

Poor working conditions were evident in another Iraqi's reflection,

> Now I have a job in the refrigerator. They call it the freezing cooler or Alaska. It is the kind of job that is so bad that a homeless person would not do. You are forced to do this job or you lose your assistance. It is cold. I lift greater than 130 pounds constantly. It is dirty. The hours are not stable. Sometimes you work 13 hours and sometimes 4 hours. You start at 4 am. I have to get up at 2 am to get to

> work. When you get back home you are tired and you take one whole hour thinking how will I make it to tomorrow . . . It is a job in the cooler. We work all the time inside the cooler. They have buckets of tomato paste inside the cooler that we have to move . . . my health is bad. I have pain in my back. (P13)

Another Iraqi who works in the same factory suggests,

> It is not like it is a special job. We do not get training. They just tell us to go to work. It does not need a special skill. It is just a physical job that does not need special training. There is no safety training or safety equipment. Our shoes are not proper to work in the environment. We have to wear layers of clothing. There should be certain kinds of clothing and shoes to work there. There are no gloves, glasses or safety shoes. We bring our own gloves. This kind of job is done by people who have a criminal history not for someone who has a degree and is trying to start a new life. (P14)

The word, "criminal", is a symbolic term that often has negative connotations. One may consider a "criminal" a "bad person" or "person who did something wrong". I wondered, 'Does working under such dire conditions make Iraqis feel like they may be labeled criminals? Is this a way they are stigmatized and, perhaps, marginalized when resettling to the U.S.?' In an effort to explore this further, I recognized other Iraqis recalled situations where they perceived discrimination when seeking employment and in their workplace.

Discrimination. A standard form of modest dress for Iraqi women is a head scarf called, *hijab*. It is symbolic attire for Muslim women and is part of their cultural heritage. Iraqi women

have experienced forms of discrimination when they wear their headdress when seeking employment. One Iraqi woman recalls,

> He asked me to take off my scarf when we went to get my ID . . . it made me very stressed. I had heard America was a free country and why did they ask me to take off my scarf to take my picture? (P19)

For this Iraqi woman, being told to "take off my scarf" was insulting and victimizing. The scarf is a part of who she is; therefore, taking off the scarf is interpreted to be comparable to losing her cultural identity and is, essentially discrimination.

Another Iraqi woman experienced the same form of discrimination when seeking a job and it caused her to decline employment. She indicated,

> I got a job . . ., but they told me I didn't keep it because I am wearing this veil (headdress). I did not know what to do . . . getting a job was important to me, but not easy . . . For me, it is difficult because it is my daughter now that has to work instead of me. (P1)

Giving up the scarf was interpreted as not a viable option for this Iraqi woman; therefore, preserving her cultural heritage took precedence over keeping employment. Finding a work environment where cultural differences are respected and valued is very hard. Conflicting cultural values and discrimination can evoke acculturative stress for Iraqi refugees as they cope with the employment process in the U.S. Such duress can threaten the stability of their employment status overall.

Employment stability. Loss of job may occur due to a decrease in demand for production or the work may have been temporary status only. However, jobs are also lost due to

misunderstanding or miscommunication, especially when discrimination is perceived to be present. Discriminatory work environments can curtail the stability of employment for Iraqi refugees. Consider one Iraqi's perception,

> They had forklifts that lift the pallets. The forklift driver tried to push some of the pallets to make it closer to him. He hit them very hard that they hit me quite a distance. They fell on my arm. I got treatment for two weeks. The driver was high. They did not question or test him. They did not change his position and allowed him to continue. They told me it was my fault and I made the mistake. A month later, they had a decision to lay off extra workers and I was first on the list. So, it was me because I talked to the manager that it was his fault. They decided to lay me off instead. (P12)

An atmosphere of alleged bias and prejudice can create an unhealthy work environment, increase stress and anxiety, and can provoke the Iraqis to quit their job out of frustration and exasperation. Likewise, losing their job because of misunderstandings or miscommunication can leave the Iraqi weary and disappointed. It is very difficult for an Iraqi to find additional employment after quitting, or losing their job, particularly when agency support is withdrawn.

Becoming Self-sufficient (Agency Support Withdrawal). This is the last stage of *Living with the choice*. While facilitating refugee resettlement in the U.S., the refugee agency strives to empower the Iraqi refugees to achieve self-sufficiency by assisting them with learning the language and finding employment. Nonetheless, the transition from intensive agency support to withdrawal of assistance was found to be distressing for the Iraqi refugees. *Unemployment* and

not knowing the laws were two prominent concepts related to their distress of becoming self-sufficient.

Unemployment. Iraqi refugees whose length of time in the U.S. was less than six months at the time of interview were particularly vocal about their fears and anxiety as they were approaching the six to eight month target date. One particular Iraqi male who was reaching the benchmarked date had not acquired a job at all. During our interview, he expressed his apprehension,

> No promise with me yet. I have not found a job in the last six months. We went to the job club at the refugee agency, but it is only talk. Nothing happens. I went to the agency today and said, 'I am not going to leave until I get a job'. The deadline for me is about met. Time for me is about up and I need a job. They have not found me a job. After that period, what will be my destiny? . . . I only have until the end of this month. I feel helplessness. Because there is no job. After the assistance stops, I still have to pay the rent and the utilities even if I have no job . . . when I think about my destiny I feel uncertain how I will pay my rent and utilities . . . I don't feel hope to keep me going. Everything here is connected to work and without a job you can do nothing. Finding a job is the biggest source of stress for me right now" (P16).

Uncertainty about the future was paramount in his mind as the time was quickly approaching for agency support withdrawal. Consider, one Iraqi couple's similar perspective, "We both have fears" (P19). "We only have four months left of help from the refugee agency. We will be homeless because I cannot pay the rent . . . I have depression now. It affects me. What if I

become homeless" (P20)? Meeting the expectations to become self-sufficient within a certain time frame for Iraqis is overwhelming as many barriers to learning the language and seeking employment were encountered.

Strategies, such as connecting with others, helped participants to manage the difficulties they faced. One Iraqi male suggests,

> We help each other all the time . . . For us, we trust each other and help each other. We hope to get a better life. After eight months, the refugee agency will not be responsible for us. We will overcome these problems. (P13).

Another Iraqi indicated,

> Once I get here, I met friends from Iraq and that had helped me manage my stress. They are my neighbors . . . we have gone through the same situations and we have the same kind of problems and we have gotten so close (P15).

Connecting with other Iraqis and forming relationships with persons in the community throughout the process of resettlement, especially during withdrawal of agency support, was understood to be a source of comfort for the Iraqi refugees. Losing the intensive support of the refugee agency where ESL classes and employment assistance was offered was frightening to those who did not feel ready to be on their own. Essentially, building relationships with others was a strategy that provided a supportive lifeline for the Iraqis during the stressful transition of becoming independent and self-sufficient.

Not knowing the laws. Another source of worry for the Iraqi refugees as withdrawal of agency support quickly drew near was they did not know the rules and regulations of societal law in America. One Iraqi refugee suggests, "We are like blind people because we do not know the

laws here" (P 16). Acquiring knowledge of laws was an important concern for participants, particularly as they were seeking more self-sufficiency.

How could self-sufficiency be achieved if the Iraqi refugees do not know the laws? Consider one Iraqi's view,

> I don't know anything. It is supposed for the refugee agency to give the refugee information about the laws. When they don't give me information about the laws and I get a job maybe I will do something wrong and make a mistake accidentally. What would I do? It is important for me to know the laws. I asked for a couple of days for orientation about the laws. If the refugee gets this training and after that a mistake is made then it is his responsibility. Otherwise, it is not if he does not know the laws. As a refugee, I don't know how to cross the street. That is the simplest thing to do, but I don't know how (P14).

Understanding the guiding principles for everyday social living was a need that all felt acutely. One Iraqi refugee indicates,

> Here, in my opinion, knowing the law is better than knowing the language. If I do something wrong, I will get in trouble and it will be a problem for me . . . I heard if I get in trouble with a girl under 18, then maybe I may be put in prison for three years. I don't know anything about these laws. In Iraq, we can have a relationship at any age (P15).

Legal trouble, in this respect, would be detrimental for the Iraqi refugees, financially and socially. Affording legal assistance would be challenging and the stigma associated with

disobeying the law would be demeaning. Therefore, Iraqi refugees want to know the laws so they can learn how to live in American society.

To this point, the core category of *Living with the choice* of Iraqi refugee resettlement is conceptualized as progressing from early agency support to intensive agency support and to now withdrawal of agency support. Contextual aspects of their environment, such as living conditions, safety, transportation, financial resources, employment, language and culture, influence their ability to transition through each stage. Iraqis use strategies such as seeking help, learning the language and connecting with others to manage intervening conditions that either facilitate or hinder their resettlement progression.

Resettlement Outcome

Results of analysis showed that for Iraqis choosing to resettle here, the outcome is dichotomous: satisfaction or regret. The appraised outcome is influenced by contextual factors, such as living conditions, financial stability, sense of safety and employment. Availability of support and access to resources significantly impacted the consequential outcome of the resettlement process. Iraqis who received support from friends, community partners and healthcare professionals early in the process seemed to be more satisfied with their resettlement choice. An Iraqi woman stated, "I made some Iraqi friends here and some American . . . I feel like I can breathe and be relieved . . . It is better for us and it is a better life" (P 18). Connecting with others, feeling safe and establishing goals was important for some Iraqis. An Iraqi couple stated, "We don't just stay here because it is a safe place, we have goals now . . . we have goals for the future . . . we want to continue our education" (P4 and P5).

Unfortunately, the experience of some Iraqi participants has not been positive. Resettlement for them has been a struggle as they have encountered day to day challenges related to inability to find a job, learn the language or successfully connect with others. One Iraqi participant stated, "I feel it is a bad thing to come here. It was a bad decision . . . I do not feel free" (P16). This gentleman was struggling to find employment and felt isolated from others.

Many Iraqis have not found the physical and mental relief that they were expecting. An Iraqi woman stated, "I am regretting that we come here. I expected a life that was comfortable, but I did not get what I expected after all that we have gone through in Iraq" (P1). How Iraqis appraise their resettlement choice can affect their health and well-being. Those who regret the choice may have prolonged stress and anxiety that can result in more severe physical and mental disorders.

Key determinants have been identified to influence the resettlement outcome, resulting in two archetypes. Those who are *satisfied with the choice* typically have housing accommodations that are perceived as safe and clean; acquired stable employment; reached a level of language proficiency that can be used to communicate independently; received access to health-related resources such as insurance coverage and medications; continued to live out their cultural beliefs and practices without discrimination; and received social support from friends (both Iraqi and American) and community partners. In contrast, those who *regret the choice* have experienced loss of professional and social status as compared to their pre-migration condition; diminished standard of living in the post-migration phase due to underemployment or unemployment and low-income housing. Those who *regret the choice* also perceive loss of choice and control, and

experience difficulty accessing treatment for physical ailments, mental illness or emotional distress.

Coping with health concerns

Iraqis faced adversities such as violence, death, displacement and loss prior to resettling to the U.S. Unfortunately, resettlement to the U.S. did not eradicate the impact of their past tragic circumstances. Such hardship had serious effects on their physical, mental, spiritual and emotional well-being. When asked the question, "What does health mean to you?" the Iraqi participants responded identically, "Health is the most precious thing in the world. Without health you have nothing". Iraqis spoke candidly about their health concerns and problems that confronted them during the resettlement process, yet acquiring help for those concerns often became problematic. Therefore, the encompassing condition of *coping with health concerns* was a conceptual dimension that could not be ignored in theoretical development.

Physical health. Unequivocally, Iraqi refugees were aware of health concerns preceding resettlement to the U.S. These included diabetes, high blood pressure heart disease and high cholesterol that may have gone untreated as they migrated to bordering countries and then resettled abroad. Of the 14 females interviewed, 7 gave a history of problems with thalassemia, a genetic disorder frequently recognized with Iraqi females. Consider one Iraqi's experience,

> When I was a child I had heart problems. As an adult, I began having problems and I had open heart surgery in 1995. I was 25-26 years old . . . I had heart surgery in Iraq . . . I went to Syria and stayed five years . . . I went back to Iraq and went to a holy shrine to visit. On the way, some asked me for my ID. They asked, 'what are you doing here?' and I said, 'I am an Iraqi'. They put me in

> prison for three months. A human rights organization argued with them that I had surgery and needed to be released so I could get my medication . . . they did not believe. After they release me, I went to Syria immediately. I never went back to Baghdad after that. The human rights organization was checking on the prisoners. That is how they came to know me. (P26)

One particular Iraqi male had difficulty obtaining his medications in Syria that continued as he resettled in the U.S. During the time of agency support withdrawal and before he could obtain disability status, he had "three to four months" where he had a gap in insurance coverage where he had difficulty obtaining his medications. He stated, "I visited the doctor during that time. I did not pay. The church helped me" (P26). Resourcefully, Iraqis find ways to seek help by connecting with others, in this case community partners, to address their physical needs.

