June 2023

"I'm Still Suffering": Mental Health Care Among Central African Refugee Populations in the Tampa Bay Area

C. Danee Ruszczyk
University of South Florida

“I’m Still Suffering”: Mental Health Care Among Central African Refugee Populations in the Tampa Bay Area

By

C. Danee Ruszczyk

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
Department of Applied Anthropology
College of Arts and Sciences
University of South Florida

Major Professor: Dillon Mahoney, Ph.D.
Nancy Romero-Daza, Ph.D.
Daniel Lende, Ph.D.

Date of Approval
June 20th, 2023

Keywords: Applied Anthropology, Mental Health Care, State Neglect, Domestic Abuse, Gender, US Refugee Resettlement

ACKNOWLEDGMENTS

I would like to take this space to acknowledge all of the support that I have received over the past two years. From my lifelong friends who encouraged me to reach for the stars yet again, to the newly found ones who are right there reaching for them with me. Thank you for being a part of my found family. To my partner who has seen me have one too many break downs, but still fed me, called me pretty, and pushed me to keep going. To my parents, who through trial and fire raised an adult with a determination to succeed, in spite of the *many* challenges that I faced during this program. To my sibling who stood by me through it all. To the community that is very much alive and here to stay. To my academic faculty who taught me not only some of the beautiful intricacies of what it means to be human, especially in the field of Anthropology, but also some important life lessons about resilience, perseverance, and that the field of mental health really is important both personally and professionally. Finally, to the director of AR4WRM and the Central African refugees that are in the Tampa Bay, it has been a pleasure to get to know you and it is my hope that we can bring about real change. I am determined to continue on my academic and social journey to a world where mental health care is considered a necessity, instead of a taboo burden that should be pushed down and away. Thank you.

TABLE OF CONTENTS

LIST OF FIGURES

ABSTRACT

An estimated 500 Central African refugee families have been resettled in the Tampa Bay Area since 2002 (RPC, 2022). The cycles of trauma that they have endured place them in vulnerable positions regarding their mental health. Struggling to exist within underfunded social programs that are rigid in their expectations and with the current system of reactive care vs preventative care, the refugees in Tampa are put in a difficult situation of navigating their own health and wellbeing in lieu of having the full support of the United States government and their community. I will discuss how these refugees experience and negotiate mental health care during resettlement – including an evaluation of the programs that currently "exist". Furthermore, I will discuss a case study that represents a stark example of how the current refugee resettlement structure within Tampa can allow for critical situations to become deadly. This critical situation was a result of neglect and evolved from a few simple issues that could have easily been resolved, and into a true crisis which resulted in numerous arrests, a teenager idolizing and attempting suicide, and domestic abuse. Utilizing focus groups, fictionalized vignettes, and participant observation, culturally appropriate mental health care methods will be discussed for future resettlement needs.

CHAPTER ONE:

INTRODUCTION

Overview of the Research

While proper and culturally appropriate mental health care is imperative for refugees to be able to integrate successfully into the receiving society, there is a severe lack of quality programs in the Tampa Bay area. Instead, refugees are often framed around their deficits rather than assets (Arnetz et al., 2013; Beiser, 2009), leaving Central African refugees in particular discussed as a burden to resettlement agencies and a drain on resettlement resources provided by the state and federal governments. Not only does such a framework ignore coping strategies refugees may have developed during their years of displacement, it also dangerously shifts the blame for slow integration into the United States' society onto the refugees themselves rather than on the power structures that perpetuate their neglect (Abu Suhaiban et al., 2019; Beiser, 2009; Berthold et al., 2014; Bosqui, 2020; Soifoine, 2022a).

This thesis focuses on three main topics: 1) how members of the Central African refugee community perceive mental health care available after resettlement in the United States, 2) their coping strategies for dealing with previous traumatic experiences that can be re-triggered through the structural insecurities they face after entry, and 3) what specific options for mental health care are available in Tampa Bay for this population in the case of an acute stress reaction. I will explore how refugees from Central Africa, particularly women, navigate their mental health care and bodily wellbeing as they resettle into the United States.

Resettlement is well known to be a stressful process that refugee women must overcome daily while dealing with adverse conditions in conjunction with many other forms of structural inequality and insecurity (Baer et al., 2017; Bosqui, 2020; Chung et al., 2021; Dhalimi et al., 2018; Familiar et al., 2021; Fine et al., 2022). Some of these challenges can be attributed to the numerous resettlement budget cutbacks (Alvarez, 2018; Amos, 2018), the systemic informalization of refugee resettlement (Jordan, 2023; Mahoney et al., 2020a), the general racism that is rampant in resettlement agencies, and differences in understanding of mental health and care. Through a collaboration with an African-run, community-based non-profit organization, this project seeks to advocate for and cultivate culturally and linguistically appropriate mental health care and programming for this population. This thesis also provides a blunt critique and recommendations to the numerous power structures and stakeholders who are tasked with the resettlement and continued care of this community.

This project builds upon several others that have been conducted with Central African refugees by faculty and students at the University of South Florida in collaboration with community partners in Tampa (Baer et al., 2017; Holbrook, 2019; Inks, 2021; Mahoney et al., 2020a; Mahoney et al., 2020b; Soifoine, 2022a). These previous studies gave me a framework around which I could quickly build rapport and make my own connections with the numerous stakeholders in the refugee and refugee resettlement communities in the Tampa Bay Area. This included an internship with a community-based non-profit, American Relief for World Migrants and Refugees (AR4WRM), and collaborations with state-run task force groups, programs within a refugee resettlement agency, and Central African refugee families living in the Tampa Bay area. My working relationship with these various stakeholders allowed to quickly apply my findings to help with struggles specific to Central African families.

In addition to contributing to the already large body of work examining refugee mental health (Abu Suhaiban et al., 2019; Arnetz et al., 2020; Beiser, 2009; Berthold et al., 2014; Bosqui, 2020; Bunn et al., 2021; Charlson et al., 2019; Chung et al., 2021; Esala et al., 2018; Familiar et al., 2021; Fine et al., 2022; Hameed et al., 2018; Hecker et al., 2015; Ibrahim & Hassan, 2017; Kaiser & Jo Weaver, 2019; Lindert et al., 2009; Miller & Rasmussen, 2017; Morina et al., 2018; Posselt et al., 2019; Riaño-Alcalá, 2008; Rohlof et al., 2014; Schubert & Punamaki, 2011; Shannon et al., 2015; Song et al., 2015; Steel et al., 2017; Tempany, 2009; Turrini et al., 2017; Verelst et al., 2014; Vinck & Pham, 2010; Wachter et al., 2018; Wright et al., 2016), this thesis will add texture to the literature by focusing narrowly on how the informalization of resettlement has widely contributed to gendered risks and domestic violence. This particular focus is especially important and adds to previous findings that resettlement practices can contribute directly to gender-based violence, including the barring of women from financial independence, mobility, or physical safety within their own homes (Arnetz et al., 2013; Soifoine, 2022a).

Drawing upon critical medical anthropology (Singer & Baer, 2018), I will provide the context necessary for understanding barriers to accessing quality mental healthcare, including the structural and political barriers, arguing that resettlement providers must be more collaborative and integrated in their approaches to the health and wellbeing of the entire person. This is something others have argued is often lacking in resettlement programs worldwide (Abu Suhaiban et al., 2019; Esala et al., 2018). Countering the narrative that refugees are deficient and lack agency, I utilize practice theory throughout this thesis to provide numerous examples of the agency and enormous capacity for resilience that refugees have despite the structural challenges

and numerous, cyclical, and traumatic events that are everyday realities to them (Ortner, 2006; Shapiro & MacDonald, 2017).