Another Iraqi male indicated he had high blood pressure prior to resettlement in the U.S., "I had high blood pressure before . . . In Turkey, I received some medications for it" (P12). When asked if there were times that he could not get his medications during the resettlement process, he stated, "Yes, here and there in Turkey. When I did two jobs here, they stopped the health insurance and the food stamps" (P12). He was not able to get his medications for "four to five months" during that time and stated:

> I managed it by using grounded garlic and lemon juice . . . It is an Arab medicine learned from the Arab people. Not like medicine from the doctors. There is a kind of tree there. If you take the leaves off and heat in a pot. Keep just the steam and people will put a cover over themselves. The steam will heal lots of

> things. First of all, the throat, allergies or the cold. My parents teach it to me. It is passed from generation to generation. (P12)

For this gentleman, heart disease became an issue during resettlement. He stated,

> My blood pressure would go high and not come down at all. 202/148 at times. It was too high . . . the doctor that did my heart surgery is a nice man . . . It was here. Eight or nine months ago. One of the arteries of the heart was 80% blocked. I did not think it was that serious. They called me at my friend's workplace and they told me to come there. I thought they would give me pills and that would be it. They did a procedure and the artery was 80% blocked. (P12)

Inability to obtain the medications necessary to treat physical health problems could exacerbate further progression of disease to the point where invasive intervention is required. As a result, risk of potential health decline and poor health outcomes could become more prominent.

Another Iraqi couple conveyed their strategy for dealing with their daughter's health issues. They revealed,

> We have our own religious practices. We believe we can treat ourselves with our religious beliefs. One of our daughters has a problem with her throat. A gland that needs to be removed that is under the face muscles and surgery would be very dangerous. We follow up with the doctor, but other than that we read the Koran with her. Both of us read the Koran and use the internet to read the Koran with her . . . Because we are Muslim, we try not to go to the doctor. We only go for emergencies. (P21).

It is understood that Iraqis use their religious practices and alternative therapy to treat their health concerns. Therefore, healthcare professionals should recognize and respectfully acknowledge these cultural practices. Additional education may be required to explain how Iraqis can manage their health conditions.

Iraqis spoke positively about the diabetes education they received. One Iraqi woman with gestational diabetes shared,

> I used to go to the hospital and they would give me classes to learn about the diabetes. They gave me a system to check my blood sugar. I forget how many hours that I went to classes. They give me a manual or a book about the kind of food and how many calories are in each one. They ask me to check the blood sugar before and after each meal. I also had to write down all the food that I ate . . . I was doing very well managing my food. I followed all the instructions they gave me. I was very worried about my child since I had diabetes . . . I manage my diet and they followed up with me every two weeks. I stopped worrying when they gave me more information and talked with me about how well I was managing things. (P22)

Another Iraqi woman who had diabetes prior to resettlement suggests,

> I had it before I came here to the U.S. I had it before, we found out about it after my mom's death in Iraq. It was in Iraq when we learned about it . . .Here they gave us guidelines on that device, how to check it and how to control it . . . the clinic they gave me information here about what to eat and how much. (P11)

Although information was given, the provided documents were written in the English language. Much of the literature that Iraqi refugees received about health issues was in English. There is potential for misunderstanding if the Iraqi refugee cannot yet read and comprehend the English language. Recognizing this possibility, they seek help in other ways by searching the internet, they "Google it" (P18) when they want to know something in regard to their health.

> We just use a key word and it takes us to the appropriate site . . . We do not have a specific site that we use. It would be great to have an Arabic website to use to get information (P18).

Unfortunately, there is no assurance that the quality of information they receive from the internet is accurate. Health literacy among the Iraqis may be limited; therefore, it is imperative to assess their learning needs so that appropriate teaching strategies and methods can be taken to convey the information they need to know.

Mental health. One of the expectations of the Iraqi refugees as they resettled to the U.S. was to get "physical and mental relief" (P1). The pressures of witnessing violence, living with fear and seeking safety by migrating to bordering countries were precursors to their resettlement to the U.S. They arrive physically and mentally exhausted, some with significant mental health problems including major depression, Post-Traumatic Stress, and major anxiety. For many, mental exhaustion persists throughout the resettlement process as contextual and intervening conditions hinder their ability to heal and regenerate themselves.

An Iraqi woman revealed her circumstance,

> I am sick with psychological and physical issues. I have not gotten the therapy that I was expecting for my issues . . . physical and mental relief . . . The hope

> was that help could be received upon resettling. Everyone has physical and mental issues before they come here. We were tired and needed relief. I don't remember what mental health means because I have been intense for a long time. Even when I pray, I have to consider, 'what am I doing'. I am missing in my prayers and forget a lot . . . I am always intense, angry, feel angry and I don't eat that much . . . My health condition has been worse. My diabetes has been more than 500 and nobody cares . . . I am here alone all the time. I don't work and feel stressed. I feel depressed. (P1)

Prayer is a strategy used by the Iraqis to connect with a higher power so they can manage their stress. An Iraqi male describes this practice,

> I feel rested when I pray and read the Koran. We wash our hands and face. We clean our body. We wear long sleeves and cover our hair. We have a special carpet that we pray on. We cover the face and keep the head clean. We pray five times a day. I read the Koran, too. (P20)

Praying is a cultural practice that is a symbolic act demonstrating commitment and dedication to their religious beliefs. Prayer is a sacred ritual and to be "missing from my prayers" is indicative of the overwhelming nature of the physical and psychological stress that has confronted them.

Resettlement has significantly changed the way Iraqis live. A single Iraqi mother suggests,

> Because of the way we are living here my daughter has had some mental issues. It has been two days since she got out of the hospital. People here are different. We are scared of other people. We came here looking for safety and security, but we did not find it. My daughter has mental issues and tried to commit suicide.

> We have many problems. She tried to commit suicide because she did not want to be a burden to me. She sees how hard I have to work to just pay the bills. She stayed in the hospital for almost one week . . . I am forced to manage my stress. I have to be strong. I pretend to be strong in front of my kids, but it is affecting my health . . . I feel depressed, but I try to keep it inside. (P 25)

Managing stress becomes a tactic for daily life that Iraqis must continually pursue. One Iraqi woman asked for a referral to a psychiatrist, but was denied by her primary physician and was prescribed a medication instead. Unfortunately, the medication was not covered by her insurance, and was therefore unaffordable. None of the Iraqi refugees in this study received mental health counseling as a therapeutic method to help them cope with their stress. Active therapy was often delayed and not received until suicidal attempts had been demonstrated.

An Iraqi woman expressed her frustrations,

> Three years ago, I tried to commit suicide once. They send me to a place like a lunatic hospital and there were insane people there. The point was to get relief. Instead, there were people completely mad or insane. It was a small facility not like a hospital. I was supposed to stay seven days, but stayed two days only. It was like a horror house. There was a . . . woman that tried to attack me with a lighter . . . They did not allow my daughter to interpret for me. They sent her back home and she was not there for me. So, my daughter just brought me home. Sometimes my daughter gets worried if I don't answer the phone. She thinks I have tried to hurt myself. (P1)

Access to mental health counseling and treatment is critical for Iraqi refugees, but providing interpreters for Iraqis as they seek help for themselves and their family's mental issues is vitally important so they can fully communicate their needs.

In particular, Iraqi refugees who are parents express concern about the mental health of their children. The trauma of a war-torn environment in Iraq, displacement from their homeland and struggles during migration not only affect adults, but impacts their children. One Iraqi mother spoke of her concerns,

> I can't forget those times in Iraq. Our child feels fear all the time. He will not sleep by himself. Even a balloon, he is afraid of that especially if he bumps it and it pops. During his birthday, we wanted to get the balloons and balloon pump, but he was afraid of that. Once when he was born after a while a bomb exploded. All the glasses in the home broke. Since that time, he has been afraid of everything. I tried to seek help for him in Jordan but because we were illegal in Jordan I could not successfully do that . . . I talked with the primary care doctor and they told me they would make an appointment for him. However, they did not respond any further . . . He still has fears. When he hears loud noises or sounds he is afraid of that. Even if his dad calls me loudly, he gets afraid of loud talking. (P18)

One participant suggested healthcare professionals need to "slow down and listen" (P20). Listening to Iraqis as they communicate their physical and mental health concerns for themselves and their families lets them know they are valued participants in their healthcare. Impaired coping and further mental health decline may be the resulting outcome if healthcare professionals are not responsive to their psychological needs.

Spiritual health. To be able to practice their cultural beliefs and spiritual practices freely without fear is a source of comfort to Iraqi refugees. Consider an Iraqi male's perspective,

> Now, we feel very safe here . . . It is a very good thing. It is very good and a strange feeling for us. If we feel safe, our health is better. As Muslims, we have to go to the mosque periodically. We still have this desire to go to the mosque. We have one mosque downtown and we are free to go there. In Iraq, it is forbidden. We feel very free here. Everyone can do what he wants to do . . . It is very important for us to have that freedom to visit the mosque. We usually pray here at home as well. We used to do some religious things like pray all the time, fast during Ramadan. (P17)

This Iraqi gentleman suggested nurses and other healthcare professionals should, "support the Iraqi patients psychologically and spiritually. That is what we need" (P17). Support, in this respect, means empowering Iraqi refugees throughout the resettlement process to find resources and ways to nurture their spiritual well-being. For one Iraqi woman, connecting with others provided the support she needs. She states, "I met this good friend because God loves me and like me. I am very grateful for that . . . My friend knows my birthday. They want to celebrate with me" (P10). Having the opportunity to develop a relationship and share in celebrations gave this Iraqi refugee a spiritual uplifting that gave her hope . . . a hope that "He (God) will take care of me" (P10).

Emotional health. Many of the refugees were spared major psychological problems such as severe, suicidal depression, but suffered lesser states of emotional upheaval: sadness, homesickness, situational anxiety, and loss. Expressing emotion was a strategy that the

participants used to cope with the circumstances that they faced. Both male and female Iraqi refugees spoke of crying as a way to release pent up feelings. An Iraqi woman suggests, "I cannot sleep . . . Sometimes, I am sleeping, but I feel my tears come down for some reason . . . Sometimes, I don't feel dead or alive. I have no hope for the future" (P1). An Iraqi male discloses, "I cry all the time to handle the stress" (P16). Crying is an outward expression of the psychological distress that Iraqi refugees are suffering. Another Iraqi mother states, "I can't sleep . . . I cry all the time . . . I stay up all night . . . thinking about my family.

Family separation is common among Iraqi refugees who have left loved ones in Iraq. Only one Iraqi female cried during an interview as she began talking about the death of her father. He had been shot in Iraq and he died. I paused the interview to allow her time to cry. As she regained composure, she revealed,

> Feeling homesick is stressful . . . because I could not see my father when he died, it was stressful for me. I am concerned about my mother and she may die as well. Even I could die and my mother will not see me and it is very stressful for me . . . When I cry, I feel better (P7).

Crying can be symbolic of the underlying depression and despair that Iraqi refugees endure. It is a way to release the frustration they feel. Allowing them to talk about their emotions is an essential step toward facilitating their healing and restoration.

Access to Care

In order to address the complexity of Iraqi refugee healthcare needs, appropriate access to care is necessary. Access is often limited due to minimal or lack of insurance coverage. An Iraqi woman shared her perspective,

> Almost two months ago I started getting SSI because I am almost like physically disabled. But, they gave me a type of insurance that most of the doctors do not accept. I have not gotten the therapy that I was expecting for my issues . . . The problem is my insurance. Many doctors do not take my insurance and I cannot just go to another physician . . . I had to drive two hours from here to see someone about my diabetes because of my insurance and now no one is controlling it for me. It is up to me. (P1)

Managing her diabetes was important, but she could not do it alone. She needed guidance from her healthcare providers, yet access to care was difficult for her due to the distance requiring travel of two hours to obtain treatment and cost of transportation. She continues, "How can I become relaxed and relieved after all of this? No one explained the system to me" (P1).

Not knowing the system is stressful, particularly for new arrival Iraqi refugees. One Iraqi suggests,

> As a refugee, I don't know the system . . . they just told us that if you get in an emergency situation, then call 9-1-1. They told us this in Lebanon. But, when we came here we did not find a telephone. How can I call if I don't have a phone? (P23)

Even though information about what to do in emergency had been provided, the resources were not available. Iraqi refugees may feel vulnerable during the early stage of resettlement because they simply do not know what to do in many situations, especially during emergencies. Consider another Iraqi's circumstance,

> At the very beginning. The first month . . . one of my daughters had a broken arm. We called our case manager and he called the ambulance. We did not know how to get to the emergency room. He call 9-1-1 for us. (P3)

Experiential training shortly after arrival may help relieve some anxiety Iraqis feel when they first arrive to the U.S. It may also save a life if the situation is critical.

Initial health screenings are completed at the health department where a physical exam is conducted and immunizations are provided. For one Iraqi family, the initial screening was done after they had been in the U.S. one month and five days. The Iraqi father voiced his concerns,

> Why do they wait one month and five days before we have our first appointment? We have our doubts about the healthcare process. It took them one month and five days before we even saw a doctor . . . They need to know that we have problems with accessing the care that we need. Why does it take a month and five days before you have a health screen at the health department? What if the refugee's health had changed during resettlement? I had an exam in Lebanon and I came here after waiting one year. Is it possible that I could contact a disease in one year that may affect someone else? Is it appropriate to delay the physicals? Maximum it should only be seven days. It should be a priority. (P23)

Certainly health status can change within a time period as he describes. Communicable diseases can be acquired and, if left untreated, the disease can be easily spread. This matter should be of concern and processes should be streamlined to facilitate health screening shortly after Iraqi refugee arrival.

Early access to care is important for Iraqi refugees to obtain the immunizations they need. However, Iraqis voiced some concern about duplication of immunizations for their children. An Iraqi mother describes her apprehension,

> They repeated all the immunizations for the children even though we had the documentation. This is a worry for us. I have my own proof, but they would not accept that. It was at the health department. My first child was 1 year and 11 months when we came here. They repeated everything for her. It made me very upset because they give her seven different immunizations in the same day. (P22)

Many Iraqi parents voiced concern about duplicate immunizations and the long term effect it would have on their child's health. The typical short term reaction was fever and parents treated the temperature with over-the-counter medications. Iraqi refugees revealed they normally use over-the-counter medications to treat cold symptoms, such as fever and cough.

On the other hand, access to prescription medications has been problematic for some Iraqis. Pharmaceutical therapy is often required to treat health problems, such as diabetes, heart disease, high blood pressure and anemia. Iraqis refugees, who are uninsured or have limited prescription medication coverage with their insurance plan, find it difficult to get the medication they need. The cost is burdensome and their overall health suffers as a result. Iraqis with co-morbidities that require prescription medications find it challenging to get what they need.

Consider the plight of a female Iraqi refugee,

> The type of insurance that I have will only allow five prescriptions to be filled per month (injections, pills, drops, etc.). After five, the insurance will not pay . . . The insurance will not pay for more than five prescriptions . . . They tell me that I

> have to choose what medicines I want because the insurance will only pay for five. So, I cannot take all the medicine that I need for my problems or health issues . . . It would be 8-10 prescriptions. I am not taking all my medicines. Last month, I did not get the insulin medicine refilled because I had a little left and I took the medicine for my stomach instead. I have to choose . . . Yes, I choose and only get five per month. I look at how much I have and make decisions on what I need the most and that is the medicine that I get for that month . . . Why do they bring us here if they don't want to treat us? I went to the pharmacy and my prescription was $121.50. I don't work, have bills to pay and I am sick. For older people like me, they should not stop the assistance. They should not stop it so early. (P1)

Without comprehensive assistance from a health care provider, it is unlikely that most Iraqi refugees can make accurate determination what medications they should refill for the month. This particular Iraqi woman stated her blood sugar levels had been over 500 for the month prior to the interview; yet she chose to refill her stomach medicine instead of her insulin because she had "some left in the bottle". She, also, stated, "I have anemia in the blood . . . I have a prescription for that and it has been at the pharmacy for one month, but I cannot take it because the insurance will not pay for it" (P1). Unfortunately, she may experience further decline in her health due to limited medication coverage and the inability to pay out of pocket for prescriptions she needs.

Communicating with Healthcare Providers

Iraqi refugees have a need to communicate effectively with healthcare providers.

Since many speak little to no English, it is essential to have an interpreter available to help Iraqis convey their needs. To avoid miscommunication and misunderstanding, it is also critical for healthcare professionals to provide instructions and education about treatments, medications and procedures with an interpreter available. One Iraqi female states,

> When I went to the emergency room when I was pregnant, they gave me a shot and I was worried that may be they would forget that I was pregnant. I was worried about that because they did not tell me what the medicine was. I was very sick and could not understand them . . . It is better to get the information in Arabic so that we can be relieved and know what medical treatment he or she gets from them. There was no interpreter. (P18)

The need to have interpreters available, especially when seeking health care, was a recurring theme.

Many times Iraqi children will serve as interpreters for their parents at doctor visits. Iraqi children learn the English language quickly and some are even fluent in more than two languages. The parents of one child suggested he was fluent in three languages, Arabic, French and English. The issue, however, is the child may observe procedures that may be inappropriate for them to see when interpreting for their parents. For instance, one young Iraqi female preteen accompanied her mother to an ob/gyn office visit. The young girl fainted when she observed the physician performing a pelvic exam on her mother. It is not practical for children to be the interpreter in some situations. Additionally, the health information that they may have to convey may not be what a child should be responsible for interpreting.

Voices from the Community

In order to broaden understanding of Iraqi refugee resettlement, the perspectives of community partners were obtained. Iraqi refugees suggested provision and use of community resources facilitated their resettlement progression. Essentially, primary sources of help came from the refugee agency and community churches. Two community partners participated in the study, an ESL instructor at the refugee agency as well as the director of refugee ministries at a local church.

ESL instructor. Iraqi refugees attend ESL classes at the refugee agency as a strategy to learn the language and cultural ways. In essence, small amount of cultural learning takes place during the ESL classes as they discuss social norms, such as how to greet your neighbor or interact with others in the community. ESL classes are offered by the refugee agency two days a week for two hours each day. The ESL instructor who participated in the study had relocated to the U.S. from Canada six months prior to the interview. In comparison, she indicated language classes are offered every day for 5 hours each day in Canada and federal funding for additional language education is typically available.

Considering the limited amount of ESL classes offered in the U.S., she observed Iraqi refugees struggling as they transitioned with resettlement. Attending classes that are only offered during the day time hours may be difficult for Iraqi refugees who obtain employment soon after their arrival. Transportation to the agency for the classes may be difficult as well if financial resources are unavailable. Child care is often not available; therefore, only one parent may be able to attend the ESL classes.

Iraqi refugees are required to meet with the ESL coordinator within one to two weeks after their arrival to the U.S. Oral assessment, picture identification, conversation questions and written reading/writing assessments are used to evaluate beginning level competency. Iraqi refugees who are more fluent with the English language are placed in an advanced class and others are assigned to a beginning level class environment.

Despite offering various teaching modalities to accommodate different learning styles, the ESL instructor indicated that some Iraqi refugees may have learning disabilities. Inability to follow instructions, inadequate memory recall and minimal comprehension are a few of the common difficulties that Iraqi refugees encounter. Illiteracy even in their native Arabic language is a challenge as well. If a learning disability is identified, referral to the health coordinator is made to initiate further evaluation.

The ESL coordinator suggested ways to improve ESL offerings for Iraqi refugees. Advocacy for stronger policies related to educational funding for new arrival refugees that can extend to general education diploma (GED) acquisition or community college level credit completion that can broaden their employment opportunities in the future. Classes should be closer to the communities where Iraqi refugees live. Also, the ESL coordinator suggested having a van that can be used to take class attendees on "field trips" to learn about their new community.

Church community partner. Faith-based organizations partner with the refugee agency to help meet the needs of Iraqi refugees. Churches reach out to all refugee types; however, Iraqis are the main focus now due to the growing resettlement population. The director of refugee ministries at a community church was interviewed to gain her perspective of Iraqi refugee resettlement.

As explained by this informant, the intent of faith-based involvement is not to duplicate services, but to coordinate efforts to provide resources, and psychosocial support to empower refugees to become self-sufficient. Additional ESL classes are offered in the evening hours with childcare provided to allow Iraqi refugees alternative opportunities to learn the language. Exercise classes for health and socialization are available that Iraqi women can attend and childcare is provided as well. Furthermore, GED classes and adult education classes, such as financial management, are offered for refugees.

From the director's perspective, Iraqi refugees struggle with the resettlement transition. In particular, Iraqis grapple with seeking employment. Regardless of past professional accomplishment or educational credentials, Iraqis acquire entry level jobs in factories and other work environments that have poor working conditions. Also, Iraqis face cycles of employment where jobs are attained, job separation or termination happens due to lack of production needs, then new jobs are sought to meet their financial needs. This can become a vicious cycle where Iraqis become very frustrated with their struggle to be independent.

As a result, Iraqis have psychosocial needs that require emotional support. The director of refugee ministries suggests, "The intent of church community support is not to promote religious conversion, but rather, to show compassion, be their friend and demonstrate unconditional love while fostering a fresh start as they endure the life changing transition of resettlement to the U.S." Ministering to their physical, mental, emotional and spiritual needs is the goal of building relationships with Iraqi refugees. The director indicates the church can have a significant role in helping Iraqi refugees, especially as withdrawal of agency support is nearing and becomes a reality.

Stronger relationships between the refugee agency and church partners are recommended to holistically care for Iraqi refugee needs. Healthcare professionals participate on the church partner's refugee ministry team. The vision of church partners is to build relationships with inter-faith clinics, community health centers and homeless clinics to develop strategies for addressing the health care needs of Iraqi refugees that is affordable and accessible. The focus of assistance should not only be for adult refugees, but support for child and adolescent health and wellness is important as well.

Follow-up Opportunity

I had the opportunity to initially interview a small group of four Iraqi refugee men who had only been in the U.S. less than two months. Within that short period of time, they had begun experiencing struggles and challenges during their resettlement process. I became curious about their situation in the months to follow; therefore, I conducted a follow-up interview with them. Theoretical sampling, in this manner, is consistent with grounded theory methodology to gain a better perspective of the contextual influence of time on resettlement experience. The additional interview allowed me to expand my understanding of the resettlement process through the expressed perceptions of these Iraqi gentlemen.

I conducted a follow-up interview with them four months after the initial interview and the impact of stress was clearly evident in their physical demeanor and stories they shared with me. They expressed feelings of anxiety, stress and fear during our conversation. All four of them had struggled with finding employment, working in poor conditions, learning the language and had minimal relationships with community partners. It was nearing the time for agency support withdrawal and they voiced concerns about becoming "homeless" or uncertainty about their

future. One stated, "I don't know what tomorrow will bring" (P14). They now looked very tired, depressed and had physically lost weight. It became very apparent to me that circumstances the Iraqi refugees face even during resettlement to the U.S. are extremely hard.

Theoretical Summary

The theory, *Living with the choice*, reveals the storyline for Iraqi refugee resettlement to the U.S. accounting for the antecedent, contextual influences, conditions that facilitate or hinder resettlement progression and strategies the Iraqi refugees use to manage their lives during the process. Iraqi refugees choose resettlement to the U.S. with expectations that America is the "land of opportunity"; however, they encounter many problems early after their arrival.

Contextually, they are living in a new environment where the language and the culture is different than their own, financial resources are limited, living conditions are not what they expected and the time of refugee agency support is restricted to a few short 6-8 months. The goal is to reach independence within this time frame; however, lack of employment opportunities and inadequate access to healthcare related resources are conditions that impact their health. Iraqis use strategies such as seeking help, attempting to learn the language, connecting with others and managing problems to help them overcome day to day challenges.

Despite their struggles, some Iraqis refugees are satisfied with their resettlement choice and continue to envision a future of hope while setting goals they would like to achieve. Others regret the choice if they do not have the support they need from the refugee agency, healthcare professionals, community and system policies.