While refugees are often framed around their deficits, including in terms of their mental health, they do bring assets and coping mechanisms (Shapiro & MacDonald, 2017). These refugees are survivors and they do have agency and power despite the continuous, international portrayals within both media and academia of the deficits of such vulnerable populations (Andersson, 2018; Hoewe, 2018; Holmes & Castañeda, 2016). Moreover, due to this continuous negative portrayal and narrative of what it means to be a refugee, powerholders within resettlement programs, and even sometimes collaborators within USF, historically have been more focused on crisis management instead of offering concerted effort to the prevention of acute mental health reactions. This focus on "crises" by anthropologists and powerholders has been critiqued heavily (Andersson, 2018; Cabot, 2019; Soifoine, 2022a). Moreover, there has been a tendency among these power holders to shift the blame of these "crises" during resettlement onto the refugees themselves instead of recognizing how the structures and policies surrounding resettlement have made it next to impossible for these refugees to achieve the expected 'success' of being fully independent within three months of entry as stipulated by the U.S. Department of State and the Department of Health and Human Services- Reception and Placement (R&P) (Bureau of Population, 2023b; Forum, 2023).

Overview of Mental Health in America

According to the Centers for Disease Control, "1 in 5 US Adults live with a form of mental illness, over 1 in 5 youth (ages 13-18) either currently or at some point during their life,

have had a seriously debilitating mental illness, and about 1 in 25 U.S. adults live with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression" (CDC, 2023). The UN Secretary General furthermore confirmed that "we are living in a global mental health crisis" based on the recent report by the World Health Organization (ANI, 2022; WHO, 2021). He further discusses how lack of resources, inaccessibility to available resources, and the general stigma of mental health that is still prevalent today globally, have put individuals at further risk for acute mental health crises. Furthermore, there have been reports that we are fast approaching a human energy crisis as we are seeing higher pressures to perform and produce more in the professional and work setting, with decreasing resources, flexibility, and support (Fisse, 2023). "On the human level we've seen languishing, depleted surge capacity, and a global mental health crisis." (Fisse, 2023).

This increased burden on the workforce has had a direct consequence on the mental health of people across the globe, not just in the United States. This burden is increasingly contributing to burnout and feelings of apathy towards work and life in general. This is all important to consider as I will be discussing the effects of individuals in power positions showing signs of burnout in refugee resettlement. This thesis will show clear examples of the effects of state entities passing responsibility of resettlement onto those with less power, resources, and ability to push back against the socio-economic structures that are inescapable in a capitalist focused economy.

Overview of the Central African Refugee Community

This thesis project focused on the refugee community from the Democratic Republic of Congo (DRC) who had been forcefully displaced due to ethnic and gender-based conflicts and

violence. The precursors for this violence include the end of colonial rule in the region, the Rwandan Genocide, and the First and Second Congo Wars (Center, 2014; Council, 2021; Eaton, 2006; Inks, 2021; Mahoney et al., 2020a; Prunier, 2009; Soifoine, 2022a; Stearns, 2012). Because of their families' displacement from the DRC, these Central African refugees are colloquially and officially labeled as Congolese Refugees by state employees, the Tampa Bay Refugee Task Force, and policy documents regarding their resettlement. This can, however, be a problematic framing due to the contestedness around the Congolese identity that were central to the past and ongoing violence in the region (Glasman, 2017; Mahoney et al., 2020a; Prunier, 2009; Soifoine, 2022a; Stearns, 2012).

> People from the DRC have "always been a mixture of multilingual and multireligious Eastern and Central African peoples… and [they] emerged as an ethnic group through community-based consolidation of displaced peoples from throughout the region seeking refuge… But at the outbreak of both Congo Wars, the Rwandan government succeeded in using these complexities—particularly differences between Congolese of Rwandan heritage and others—as a way to militarize and mobilize Congolese villages to turn on one another (resulting in the death and displacement of millions of civilians)" (Mahoney et al., 2020a).

According to the Internal Displacement Monitoring Center, there are over 5.2 million internally displaced citizens within the Democratic Republic of Congo (DRC) and over two million refugees still reside within the surrounding countries due to the ongoing conflict and violence (Center, 2014; IDMC, 2021). The eastern DRC has long been either number one or two at the top of the Norwegian Refugee Council's list of Most Neglected Displacement (Council,

2021). This is due to lack of media and to widespread donor fatigue from supporting those affected by violence for the past 20 years.

An estimated 500 Central African refugee families have been resettled in the Tampa Bay Area since 2002 (RPC, 2022) and Kiswahili and Kinyarwanda-speaking families continue to arrive in large numbers through early 2022 (Force, 2021; Mahoney & Wright-Soifoine, 2021). Having completed the registration process through the United Nations High Commission for Refugees (UNHCR), many of these individuals have been in refugee camps throughout Central and East Africa for the past 10-20 years in countries like Burundi, Rwanda, Zambia, Kenya, Tanzania, Zimbabwe, Malawi and Uganda (Jansen, 2008; Thomson, 2012).

Central African refugees come to the United States in hopes of having a better, more stable life – one they have seen through American mass media. They are also looking to escape ethnic and gender-based violence and gain citizenship in a country that legally guarantees them protections and security (Mahoney et al., 2020a; NCTTP, 2018; Posselt et al., 2019). Almost all adult Central African refugees have survived through traumatic situations and the phases/cycles of trauma that Central African refugees have had to endure (and in most cases continue to endure) place them in a particularly vulnerable position regarding their mental health (Abu Suhaiban et al., 2019; Arnetz et al., 2020; Association, 2020; Beiser, 2009; Berthold et al., 2014; Bosqui, 2020; Chung et al., 2021; Familiar et al., 2021; Fine et al., 2022; Hameed et al., 2018; Hecker et al., 2015; Ibrahim & Hassan, 2017; Koegler, 2019; Levy & Sidel, 2009; Lindert et al., 2009; Miller & Rasmussen, 2017; Morina et al., 2018; Pearlin, 2005; Posselt et al., 2019; Schubert & Punamaki, 2011; Song et al., 2015; Steel et al., 2017; Steiner et al., 2009; Tempany, 2009; Thomson, 2012; Turrini et al., 2017; Verelst et al., 2014; Wachter et al., 2018; Wright et al., 2016).

However, when Central African refugees arrive in the United States, they experience a different sort of violence - an everyday violence where they must navigate within the broader structural inequalities and bureaucracy in an effort to maintain their agency (Farmer, 1996; Lockhart, 2008; Schepher-Hughes, 1992). With national refugee resettlement budget cuts that are still affecting staffing of resettlement agencies, and thus the subsequent state and federal push to informalization and reliance on volunteer time, the effectiveness of the available programing for refugees, such as housing, employment, and language development, are limited, if non-existent. Still, refugees are expected to be completely self-sufficient within three months of arrival (Alvarez, 2018; Amos, 2018; Holbrook, 2019; Lorenz, 2022; Mahoney et al., 2020a; Rodriguez et al., 2020). This leaves many families in limbo during the resettlement process as they struggle with little to no formalized support.

Previous Research Among the Study Population

In order to be inclusive and cognizant of the multiplicity of identities, anthropologists working with this population in previous studies from the University of South Florida (USF) have referred to this community as either Refugees from the Congo Wars (RFCW) (Baer et al., 2017; Billingsley & Mahoney, 2021; Holbrook, 2019; Mahoney et al., 2020a), or as Central African Refugees (Soifoine, 2022a). In particular, there are community divides between those who claim Congolese decent and those of both Congolese and Rwandan decent. Even among those of Rwandan decent, there are further divides between those who might identify or be identified as “Hutu” or “Tutsi.”