Figure 4 depicts the theoretical model, *Living with the choice.* The antecedent, *choosing to seek a new life*, is illustrated in the uppermost part of the diagram as a precursor for resettlement

to the U.S. A map of the U.S., their designated new home, is situated in the center of the diagram. The square border around the center depicts the contextual factors, such as living conditions, language, safety, housing and cultural factors that influence the resettlement process. Within the square, the domains of physical, mental, emotional and spiritual health are emphasized in bold letters to represent the health related impact the resettlement process has on Iraqi refugees. Encircling the center are the strategies of learning, connecting, seeking and managing that Iraqis use to overcome day to day obstacles and challenges. There are four outer circles with arrows pointing to the center to represent sources of support within the community. Accessibility of these resources can have an impact on how the resettlement choice is perceived. The ultimate consequence is either satisfaction or regret. The process unfolds during the time frame from early agency support to agency support withdrawal, a period that extends from arrival to 6 or 8 months.

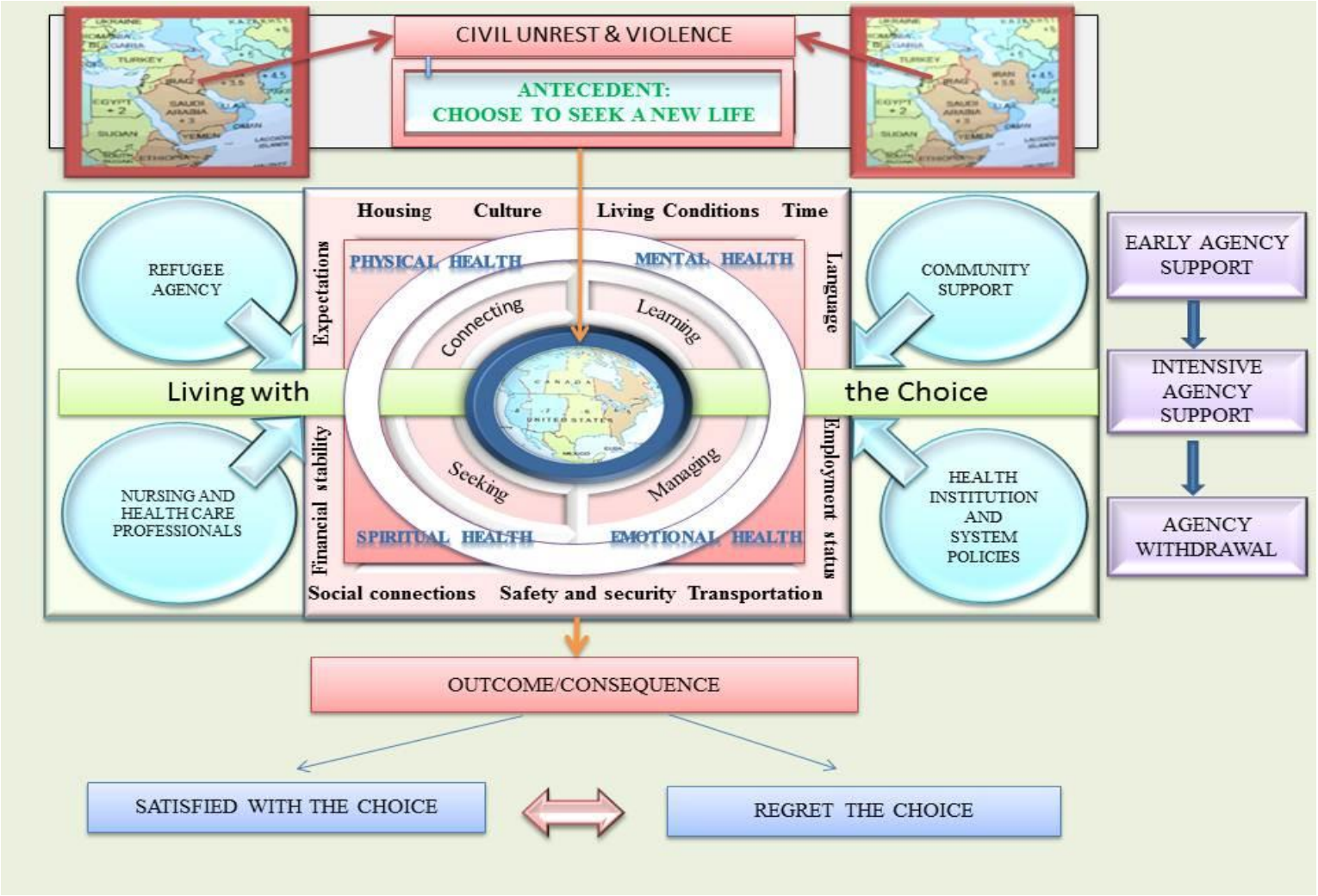

Figure 4: Conceptual Model: Theory of Living with the Choice of Resettlement to the U.S.

Chapter 5

Discussion and Recommendations

I began this study by using Roy's Adaptation Model (2009) as the theoretical launching point for exploring the phenomenon of Iraqi refugee resettlement. In essence, we draw upon what we know to better understand what we do not know (Corbin & Strauss, 2008). Examining the perceptions of participants in this study has given me the opportunity to better understand the process of Iraqi refugee resettlement. Conceptual properties and dimensions of the developed theory, *Living with the Choice: A grounded theory of Iraqi refugee resettlement to the U.S.*, now has a level of abstraction, substance and meaning. At this point, theoretical comparison with extant literature is necessary.

Theoretical Comparison

According to Roy (2009), adaptation is the "process and outcome whereby the thinking and feeling person (bio-psycho-social being) as individuals or groups use conscious awareness and choice to create human and environmental integration" (p. 29). Conversations with Dr. Denise Bates, an expert in refugee research, highlighted the reality that the concept of integration is prevalent in refugee literature more so than the concept of adaptation. In order to understand the conceptual relationships between adaptation and integration, I chose to contact Sister Callista Roy to advance my understanding of how adaptation and integration are interrelated.

A phone interview was conducted with Sister Callista Roy. According to Roy (personal communication, November 2012), adaptation exists along a continuum. Integration is the "highest level of adaptation for individuals and/or groups". An

individual or group who has to work harder to deal with change may only achieve a compensatory level or, at best, a compromised level of adaptation. In the 21st century, Roy suggests, "nursing has an integral role in examining the changing global needs of society, especially as American society becomes more diverse in ethnicity and culture" (personal communication, November 2012). It is imperative for nursing to examine assumptions and broaden conceptual understanding of attributes that affect the capacity for individuals or groups to integrate into a community or society.

According to UNHCR (2012a), integration requires "pre-departure preparation; the active participation of refugees in all stages of the process; opportunities for language training, skills development, and employment; the support of communities in the resettlement countries, including the availability of services tailored to vulnerable groups; and the coordination and engagement of all relevant governmental authorities, particularly at the local level" (p. 5). Integrative adaptation is not achieved by refugees adapting to the U.S. exclusively.

Essentially, integrative adaptation requires mutual acceptance by both the refugee and the communities in which they live. Integration requires individuals and communities working together to accomplish mutual goals and purposes (Roy, 2011). To support Iraqi resettlement, mutual goals between the refugee, refugee agency, community partners, healthcare professionals and system policies of public institutions need to be established. The desired outcome of integration, in Roy's perspective, is "not equilibrium, but rather transformation and growth" (personal communication, November 2012).

Ager and Strang (2008) conceptually analyzed integration of refugees and through their qualitative research identified core indicators that comprise a framework for refugee integration. The core indicators included public outcomes, such as employment, housing, education and health; social connections; facilitating factors, such as language, and cultural knowledge along with safety and stability; and system policies related to citizenship and rights. The implicit definition of integration in their framework is, "an individual or group is integrated within a society when they achieve public outcomes . . . are socially connected to members of a community . . . and have sufficient linguistic competence and cultural knowledge to confidently engage in that society in a manner consistent with shared notions of nationhood and citizenship" (p. 5).

How does the theory, *Living with the choice: Iraqi refugee resettlement to the U.S.* differ from the theoretical framework developed by Ager and Strang (2008)? First of all, the integration framework of Ager and Strang (2008) does not clearly identify the relationships between the conceptual domains, nor does it demonstrate the process of integration. Secondly, the concept of social connections is recognized, but the importance of a mutual accepting relationship among refugees and community partners is not acknowledged. Thirdly, development of mutual goals for the refugee and community to facilitate successful refugee resettlement is absent. Lastly, the framework is non-specific to a particular refugee group.

For particular groups of people, such as Iraqi refugees, the antecedent for resettlement may be different than it is for others. War and conflict was the stimulus for the Iraqis to migrate from their homeland to neighboring countries and then resettle abroad. The bio-

psycho-social needs of Iraqi refugees, who have experienced trauma, death and destruction on a huge scale, and sometimes physical injury, may be largely different from other refugee types as a result. Although commonalities exist, one cannot assume that what meets the needs of one group will meet the needs of another.

Findings from this study suggest access to cultural, material (housing, money or transportation), social and health related resources can facilitate the resettlement process; whereas constrained or limited access to these resources can impede physical and psychological well-being. Ryan, Dooley and Benson (2008b) suggests refugees become further distressed when the host resettlement society places restrictions on the resources that are required to meet their basic needs. The argument for a resource-based theoretical model approach in their refugee research parallels application of findings from this grounded theory study.

Iraqi refugees have experienced loss of resources during their pre-migration phase in the form of the loss of a family member, loss of their home, or loss of their safety due to violence and civil unrest. Iraqis may continue to experience loss of resources as they migrate across borders to neighboring countries. Loss, in this respect, may be losing a sense of belonging, loss of material resources due to fleeing unexpectedly or inability to obtain employment in the country of asylum. Once they resettle to America and transition to the post-migration phase, further extensions of loss related to societal constraints on needed resources can severely impact the outcome of the resettlement basic social process.

Ryan, Dooley and Benson (2008b) suggest host societies have a key responsibility to evaluate the loss of resources that refugees experience during their migration journey. The intent is to minimize further loss of resources and maximize resource gain to meet their basic needs so they can reach their highest potential. Some Iraqi participants in this study have expressed their desire to set goals for themselves and their families. Transformation and growth can occur when community partners work collaboratively with the refugees to assess their loss, establish goals, and identify the resources needed to help them reach those goals. The challenge is to create better policies to make those resources accessible and affordable. Tangible support can foster a sense of hope and optimism for Iraqi refugees as they establish a sense of belonging in their new contextual environment. When this occurs, integration of the refugee within the communities in which they live becomes a reality.

Recommendations

This grounded theory research study contributes to the body of knowledge on refugee resettlement, particularly for the Iraqi refugee population. The basic social process of resettlement for Iraqi refugees had been relatively unexplored; therefore, this study has narrowed the gap in understanding by elucidating a theory grounded in the Iraqi refugees' resettlement experience.

As I have listened to the stories of Iraqi refugees who participated in this study, a substantive theory explaining the process of Iraqi refugee resettlement has been developed. Meleis (2007) suggests that theory development inspires scholarship in nursing. Essentially, it inspires one to action for advocacy on behalf of others.

Implications for nursing practice, education, research and policy can as a result now be recommended.

Nursing practice.

Iraqi refugees have distinct cultural characteristics and practices that healthcare professionals need to recognize, understand and respect. The native language is Arabic; therefore, information about their health concerns needs to be presented in a way that is conducive for their learning needs. For instance, health literature in the Arabic language may be necessary to provide the information refugees need to care for themselves and their families. Pre-printed instruction sheets (in Arabic) can be available for certain medications or treatments. This will not help those who are illiterate even in Arabic, but it may guide family members who care for them at home. Efforts should be made to have interpreters available during physician or mid-level provider healthcare visits. Misunderstandings and miscommunication can often occur if an interpreter is not available. As a result, significant knowledge deficits can prevent success of intended treatment.

Praying is a cultural practice that many Iraqis use to nurture their spiritual well-being while managing the stressors of resettlement. Allowing them to pray during healthcare encounters may reduce tension and anxiety about certain procedures and treatments. Additionally, emotional support is necessary when Iraqis verbalize their mental health concerns. Acknowledging spiritual health is critical. Not all Iraqis are Muslim, but many are. Nurses must be informed about Muslim faith and respect the refugees' beliefs. Nursing practice must focus on provision of care and unconditional acceptance of

patients and their religious beliefs. For some nurses, the urge to "convert" others will surface. Yet the focus of care must be on wellness and support, not on coversion. Lack of respect demonstrated by a nurse can negate otherwise positive health messages.

Culturally appropriate care is vitally important as we address Iraqi health care needs. Professionals need to be attentive to Iraqi diet requirements, such as Halal meat and any alternative treatments they may use to treat any physical ailments. Additionally, Iraqis are very observant of the non-verbal behavior of healthcare providers. One Iraqi suggests, "I feel respected when someone smiles at me" and he also, recommends "I want the nurses to slow down . . . Slow down and listen" (P20). Allowing them time to voice their concerns and acting upon them with mutually developed health care goals will facilitate confidence that their input is valued and respected.

Nursing education.

As the diversity of American society increases, it is imperative for nursing education to facilitate faculty development and nursing student competency in culturally appropriate care for the various cultures they may encounter in daily practice. Clinical immersion experiences with heterogeneous populations may increase awareness and competency for working with various ethnic groups. Iraqis have unique health care concerns; therefore, indicators of physical and mental health disorders must be recognized. Nursing students should be encouraged to devise a plan of care that is culturally appropriate and creatively addresses the health needs of Iraqi refugees.

Nursing faculty also have a responsibility to encourage nursing students to explore their own assumptions, biases and beliefs regarding care for diverse patient populations.

Reflective dialogue with nursing faculty and students following clinical immersion experiences can allow assumptions and biases to be made explicit. How one's assumptions and biases impact quality of care should be explored as students discuss their experiences.

Nursing faculty should incorporate the concept of culturally appropriate care as a thread throughout the curriculum. In order to advocate patient-centered care, one must be sensitive to the cultural beliefs and practices of our growing diverse society. Role play or simulation experiences can enhance the opportunity to strengthen cultural sensitivity and awareness.

In nursing it is critical to provide care that is holistic, yet students need to be guided to develop skill in assessing the complexity of the human experience. A refugee who may have been a doctor in Iraq, but whose job in the U.S. is in a fast food chain, may have much knowledge of the human body, and very poor self-esteem, embarrassed by his/her loss of standing. The nurse must take time to know the full history of a person, and understand that family and economic factors can impact care. Nursing faculty must mentor students to do this.

Nursing research.

Although the theory of *Living with the choice: A grounded theory of Iraqi refugee resettlement to the U.S.* has been developed, the need for further expansion and testing of the theory is needed. Implications for further research are numerous. Research can inform nursing practice and policy development; therefore, both qualitative and quantitative approaches can be taken to expand the body of knowledge on Iraqi refugee

resettlement. Instrumentation development and research with psychometric analysis should be performed to measure the effect of stress with Iraqi refugees as well as coping abilities. Uncertainty is a concept that deserves to be explored with the Iraqi refugee population.

Interventional research can be done to examine the effect of education, exercise, or counseling on physical and mental health of Iraqi refugees. Self-efficacy among Iraqi refugees can be explored as well. Chronic disease management research can be conducted. Also, action research studies can be developed to examine various teaching modalities when providing health education for Iraqi refugees. The perspective of health care professionals who work with Iraqi refugees should be qualitatively explored as well. Longitudinal qualitative and/or quantitative research can be conducted as well to examine the long term effects of stress on Iraqis that are associated with resettlement. Therefore, it is recommended to examine incremental time frames, such as arrival, 3 months, 6 months, 9 months and longer to measure the impact of stress as resettlement progresses.

Although the concept of safety was recognized in this study, the meaning of safety for Iraqi refugees was not broadly explored and is weakness of the study. It is recommended to examine the meaning of safety for both male and female Iraqi refugees.

Nursing policy.

The problems Iraqi refugees encounter during resettlement stem from rigid system policies, such as length of agency support, amount of financial support and boundaries associated with health insurance coverage. It is recommended to review current policies that are in place, examine the effectiveness of such policies and revise policies that

promote gaps in coverage where the health of Iraqis can significantly suffer. Nursing certainly has an integral role in leading the policy advocacy initiative. The intent is to recognize vulnerable populations and the system policies that leave them powerless and voiceless. Nurses should advocate better solutions for those that are underserved.

Nurses can facilitate advocacy initiatives that are not too costly. As part of a "welcome package" when a refugee arrives in their resettlement city, as nurse may, a) give basic information on how long it will take to get health exams; b) how to call for help in an emergency; c) explain rationale for child immunizations to decrease their anxiety; and d) work within the agency to provide a pre-paid cell phone with very limited time on it for a "survival" call so they can dial 9-1-1 in a true emergency if needed, and explain how and when to use it. These actions can contribute to a refugee's sense of welcome and safety.

Limitations

In any research there are limitations imposed by circumstances. These limitations must be recognized and acknowledged. Language, filtering, and selection bias are three potential limitations that could have an impact on interpretation of these study results.

Language. Research participants all spoke Arabic as their first language. Seven participants did not speak any English, nineteen spoke some English and only three were fluent in English. Thus, there was potential for language-related miscommunication and misunderstanding. An Arabic speaking interpreter was used to assist communication during all the interviews. To address this concern, interpreter services were provided. However, the use of an interpreter itself introduced some limitations: a) introducing a

third person into every conversation/interview, b) this third person may have potentially posed a threat to confidentiality and participant comfort, and c) the interpreter was filtering participant responses through the lens of their own experience and background knowledge.

Filtering. Participants may have given a response that they perceived to be socially desirable or "safe" rather than what they actually think, feel, or do. Safety becomes a concern if participants withhold information that they fear might result in retaliation against family members who remain in Iraq, or harm that might come to them if their whereabouts were discovered. There is no way to know what information may have been withheld, but the possibility is acknowledged. This is essentially "filtering" their ideas to select only what they want the interviewer to know. Filtering may also happen with the interpreter who may intentionally not convey certain information they perceive as inconsequential, or who may unintentionally skew remarks in light of "insider knowledge" about Iraq, or their own refugee experience with migration. As a result, multiple layers of "filtering" may have occurred. To address this concern before the study began, I requested the interpreters to relay as closely as possible the exact words of the participant. Those who participated in couple or small group interviews may have been selective in what they shared as well.

Bias. Selection bias is another limitation of concern. Each participant was provided a $10 WalMart gift card for completing a research interview. Considering twenty-one of the participants were unemployed, the gift card may have been an attractive incentive to volunteer for the study. Iraqis with more professional stature (either now or in the past)

may have been hesitant to participate. Once again, some of these participants may have had past employment with government forces in Iraq, and since they had no idea what topics the interview might broach, may have considered $10 not worth the risk of exposure.

As I conclude this research study, I feel compelled to continue working with Iraqi refugees. A trajectory of research can be taken to address the plethora of health care needs they have as they resettle to America. Completion of this research has provided me the opportunity to gain a beginning understanding of Iraqi refugee resettlement so that I can now advocate on the behalf of Iraqi refugees in a more holistic way. The moral imperative for nurses and other healthcare professionals is to provide compassionate care, even to the least of these.

Final Reflection

While completing this grounded theory research study, I have learned a great deal about Iraqi culture and my own assumptions and biases. Most interviews took place in the homes of Iraqi refugees. Therefore, suspending my assumptions and biases was important as I crossed the thresholds into their homes. Developing their trust was important to creating an atmosphere where they could share their resettlement experiences with me. The interpreters were extremely valuable in helping me bridge the trust barrier.

I learned that hospitality is a cultural value of Iraqis. I was made to feel welcome in their homes as they shared their resettlement experiences with me. The Iraqis were open about their cultural beliefs and religious practices. I distinctly remember one participant

who described to me in detail his ritual of prayer. He excitedly showed me his prayer rug and demonstrated how he positions himself for prayer. Praying was his strategy for managing his stress of resettlement and the spiritual connection was meaningful to him. His openness to share was what stood out to me. When I, as a nurse, expressed caring and acceptance, he demonstrated remarkable openness. Conducting interviews in his home environment helped me learn about his cultural practices that I may not have had the opportunity to experience if the interview was conducted at another location, such as the refugee agency.

Conducting the interviews was challenging to me. The explicit narratives of strife and struggles that they shared affected me personally. I experienced compassion stress as I listened to their stories, and analyzed the interview data for theory construction. The emotional labor of qualitative work was most surprising to me. I began to worry about what the future would hold for them (Iraqis) as they transitioned through the resettlement process. I completed a follow-up interview with a small "family" group of Iraqis. The impact of the stress they were experiencing was very apparent in their physical appearance as they had lost weight and showed signs of depression in their demeanor. It was very frustrating to observe the decline in their physical and psychological well-being, knowing there was nothing I personally could do to impact their situation. I was overcome with emotion when I left that interview and began to cry as I considered the plight of their circumstance. If these interviews were difficult for me, how much more taxing must it be for caseworkers who interface with many families, for years on end?

Recognizing the gaps in the resettlement process that impeded successful resettlement for Iraqis was alarming to me. I had feelings of sadness, yet anger at the same time when I realized such severe deficiencies exist within bureaucratic system policies that constrain the availability of resources to meet their basic needs. Suddenly, I felt an overwhelming desire to advocate for change. How could one person, such as I, create change? Conducting this grounded theory research study was the first step toward change. Disseminating the findings will be a second step.

Indeed, I have been altered professionally and personally by completing this research. This experience has taught me to appreciate the diversity of others, have courage to explore another's worldview while suspending my own, and to have respect for the values of others, and fully appreciate that the depth of a person's struggles is not always readily apparent. I now realize my professional responsibility as a nurse has much broader implications to care for the most vulnerable and marginalized in our society. Therefore, I have a stronger commitment to continue pursuing a trajectory of refugee research, particularly with Iraqi refugees. I am forever grateful for the opportunity to meet, interact, and develop trusting relationships with the participants in this study and the interpreters who were at my side. I wanted to know their stories and they willingly shared them with me. As a result, I now better understand these fellow human beings and the journey they have taken. My hope and intent through this completed research is to advocate for greater access to resources and support for their resettlement transition.

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Appendices

Appendix A

Letter of Support

Bridge Refugee Services, Inc.
7035 Middlebrook Pike, Suite A, Knoxville, TN 37909
Ph: (865) 540-1311 Fax: (865) 540-1021
info@bridgerefugees.org

4791/A Hal Dr Chattanooga, TN 37416 Ph: (423)954-1911 Fax: (423) 945-9499

February 7, 2012

To Whom It May Concern:

Bridge Refugee Services, Inc. supports Ms. Lisa Davenport in her dissertation research on refugees. Bridge and its employees will allow and assist Lisa in recruiting study participants for the study at the office (posting flyers, communicating study to case managers, and communicating the study to potential participants in person during English as second language classes). Lisa also has full permission to conduct interviews here at the Bridge Refugee Services office.

If you have any questions, please do not hesitate to contact me at 865-540-1311 ext 11 or jenatbridge@aol.com.

Sincerely,

Jennifer Cornwell, MPH
Executive Director

Appendix B

Translator's/Interpreter Pledge of Confidentiality

Research Project Title:

Building a Theory of Iraqi Refugee Resettlement: A Proposed Grounded Theory Study

Principal Investigator:

Lisa Davenport
ldavenp1@utk.edu

As a translator/interpreter for this research project, I understand that I will be hearing and translating confidential information during face to face, voicemail, and email interactions with study participants. The information that is revealed by research participants in this project is given in good faith that their personal information will remain strictly confidential. I understand that I have a responsibility to honor this confidentiality agreement. I hereby agree not to share any information revealed in any mode of communication with study participants to anyone except the primary researcher of this project, Lisa Davenport. Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

_____ _____

Translator/Interpreter Signature Date

Appendix C

ORIGINAL INFORMED CONSENT STATEMENT

Building a Theory of Iraqi Refugee Resettlement: A Proposed Grounded Theory Study

INTRODUCTION
You are invited to participate in a research study on refugee resettlement in the United States. The research will be conducted by Lisa Davenport who is a doctoral nursing student with the University of Tennessee. The purpose of this research study is to:

1. Learn about Iraqi refugees' resettlement in the U.S so nurses and healthcare professionals can better understand how to assist them.

INFORMATION ABOUT PARTICIPANTS' INVOLVEMENT IN THE STUDY
Prior to beginning the study, you will be requested to sign this consent document using your legal name. If you object to signing your legal name, then you can give verbal consent prior to an interview, and your verbal consent will be audio recorded, and kept separate from your interview. All audio-recorded verbal consents will be kept locked and confidential with all research documents.