I am cognizant of the political nature of “tribe” or ethnicity in Africa (Mahoney, 2017; Southhall, 1970; Vail, 1991), as well as the traumatic and genocidal events that have framed this

population's past. These shared communities work well in the sense that they are interpersonal networks of reciprocity that are important to survival when there is a lack of formal resources. However, these are not democratic networks, and they can have their own internal power dynamics that are reproduced. Something that often puts these groups in a new type of competition and relationship guided by animosity here in the US. I also highlight the desire by most individuals (especially women and children) to distance themselves from their past experiences of violence - the younger generations in this population have little to no connection to the DRC since they were children when they fled or were born in the camps. Therefore, I will follow in Soifoine's footsteps and continue to refer to them as Central African Refugees (Soifoine, 2022a).

Soifoine's work on the intersections of food insecurities, gender violence and mobility with this population allows a nuanced look into how changes in resettlement, supply chain issues during the COVID pandemic, and gender expectations can have serious consequences to the population in question (Soifoine, 2022a). Ink's work on bullying within the Hillsborough school districts shows the direct correlations between the bullying, racism, and mental health issues with the younger Central African refugees to structural issues within resettlement (Inks, 2021). Mahoney's work in 2020 sought to build programming that is accessible to young refugees in an effort to motivate them, provide a space to learn English, and provide a space to be comfortable with themselves. The product of his work, a set of educational videos that are easily accessible to members of the community via YouTube, allowed knowledge gaps to be closed in a collaborative manner (Mahoney et al., 2020b). Finally, Holbrook and Baer's continuous work on the maternal health and nutrition of this population further shows how dearth in care for the population have serious and deadly consequences for their ability to resettle and their general

wellbeing (Holbrook, 2019). Building on these previous projects, my goal was to improve access to mental health care for refugees while continuing to stress the importance to resettlement agencies of understanding population-specific issues regarding broader mental health care.

Research Aim and Questions

Through frameworks of the anthropology of mental health (Drake, 2015; Kleinman, 2012; Westermeyer, 2011; Whitley, 2014), critical medical anthropology (Singer & Baer, 2018), structural violence (Farmer, 2016), everyday violence (Schepher-Hughes, 1992), practice theory (Ortner, 2006), and asset/ deficit discourse (Shapiro & MacDonald, 2017), the goal of this research was to assess the mental health care, needs and assets of this population from a grounded and applied ethnographic perspective. Furthermore, I intended to also identify the already in-use coping strategies that this population was implementing, with the hope of finding a way to distribute these strategies to the population at large and any newly arrived refugee families. This would then allow for implementation and development of mental health care and social programming that would work with this specific population's cultural understandings of mental health and its somatization, instead of blaming the population for struggling with the inadequate and inappropriate resources 'provided' to them.

My research focused on the main following questions:

1) How does this population understand mental health and what forms of mental health care do they normally utilize?

2) What types of services are out there for this population, are they culturally appropriate, and do these services have the ability to treat cross-culturally and linguistically?
3) What new methodologies of mental health treatment can be developed with this specific population's needs in mind?

A central aim is to reframe and shift the deficit and crisis narratives that are generally negative and focus solely on everything refugees have lost or endured, to a more immediate and applied anthropological approach that will uplift the voices of this population and show that there is an incredible capability of resilience and determination among them. By focusing on the agency, assets, perceptions, and knowledge that this community possesses, despite encountering numerous instances of structural and everyday violence through the experience of resettlement, my collaborators and I would then propose to powerholders, such as health care practitioners and resettlement agencies, new methodologies, and understandings of the mental health care needs of this population. To accomplish this, I worked closely with the founder of the non-profit AR4WRM, refugees themselves, and other graduate students who had been working with this population longer than myself. The relationships and internships that I developed and participated in over the course of this fieldwork from initial volunteer work in the community in the Fall of 2021 to Spring 2022, to this specific project in the Summer and Fall of 2022, were jumpstarted by my major professor, Dr. Dillon Mahoney, to whom I own my gratitude.