In order to protect your privacy, the researcher will also request you to provide a pseudonym (nickname or alternate name) that you would like to use for identification purposes. This fake name will be used on all transcripts and will protect your real name. A master list that matches your name with the alternate (fake) name will be kept under lock and key by the researcher.

You will be requested to participate in an initial, digitally audio voice recorded interview that will last approximately one hour, but it may be shorter or longer depending on what you have to say. The interview will be over when you tell me it is over. No photos and no videos will be taken. You may also be asked to complete a follow-up interview lasting approximately one hour if the investigator needs further explanation of your experiences.

You will be interviewed in person at a private location of your choosing regarding your experience of resettlement in the United States. You will be allowed to choose the location of the interview. Permission has been granted to conduct interviews at Bridge in a private room. This will give you the most privacy. You may also choose an alternate location for the interview, such as your home, local mosque or a private room in a local library. Those locations may be slightly less private because they are in a public place. The investigator may invite you to read a summary of the study findings and share your opinions as it compares to your own experiences.

_____ Participant's initials

You will be asked a set of questions such as your age, gender, ethnic origin, length of time in the U.S. You will also be asked to respond to interview questions such as, "Tell me, as much as you are comfortable sharing with me, your experience of resettlement in the United States". If you are a member of the community who works with refugees, you may be asked to respond to "Tell me your experience of working with Iraqi refugees as they resettle in the United States".

INTERPRETER

All interviews with Iraqi refugees will be translated and interpreted by an Arabic speaking person. You have the choice to have a male or female interpreter who will be present for all interviews and will sign a confidentiality agreement stating that he/she will not discuss information revealed in the interview with anyone. Interviews conducted with community partners will be conducted in English.

BENEFITS

There will be no direct benefit to you for participating in the research study. However, participation will give you the opportunity to share your perceptions of the adaptation experiences you have had while resettling in the United States. Your participation in the study will contribute great insight into refugee experiences so that nurses and healthcare professionals can better understand how refugees can be assisted in the future as they resettle in the U.S.

RISKS

The anticipated risk of participating in the proposed research is minimal. However, reflecting on your experiences may elicit painful memories and emotions, or you may feel uncomfortable talking about some issues during the interview. You are free to decline to answer any question(s) that you do not want to answer, or stop the interview at any time without penalty. Loss of confidentiality is another risk. The use of an interpreter/translator may increase the risk of loss of confidentiality. However, the interpreter has been trained in research methods and has signed a confidentiality agreement stating that he/she will not reveal the contents of interviews to anyone other than the principal investigator. Another risk is that your identity could become known. To protect against this, no real names will be used when the findings are presented at professional meetings or conferences. All names and locations mentioned in the interviews will be changed to protect your identity. All records will be locked in a secure office.

CONFIDENTIALITY

All information in the study records will be kept confidential. Digital recordings, transcriptions and any other research data will be stored securely in a locked file as well as a password protected computer and will be made available only to persons conducting the study unless you specifically give permission in writing to do otherwise. No reference will be made in oral or written reports which could link you to the study.

_____ Participant's initials

Transcripts, digital recordings, informed consents, confidentiality statements, electronic data storage devices and all other research information will be kept in the office of Dr. Susan Speraw, dissertation chair, for three years. Transcripts that have no identifying information about you on them will be kept indefinitely by the principal investigator for further research purposes. All other research documents including digital audio recordings, informed consents, confidentiality statements, electronic data storage devices and pseudonym master lists will be destroyed after three years by shredding all paper documents as well as deleting all digital recordings. Electronic computer files related to the research study will be kept on a password protected computer owned by the principal investigator until the study is completed. When the study is complete, all electronic computer files will be placed on a data storage device that will be given to Dr. Susan Speraw to keep in her office. The electronic files will be deleted from the principal investigator's password protected computer and the data given to Dr. Speraw will be kept for three years and then destroyed by deleting all electronic information.

The only time when confidentiality must be broken is if you tell the researcher that there is an immediate danger that you will seriously harm yourself or another person, or if you tell about a potential significant risk of harm to a child, an elderly person, or a disabled person. If you report this kind of immediate risk the researcher is legally required to file a report with the authorities who can step in to help assure your safety and protection.

COMPENSATION

You will receive a $10 gift card to WalMart after each interview for participation in the study. You will receive the gift card regardless of how long the interview lasts.

EMERGENCY MEDICAL TREATMENT

The University of Tennessee does not "automatically" reimburse you for medical claims or other compensation. If physical injury is suffered in the course of research, or for more information, please notify the investigator in charge (Lisa Davenport, Principal Investigator, 1-865-309-0968).

CONTACT INFORMATION

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study,) you may contact the researcher, Lisa Davenport at ldavenp1@utk.edu and 1-865-309-0968. If you have questions about your rights as a participant, contact the Office of Research Compliance Officer at (865) 974-3466.

_____ Participant's initials

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

CONSENT TO PARTICIPATE IN THE STUDY

I have read the above information. I have received a copy of this form. I agree to participate in this study.

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

CONSENT TO REVIEW STUDY FINDINGS

I agree to review a summary of the study findings and give feedback.

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

I may be contacted at:

Phone: _____

Email: _____

Address: _____

ORIGINAL TO ARABIC INFORMED CONSENT STATEMENT

بناء نظرية حول تكيف اللاجئين العراقيين: دراسة ترتكز على نظرية مقترحة

مقدمة

انتم مدعوون للمشاركة في دراسة بحثية في مجال تكيف اللاجئين لإعادة توطينهم في الولايات المتحدة. وستقوم بالبحث ليزا دافنبورت طالبة الدكتوراه في كلية التمريض في جامعة تينيسي. والغرض من هذه الدراسة البحثية هي:

1. معرفة كيفية إعادة توطين اللاجئين العراقيين في الولايات المتحدة حتى تستطيع الممرضات والعاملين في مجال الرعاية الصحية المساعدة بصورة أفضل.

معلومات حول الاشتراك في الدراسة

قبل بدء الدراسة سيطلب منك توقيع وثيقة الموافقة هذه مستخدما اسمك كما يظهر في اوراقك الرسمية. في حال رفضك ذلك فان بإمكانك اعطاء تخويل شفهي قبل المقابلة وسيتم تسجيل تخويلك الشفهي صوتيا وحفظه بمعزل عن مقابلتك. كل التخويلات المسجلة صوتيا سيتم حفظها بسرية مع وثائق البحث الاخرى.

ولغرض حماية خصوصيتك فسيطلب منك الباحث تقديم اسم مستعار (كنية او اسم بديل) قد ترغب في استخدامه لاغراض التعريف عن نفسك. و سيتم استخدام هذا الاسم المزيف في كل النصوص كما سيحمي اسمك الحقيقي. وستكون هناك قائمة رئيسية يتطابق فيها اسمك الحقيقي والمزيف يحفظها الباحث بالقفل والمفتاح.

سوف يطلب منك أن تشارك في مقابلة أولية مسجلة صوتيا والتي تستمر ساعة واحدة تقريبا قد تكون مقابلة أقصر أو أطول من ساعة واحدة اعتمادا على ما لديك لتقوله. والمقابلة تنتهي عندما تقول لي أن تنتهي. ولن يتم اخذ صور او مقاطع فيدو اثناء المقابلة. وبالإضافة إلى ذلك، قد يطلب منك حضور مقابلة إضافية لاستكمال مقابلة سابقة قد تستمر لساعة واحدة إذا كان الباحث يحتاج إلى مزيد من التوضيح حول تجربتك.

وستتم مقابلتك شخصيا في مكان خاص من اختيارك للحديث عن تجربة تكيفك مع إعادة التوطين في الولايات المتحدة. وسيسمح لك باختيار موقع المقابلة. تم الحصول على موافقة لاجراء المقابلات في غرفة خاصة في منظمة بريج. وباستطاعتك تغير موقع المقابلة الى موقع اخر كبيتك او المسجد او غرفة خاصة في مكتبة عامة لكن هذه الاماكن ربما تكون اقل خصوصية لانها تعتبر اماكن عامة. قد يدعوك الباحث لقراءة ملخص لنتائج الدراسة وتبادل الآراء الخاصة بك لأنها تعكس التجارب الخاصة بك.

سيتم طرح مجموعة من الأسئلة عليك مثل السن والجنس و العرق، وطول مدة الإقامة في الولايات المتحدة، وما إلى ذلك. سوف يطلب منك أيضا الرد على أسئلة معينة في المقابلة مثل، " اخبرني، بقدر ما تشعر بالارتياح في التكلم معي، عن تجربة إعادة توطينك في الولايات المتحدة ".

الحروف الاولى لاسم المشترك: _____

المترجم

وسيتم ترجمة جميع المقابلات وتفسيرها من قبل شخص يتحدث اللغة العربية. سيكون لديك الخيار في إجراء المقابلة مع مترجم أو مترجمة. سيكون المترجم حاضرا في جميع المقابلات وسيوقع على تعهد يفيد أنه لن يناقش أي معلومات تتعلق بالمقابلة لأي شخص.

الفوائد

لن تكون هناك فائدة مباشرة لك من المشاركة في هذه الدراسة. ومع ذلك، فإن المشاركة تعطيك الفرصة لتبادل الآراء الخاصة بك عن تجربتك في التكيف بينما أعيد توطينك في الولايات المتحدة. ومشاركتك في هذه الدراسة ستساهم بالكثير بحيث ستمكن الممرضات والمختصين في مجال الرعاية الصحية من فهم ومساعدة اللاجئين في المستقبل بصورة أفضل بينما يتم إعادة توطينهم في الولايات المتحدة.

المخاطر

المخاطر المتوقعة من المشاركة في البحث المقترح هي الحد الأدنى. ومع ذلك، فان التحدث عن تجربتك الشخصية ربما يثير ذكريات وعواطف مؤلمة أو قد تشعر بعدم الارتياح في الحديث حول بعض القضايا خلال المقابلة. أنت حر في رفض الإجابة عن أي سؤال لا ترغب بالرد عليه، أو التوقف عن المقابلة في أي وقت من دون عقوبة. فقدان السرية هي خطر آخر. فإن استخدام مترجم / مترجمة تزيد من خطورة فقدان السرية. ومع ذلك، فقد تم تدريب المترجم على طريقة البحث، وقد وقع على تعهد للسرية يفيد انه / انها لن يكشف عن محتويات المقابلات مع أي شخص. وهناك خطر آخر هو أن هويتك يمكن أن تصبح معروفة. للحماية ضد هذا، سوف تستخدم أسماء غير حقيقية عندما يتم تقديم نتائج البحث في الاجتماعات أو المؤتمرات المهنية. وسيتم تغيير جميع الأسماء والمواقع المشار إليها في المقابلات لحماية هويتك.وسوف يتم حفظ كافة السجلات في مكتب آمن.

السرية

ستبقى جميع المعلومات المسجلة في الدراسة سرية. وسيتم تخزين التسجيلات الرقمية، وتدوين أية بيانات للبحوث الأخرى بشكل آمن في ملف مؤمن، فضلا عن جهاز كمبيوتر محمي بكلمة مرور، وسوف تتاح هذه المعلومات للأشخاص المشتركين في الدراسة فقط إلا إذا كنت قد أعطيت إذن خطي للقيام بخلاف ذلك. وسوف لن ترد أي إشارة في تقارير شفوية أو كتابية من شانها أن تربطك بالدراسة.

النصوص والتسجيلات الرقمية ووثيقة موافقتك على المشاركة وسرية البيانات وادوات خزن المعلومات الرقمية بالاضافة الى كل المعلومات المتعلقة بالبحث ستخزن في مكتب الدكتورة سوزان سبرو المسؤولة عن الاطروحة. اما بالنسبة الى النصوص التي لاتحتوي على معلومات تتعلق بهويتك سيحتفظ بها الباحث بالتاكيد لاغراض بحثية اضافية. وسيتم تدمير جميع الوثائق البحثية الأخرى بما في ذلك التسجيلات الصوتية الرقمية، والموافقات، والبيانات السرية، وأجهزة تخزين البيانات الإلكترونية والقوائم التي تحتوي على الاسماء المستعارة بعد ثلاث سنوات كما سيتم حذف جميع التسجيلات الرقمية كذلك. وستبقى ملفات الكمبيوتر الإلكترونية المتعلقة بالبحث على جهاز كمبيوتر محمي بكلمة سر يملكها الباحث الرئيسي حتى يتم الانتهاء من الدراسة. عندما تنتهي الدراسة، سيتم وضع جميع ملفات الكمبيوتر الإلكترونية على جهاز تخزين للبيانات وتعطى الى الدكتورة سوزان سبرو لتحتفظ بها في مكتبها.

الحروف الاولى لاسم المشارك _____

وسيتم حذف جميع البيانات من كومبيوتر الباحث المحمي بكلمة السر. اما البيانات المعطاة الى الدكتورة سبرو سيحتفظ بها لمدة ثلاث سنوات ليتم تدميرها بحذف جميع الملفات الالكترونية.

المرة الوحيدة التي يجب فيها كسر السرية هي اذا قلت للباحث أن هناك خطر داهم بحيث تلحق ضررا بالغا بنفسك أو أي شخص آخر، أو إذا اخبرته عن خطر كبير محتمل من شانه ايذاء طفل أو شخص مسن، أو شخص معاق. إذا ابلغت عن هذا النوع من الخطر الفوري فانه الباحث ملزم قانونيا بإبلاغ السلطات المعنية التي يمكن أن تقدم المساعدة في ضمان سلامتك وحمايتك.

تعويضات

سوف تحصل على بطاقة هدية قيمتها 10 دولار إلى وول مارت بعد كل مقابلة للمشاركة في الدراسة. سوف تتلقى بطاقة هدية بغض النظر عن مدة المقابلة.

العلاج الطبي الطارئ

جامعة تينيسي لا تسدد لك المطالبات الطبية أو تعويضات أخرى تلقائيا. إذا لحق بك ضرر مادي في سياق البحث، أو لمزيد من المعلومات الرجاء إبلاغ الباحثة (ليزا دافنبورت، الباحثة الرئيسية، 1-865-309-0968).

للاستفسار:

إذا كانت لديك أسئلة في أي وقت عن الدراسة أو الإجراءات، (أو كنت تواجه آثار سلبية نتيجة للمشاركة في هذه الدراسة،) يمكنك الاتصال بالباحثة ليزا دافنبورت على البريد الالكتروني:

ldavenp1@utk.edu

او على الهاتف الأتي:

1-865-309 -0968

إذا كانت لديك أسئلة عن حقوقك كمشارك، اتصل بمكتب الموظف المسؤول عن البحوث على الهاتف الاتي:

(865) 974-3466 .

المشاركة في البحث

مشاركتك في هذه الدراسة هي طوعية، تستطيع رفض المشاركة من دون اي عقوبة. إذا قررت المشاركة، فانك تستطيع الانسحاب من الدراسة في أي وقت من دون عقوبة ودون فقدان للفوائد التي من المفترض ان تحصل عليها. وإذا قررت الانسحاب من الدراسة قبل اكتمال جمع البيانات فانه سيتم إعادة البيانات إليك أو تدميرها.

_____الاحرف الاولى لاسم المشترك

الموافقة على المشاركة في الدراسة

لقد قرأت المعلومات الواردة أعلاه وحصلت على نسخة من هذه الاستمارة. وانا أوافق على المشاركة في هذه الدراسة.

توقيع المشترك _____التاريخ _____

توقيع الباحث _____ التاريخ _____

الموافقة على عرض نتائج الدراسة

أنا موافق على عرض مختصر لنتائج الدراسة وإبداء الرأي:

توقيع المشترك_____التاريخ _____
توقيع الباحث _____ التاريخ _____

يمكن الاتصال بي بالطريقة الاتية:

هاتف: _____
البريد الإلكتروني: _____
العنوان: _____

Arabic to English Back Translation of Informed Consent Statement
Statement of Agreement's Announcement

Building a theory about Iraqi Refugees' Resettlement: A study based on suggested (proposed) theory.

Introduction

You are invited to participate in a research study in the field of refugees resettlement in USA . Lisa Davenport, the PHD student in nursing college at UT will do the research. And the purpose of the research's study is:-

1. Learn how the Iraqi refugees resettle in USA so the nurses and the workers (people who work) in the field of health care can help them in a better way.

Information about the participation in the study

You will be asked to participate in a pre-interview which lasts for almost one hour. The interview might last for more or less than one hour based on what you have to say. And the interview ends when you ask me to end it. In addition to that, you might be asked to attend another interview to complete a previous one which might last for one hour if the researcher needs more clarification about your experience. You might be asked by the researcher (the researcher might ask you) to read a summary of the study's results and exchange your opinions because they reflect your own experience.

And you will be met in a special (private) place of your choice to talk about your adaptation's experience with the resettlement in USA. You will be asked a group (series) of questions about you like age, sex, and race, and the length of your stay in USA (how long have you been in USA) and so on. You will be asked to answer specific questions during the interview like, "tell me, as much as you feel comfortable to talk with me, about your experience for resettlement in USA". No pictures will be taken and no video clips. And your identity will not be revealed. And the interview will be audio recorded only.

Interpreter

All the interviews will be interpreted and explained by a person who speaks Arabic language. You will have the choice to do the interview with a male or female interpreter. The interpreter will attend in all the interviews and he/she will sign a pledge that he/she will not discuss any information regarding the interview with any person.

Benefits

There will be no direct benefit for you from your participation in this study. However, the participation gives you the opportunity to exchange your personal opinion

_____ initials of the participant

about your experience for the adaptation while you were resettled in USA. And your participation in this study will contribute a lot, so that the nurses and the workers in the health care field can understand and help the refugees in the future in a better way while they resettle in USA.

Risks

The anticipating (potential) risks in participating in the suggested (proposed) research are the minimal. However, speaking (talking) about your personal experience may raise memories and painful emotions or you might feel uncomfortable to talk about some issues during the interview. You are free to refuse answering any question you don't want to answer, or you may stop (end) the interview any time without any penalty. The loss of confidential is another risk. Hence, the use of male/female interpreter increases the risk of confidentiality loss. However, the interpreter has been trained for (about, on) the research's way, and he/she signs a pledge of confidentiality stating that he/she will not reveal the content of the interviews with any person. There is another risk that your identity may be known. To protect that, unreal (fake) names will be used when the research's results presented in the meetings or confessional conferences. All the names and the locations (places) which are referred to in the interviews will be changed to protect your identity and all the records will be kept in a safe place (office).

Confidentiality

All the registered information for the study is Confidential. And the digital recordings will be stored, and any data that will be written for the other records, will be stored in a safe way in a safe (secured) file, as well as a computer secured (protected) with a password, and this data (information) will be available to the people who are participated in this study only unless you gave a written permission to do otherwise. And there would not be any sign in a verbal (oral) or written reports that related you to the study.

Compensation

You will get a gift card that worth $10 to Wal Mart after each interview for participating in the study. And you will get a gift card regardless of the length of the interview.

Emergency Medical Treatment

UT does not pay you any medical claims or any other compensation automatically. If you get any physical damage in the research's context, or for more information please inform the researcher (Lisa Davenport, the chief (senior) researcher, 1-865-309-0968)

_____ initials of the participant

For information:-

If you have any questions anytime about the study or the procedures, (or you are facing (experiencing) negative affects due to participating in this study,) you can contact the researcher Lisa Davenport via Email: ldavenp1@utk.edu

Or via the following phone number:

1-865-309-0968

If you have questions about your rights as a participant, call the employee office who is responsible of researches via the following phone number:-

(865) 974-3466

Participation in the research

Your participation in this study is voluntarily, you can refuse the participation without any penalty. If you decide to participate, you can quit (withdraw) from this study anytime without any penalty and without losing the benefits that you suppose to get. And if you decide to quit (withdraw) from the study before the completion of the data (information) collection, then all the data will be returned to you or destroyed.

Agreement to participate in the study

I have read the above information and I got a copy of this form. And I agree to participate in this study.

Participant's signature _____ date _____

Researcher's signature _____ date _____

Agreement to present the study's results

I agree to a brief presentation to the study's results and give the opinion:-

Participant's signature _____ date _____

Researcher's signature _____ date _____

You may contact me via the following way

Phone:-_____

Email:-_____

Address:-_____

Appendix D

Original Study Advertisement

Now Enrolling Iraqi Refugee Participants in a Research Project

You are invited to participate in a research study on refugee resettlement in the United States. The purpose of this research study is to:

1. Learn how Iraqi refugees experience resettlement in the U.S so nurses and healthcare professionals can better understand how to assist refugees in the future.

This research will be conducted by Lisa Davenport who is a nursing student with the University of Tennessee and is part of her doctoral dissertation research on Iraqi refugee experiences with resettlement in the United States. Information obtained will help nurses and healthcare professionals better understand the resettlement experience and how Iraqi refugees adapt to resettlement in the U.S. Your participation will include at least one hour long interview in a private location of your choosing. It is voluntary and all information will remain confidential. No photos and no videos will be taken. No information will be disclosed about your identity or location. The interview(s) will be digital voice recorded only.

You are eligible to participate in this study if you:

1. are an adult man or woman age 18 or older
2. have resettled in the U.S. as an Iraqi refugee
3. have come to the U.S. within the last ten years
4. can speak either English or Arabic

For further information or to arrange an interview, you may contact:

Lisa Davenport

Email: Ldavenp1@utk.edu

Toll Free Number: 1-865-309-0968

Original to Arabic Translation of Study Advertisement

إشراك ألاجئين العراقيين في مشروع بحث

انتم مدعوون للمشاركة في دراسة بحثية في مجال تكيف اللاجئين في عملية إعادة توطينهم في الولايات المتحدة. والغرض من هذه الدراسة البحثية هي:

1. معرفة كيفية تكيف اللاجئين العراقيين مع تجربة إعادة توطينهم في الولايات المتحدة حتى تستطيع الممرضات والعاملين في مجال الرعاية الصحية أن يفهموا بشكل أفضل كيفية مساعدة اللاجئين في المستقبل.

وستقوم بهذا البحث ليزا دافنبورت طالبة التمريض في جامعة تينيسي ويشكل البحث جزءا من أطروحة الدكتوراه الخاصة بها التي تدور حول كيفية تكيف اللاجئين العراقيين مع تجربة اعادة التوطين في الولايات المتحدة. وسوف تساعد المعلومات التي
سيتم الحصول عليها الممرضات والعاملين في الرعاية الصحية على فهم أفضل لتجربة إعادة التوطين وتكيف اللاجئين العراقيين
معها في الولايات المتحدة. مشاركتكم سوف تشمل مقابلة طولها ساعة واحدة على الاقل في مكان خاص من اختياركم. المشاركة طوعية وستبقى المعلومات التي تدلون بها سرية. لن يتم التقاط صور او مقاطع فيدو لكم.كما لن يتم الإفصاح عن معلومات حول هويتكم أو عناوينكم. سيتم تسجيل المقابلات رقميا فقط.

انت مؤهلا للمشاركة في هذه الدراسة إذا كنت:

1. امرأة أو رجل بالغ سن 18 سنة أو أكثر
2. أعيد توطينك في الولايات المتحدة كلاجئ عراقي
3. جئت إلى الولايات المتحدة في غضون السنوات العشر الأخيرة.
4. تستطيع أن تتحدث العربية أو الإنجليزية.

لمزيد من المعلومات أو لترتيب مقابلة مع الباحثة تستطيع الاتصال ب :

ليزا دافنبورت

البريد الالكتروني: Ldavenpl@utk.edu

هاتف: 1-865-309-0968

Arabic to English Back Translation

Research announcement

Involvement of Iraqi Refugees in research project

You are invited to participate in a research study in the field of refugees' in the process of their resettlement in USA. And the purpose of this research study is:

1. Knowing (learn) how the Iraqi Refugees experience resettlement in USA, So the nurses and workers in the health care field would understand better how to help the refugees in the future.

Lisa Davenport, a nursing student in UT will do this research and it will be a part of her doctoral dissertation (thesis) which revolved around how to adapt the Iraqi refugees with the experience of resettlement in USA. The data that will be collected would help the nurses and the workers in the health care field to better understanding the experience of resettlement in USA. Your participation will involve an interview for at least one hour in a special (private) place of your choice. The participation is voluntary, and all the information that you would say will be confidential. There will be no pictures or video clips of you. And there will be no reveal of information about your identity or your addresses. The interview will be digitally recorded only.

You are eligible to participate in the study if you are:

1. Male or female of age 18 or more.
2. You have been resettled in USA as an Iraqi refugee.
3. You have come to USA during the last 10 years.
4. You can speak Arabic or English.