Thesis Organization

This thesis is organized into seven chapters. The present chapter (Chapter 1) introduced the overall argument of the need for mental health care among refugee populations, particularly

for US-based African refugees. It discussed mental health care and needs of people living in the United States and globally in general and how mental health care might be needed for this population in particular. The chapter also explained how this project builds upon previous research conducted among Central African refugees in Tampa, Florida. Finally, it discussed the research questions that have guided this project and outlines the structure of this thesis.

Chapter 2 introduces the realities of resettlement for Central African refugees in Tampa Bay and the need to have a greater focus on cross-cultural mental health. It frames the project within the theoretical frameworks used for the research and it examines literature relevant to the intersections of this project, which include mental health, refugee resettlement, gender, and mobility. It also discusses how the structure of the U.S. refugee resettlement system puts Central African refugees at a particular disadvantage, including the devastating effects of the recent defunding of the U.S. resettlement system. Finally, it discusses some of the specific issues that refugees resettled in Florida must overcome in their daily lives. These are all common issues that can further negatively affect the mental health of refugees.

Chapter 3 situates this project within the field of applied anthropology and discusses some of the politics and issues that I encountered while conducting this community-based research. It then describes entry into the field, community partnerships, recruitment, sampling, and details the research methods that were adapted to this specific project and population. The methods include ethnographic interviews, participant observation, focus groups, surveys, fictionalized vignettes, and semi-structured interviews. This chapter ends with my ethnographic sections of positionality, bias, reflexivity, and a discussion of any risk that was possible for this population during the course of this research.

Chapter 4 presents a case study that will be used to highlight some of the main issues that resettled refugees commonly face, as this situation is a stark example of how the informalization of refugee resettlement allowed for a very dangerous situation to unfold. This chapter includes discussions of mental health, trauma, suicidal ideation, suicidal attempts, domestic abuse, emotional abuse, and neglect.

Chapter 5 presents the findings from the focus group that was conducted with members of the community after a continuous drivers' education program, which was developed after a previous colleague's work with mobility and gender issues (see Soifoine 2022). This section gives more context to refugees' lived experiences while also not questioning them directly on their own histories of trauma. This section deals with participant's perceptions of mental health coping techniques, recommendations that they would give a newly arrived refugee who was struggling, and best strategies for coping with the challenges they face during resettlement.

Chapter 6 presents the findings of the structured interviews and the survey of mental health practitioners potentially accessible to refugees looking for culturally appropriate mental health care. This chapter highlights some of the broader research themes such as informalization of refugee resettlement and the prevalence of neoliberal ideologies in guiding resettlement policy. In the end, the available resources were few and far between, and gender and racial biases were highlighted.

Chapter 7 summarizes the findings of this project as well as the scholarly contributions to applied anthropology. It then discusses how the findings of this project have been applied, including future possibilities for further research and appropriate mental health care programming. This chapter also provides five recommendations for improving local refugee capacity by building social networks in order to combat feelings of isolation, neglect, and other

unmet community needs. Finally, I offer a reflection on some of the broader changes, including attitudes and approaches, that need to happen to avoid a continuation of the types of acute stress induced reactions and other dangerous mental health cases I witnessed and describe here.

CHAPTER TWO:

REFUGEE RESETTLEMENT AND CROSS-CULTURAL MENTAL HEALTH

Introduction

"I've had leukemia for the past five years and I can't afford my treatment. It's so much money and I'm just suffering so much" – Congolese woman, 50s.

I remember sitting in the kitchen of the woman quoted above after watching her cook a traditional East African meal of fish and cassava leaves. I had not spoken Kiswahili in over a year and a half, and she was telling me a story of how she was resettled in the United States over five years ago. When she first arrived, she was sick, and no one knew what was wrong with her, despite multiple visits to the doctor. She explained that it took numerous years for them to appropriately diagnose her and her cancer. This woman was sobbing at her kitchen counter telling me that her chemo treatments were so expensive and that she was a "businesswoman". She wanted to be making money and working, and instead, she could barely do a few hours of normal activities before needing a nap. She said that she was only getting treatment for her cancer when she could afford it, and that there were no services to support her emotionally through her ordeal.