For more information or to arrange a meeting with the researcher, you may contact:

Lisa Davenport

Email: ldavenp1@utk.edu

Phone: 1-865-309-0968

Appendix E

Original Demographic Profile

Gender: □ Female □ Male

Age: _____ Marital Status: □ Married □ Single □ Divorced □ Widowed

Ethnic Origin: _____Primary language:_____

English Fluency: □ Can Speak English fluently

□ Can speak some English

□ Cannot speak any English

Length of time in the U.S. _____

Level of education prior to resettlement _____

Occupation in Iraq before resettlement _____

Occupation in the U.S. after resettlement _____

Employment status in the U.S.: □ Employed full-time

□ Employed part-time

□ Not employed

Length of employment: _____

Health insurance: □ Private insurance through employer

□ Private insurance w/o employer assistance

□ Medicare

□ Medicaid/Public insurance (Such as TennCare)

□ Uninsured

□ Don't know

Who lives in your household? (Check all that apply)

□ Husband/wife □ Children □ Older Parents □ Aunts □ Uncles □ Brothers □ Sisters □ Other

Total number of persons living in household: _____

Total number of children living in household: _____ Adults _____

Original to Arabic Translation

الملف الشخصي

الجنس: أنثى □ □ ذكر

العمر:_____ الحالة الاجتماعية: متزوج □ □ عازب □ مطلق □ أرمل

الأصل: _____اللغة الأم:_____

اللغة الانجليزية □ أتحدث الانجليزية بطلاقة
□ أتكلم بعض الإنجليزية
□ لا أتحدث الإنجليزية
مدة الإقامة في الولايات المتحدة. _____
مستوى التعليم قبل إعادة التوطين _____
الوظيفة في العراق قبل إعادة التوطين _____
الوظيفة في الولايات المتحدة بعد إعادة التوطين _____
وضعية عملك في الولايات المتحدة: □ عمل بدوام كامل
□ عمل بدوام جزئي
□ لا تعمل
طول مدة العمل: _____

التأمين الصحي: □ تامين خاص من خلال رب العمل
□ لدي تامين خاص بدون مساعدة رب العمل
□ ميدي كير
□ ميدي كيد / تامين صحي عام (مثل تني كير)
□بدون تامين
□ لا أعرف
من يعيش في منزلك؟ (اختر كل ما ينطبق)
□ الزوج / الزوجة □ الأطفال □ الآباء الكبار□ العمات □ الأعمام□ الإخوة □الأخوات □ أخرى
عدد الأشخاص الذين يعيشون في الأسرة: _____
عدد الأطفال الذين يعيشون في الأسرة: _____ عدد البالغين _____

Arabic to English Back Translation

Personal file

Sex: □ male □ female

Age: _____ Marital status: □ Married □ Single □ Divorced □ Widowed

Originality(race, ethnicity): _____ Mother tongue language: _____

English language: □ I speak fluent English.

□ Speak some English.

□ Don't speak English.

How long have you been in USA: _____

Education level before resettlement: _____

Occupation in Iraq before resettlement: _____

Occupation in USA after resettlement: _____

Status of your job in USA: □ Full time job

□ Part time job

□ No job

Length of work (It may mean: how long have you been working): _____

Health Insurance: □ I have private insurance through an employer

□ I have private insurance without the help of the employer.

□ Medicare

□ Medicaid/general health insurance (like Tenn Care)

□ Without insurance

□ Don't know

Who lives in your house (choose all that apply)

- □ Spouse (husband/wife)
- □ Children
- □ Elder fathers (it may be mother/father)
- □ Aunts
- □ Uncles
- □ Brothers
- □ Sisters
- □ Others

Number of people who live in the family: _____

Number of children who live in the family: _____ Number of adults: _____

Appendix F

Original Interview Protocol

The interview process will begin with an open-ended broad statement:

> "Tell me, as much as you are comfortable sharing with me, your experience as you have resettled in the United States".

As certain concepts emerge from the answer to the above statement, additional questions will be posed to the research participant about their general and health adaptation. Below are some questions to help guide the interview if needed:

1. What has helped you during this time in your life of resettlement?
2. What barriers have you experienced while resettling in the U.S.?
3. How has resettlement changed the way you live?
4. How has resettlement changed the way you think or feel about yourself?
5. How has your family or friends helped you during this time?
6. What does health mean to you?
7. How would you describe your health?
8. What health concerns(s) have you experienced before and during your resettlement experience?
9. When did you first experience these health concerns?
10. According to you, what caused these health concerns?
11. If you sought help for your health concerns, tell me about your visit and experience of seeking help
12. What treatments or recommendations did the health care provider or healer give you?
13. What treatments or recommendations have been offered by friends or family members?
14. What do you consider to be the best treatment for your health concerns?
15. How did the treatment or recommendation help you?
16. What other treatments or therapy have you done for your health concerns(s)?
17. What has helped you to receive the care you need for your health concerns?

18. What barriers have you experienced when seeking care for your health concerns?
19. What is your perception of health care in the United States?

All interviews will close with the following three questions:

20. Based on the experience you've shared with me, was resettlement in the U.S. worth it to you?
21. How can nurses or healthcare professionals ease the transition of resettlement for refugees?
22 Is there anything else you would like to add?

Original to Arabic Translation

طريقة المقابلة

ستبدأ المقابلة بعبارة ذو نهاية مفتوحة وواضحة:

"اخبرني، بقدر ما تشعر بالارتياح في التكلم معي ، عن تجربة إعادة توطينك في الولايات المتحدة".

بينما تنبثق بعض المفاهيم من الإجابة على العبارة المذكوره أعلاه، فسيتم طرح أسئلة إضافية على المشارك في البحث عن تكيفه العام و مع النظام الصحي. فيما يلي بعض الأسئلة للمساعدة في توجيه المقابلة إذا لزم الأمر:

1. ما الذي ساعدك خلال هذا الوقت من حياتك في إعادة التوطين؟
2. ما هي العقبات التي واجهتك في إعادة توطينك في الولايات المتحدة؟
3. كيف غير إعادة التوطين الطريقة التي كنت تعيش بها؟
4. كيف غير إعادة التوطين الطريقة التي تفكر أو تشعر بها عن نفسك؟
5. كيف ساعدك أصدقائك أو عائلتك خلال هذا الوقت؟
6. ماذا تعني لك الصحة؟
7. كيف تصف صحتك؟
8. ما المخاوف الصحية التي واجهتك قبل وأثناء تجربة إعادة التوطين الخاصة بك؟
9. متى واجهت أول هذه المخاوف الصحية؟
10. ما الذي سبب هذه المخاوف بالنسبة لك؟
11. إذا كنت قد طلبت المساعدة لبحث المخاوف الصحية الخاصة بك، أخبرني عن زيارتك و تجربتك في الحصول على المساعدة.
12. ما هي العلاجات أو التوصيات التي قدمها لك تامينك الصحي والطبيب الخاص بك؟
13. ما هي العلاجات أو التوصيات قدمت لك من قبل الاصدقاء او افراد الاسرة؟
14. ما هو العلاج الافضل لمخاوفك الصحية حسب رأيك؟.
15. كيف ساعدك العلاج أو التوصية ؟
16. ما العلاجات الأخرى التي قمت بها لمعالجة المخاوف الصحية الخاصة بك؟
17. ما الذي ساعدك في تلقي الرعاية اللازمة للتغلب على المخاوف الصحية الخاصة بك؟
18. ما هي العقبات التي واجهتك في البحث عن الرعاية الصحية للتغلب على مخاوفك الصحية؟
19. ما هو تصورك عن الرعاية الصحية في الولايات المتحدة؟

وسوف تغلق جميع المقابلات مع اثنين من الأسئلة التالية:

20. بناءا على التجربة التي تشاركت بها معي, هل كانت تجربة اعادة التوطين تستحق العناء بالنسبة لك؟
21. كيف يمكن للممرضات أو المتخصصين في الرعاية الصحية تسهيل عملية الانتقال في إعادة التوطين للاجئين؟
22. هل هناك شيء تود أن تضيفه؟

Arabic to English Back Translation

Interview method (way)

The interview will start with a clear and open end expression.

"Tell me, as much as you feel comfortable to speak (talk) with me, about your experience of your resettlement in USA."

While some concepts will arise from the answer for the above expression, some additional questions will be asked to the participant in the research about his general (whole) resettlement experience and adaptation of health. As following, some of the questions to help organize (guide) the interview if needed:

1. What did help you during this time of your life in resettlement?
2. What were the obstacles (problems) that faced you in resettlement in USA?
3. How did the resettlement change the way you used to live?
4. How did the resettlement change the way you think or feel about yourself?
5. How did your friends or family help you during this time?
6. What does the health mean for you?
7. How would you describe your health?
8. What were the health concerns (fears) that you faced before and during your experience of resettlement?
9. When did you face the first health concerns (fears)?
10. What cause the fears for you?
11. If you asked for help to discuss your health concerns, tell me about your visit, and your experience of getting that help?
12. What were the treatments and the recommendations that your health insurance and your personal (private, primary care) doctor gave you?
13. What were the treatments and recommendation that given (provided) to you from the friends and your family members?
14. In your opinion, what is the best treatment for your health concerns?
15. How did the treatment and the recommendation help you?
16. What were the other treatments you did here to treat (work on) your health concerns?
17. What did help you to get the necessary care to overcome your health concerns?
18. What were the obstacles you faced in looking for the health care to overcome your health concerns?
19. What do you think about the health care in USA.

All the interviews will be ended by either 3 of the following questions

20. According to (based on) your experience you shared with me, was the resettlement worth it?
21. How can the nurses or the professionals (specialists) in the health care ease the transition process of the resettlement for the refugee?
22. Do you have anything to add? (Do you want to add something?)

Appendix G

Transcriber's Pledge of Confidentiality

Research Project Title:

Building a Theory of Iraqi Refugee Resettlement: A Proposed Grounded Theory Study

Principal Investigator:

Lisa Davenport
ldavenp1@utk.edu

As a transcribing typist of this research project, I understand that I will be hearing digital recordings of confidential interviews. The information on these recordings has been revealed by research participants who disclosed personal information in good faith that their interviews would remain strictly confidential. I understand that I have a responsibility to honor this confidentiality agreement. I hereby agree not to share any information from these recordings with anyone except the primary researcher of this project, Lisa Davenport. Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

_____ _____

Transcribing Typist Signature Date

Appendix H

Institutional Review Board Approval

THE UNIVERSITY of TENNESSEE KNOXVILLE

DATE: June 11, 2012

Institutional Review Board
Office of Research
1534 White Avenue
Knoxville, TN 37996-1529
Phone: 865.974.3466
865.974.7400

IRB #: 8869 B
TITLE: Building a Theory of Iraqi Refugee Resettlement: A Proposed Grounded Theory Study

Davenport, Lisa
Nursing
4813 Lake Park Drive
Kingsport, TN 37664

Speraw, Susan
Nursing
1200 Volunteer Blvd.
Campus - 4180

The points of clarification you submitted to this office regarding the above-captioned project, satisfied the concerns of the reviewers and the IRB thus, your project has been granted approval.

Approval is for a period ending one year from the date of this letter. Please make timely submission of renewal or prompt notification of project termination (see item #3 below).

Responsibilities of the investigator during the conduct of this project include the following:

1. To obtain prior approval from the Committee before instituting any changes in the project.
2. To retain signed consent forms from subjects for at least three years following completion of the project.
3. To submit a Form D to report changes in the project or to report termination at 12-month or less intervals.

The Committee wishes you every success in your research endeavor. This office will send you a renewal notice on the anniversary of your approval date.

Sincerely,

Brenda Lawson
Compliances

Enclosure

Vita

Lisa Ann Davenport was born in Kingsport, Tennessee. She received her Bachelor of Science degree in nursing May, 1990 from the University of Tennessee. Her professional clinical experience includes medical-surgical, critical care, and emergency/trauma nursing. She has received specialty certification in emergency nursing. In August, 2007, she completed a Master of Science degree in nursing from the University of Tennessee in a Homeland Security Nursing Concentration with Management Focus. She then accepted a teaching position at East Tennessee State University as an assistant professor in the undergraduate nursing program. Currently, she holds membership in four professional nursing organizations and Sigma Theta Tau Nursing Honor Society. She has continued her education at the University of Tennessee where she has now completed requirements for a Doctorate of Philosophy in Nursing.