This is just one of many stories of refugees from the eastern DRC who have resettled in the United States after surviving years of conflict and violence. She had escaped the immediate violence in her country of birth, but she was still suffering. While I have a background in both East Africa and working with mental health issues, this blunt and emotional appeal was

something that I had never encountered, and it left me with numerous questions and concerns. How can a population that we have taken under the wings of the United States still be left with so little support for addressing issues of trauma and mental health care? How can people who came to this country in search of legal protection and security still be struggling to feel secure and maintain their mental health? How can we ensure that the mental health care and resources available for these refugees are not contributing to or reproducing other forms of structural, everyday, and symbolic violence?

Refugee Resettlement in the United States

According to the UNHCR fact sheet for the United States and the American Psychiatric Association: "Refugees do not choose which country they would like to live in. The United Nations High Commissioner for Refugees makes recommendations to select countries. There are eight U.S. federal agencies, six security database biometric security checks, three in-person interviews with the Department of Homeland Security, and medical checks that are involved in the thorough screening of refugees which can take between 1-2 years." (Association, 2020).

[1]Since the 1970s the U.S. resettlement program was among the largest in the world for the resettlement of the most vulnerable populations (Association 2020). Up until the recent Trump administration, the number of refugees admitted into the United States for resettlement was averaging 75,000 refugees yearly. This number dropped significantly to just over 20,000 in the year 2018 (Kerwin & Nicholson, 2021; Soifoine, 2022a). The current U.S. Refugee resettlement system is effectively a product of a desire for global leadership and a vehicle of humanitarian assistance following World War II - initially designed to primarily assist displaced

[1] Everything in the next two paragraphs is coming from Haines (2022) and Soifoine (2021).

Europeans (Soifoine, 2021; Haines, 2022). Since the end of World War II, religious organizations were given the authority to aid refugees needing resettlement and to generate the appropriate funding sources to do so. With the turn of the 1980s, and the Presidency of Ronald Reagan, resettlement was slashed, bureaucratized, and essentially dismantled. This reflected broader and systematic political overtures in the U.S. to cut most public benefits to all citizens and non-residents.

Refugee admissions were set at 50,000 with the passing of the 1980 Refugee Act, but the actual number of arrivals were far lower than that. The U.S. saw a larger number of refugees from less privileged and more diverse backgrounds in the two decades following that. In the early 2000s, African refugee arrivals jumped sharply from essentially zero previously to nearly 50% of all newly arrived refugees. During the administrations of Bush and Obama, the refugee admissions cap was set between 40,000 and 85,000 per year, with the exception of the two years following 9/11 where the U.S. saw drastically lower admission rates. Under Obama, there were greater efforts to admit more refugees under the guise of humanitarianism, but the budget to resettlement and the time requirements of resettlement did not increase to reflect these grand gestures (Soifoine, 2022a).

Then, in more recent years with the Trump Administration, the levels of admitted refugees did not reflect accordingly to the record numbers of people that were forcibly displaced worldwide. The refugee admissions cap was drastically cut, even setting it to an all-time low of 15,000 in the last few months of his administration in 2021 (US Department of State 2021, Soifoine 2022). This effectively "smothered" the agencies that were charged with resettlement and capped the number of admitted refugees (Amos, 2018), and the ability to resettle refugees in an appropriate manner was gutted. The damage to resettlement brought by these cuts has had

lasting effects on the current realities of resettlement in states like Florida, and it will be years to come before the damage is assuaged (Kerwin and Nicholson 2021, Soifoine 2022).

The Biden administration has increased the cap on admitted refugees once again, but recently, there was a large push by the administration to informalize the resettlement process and rely on the use of volunteer networks for the successful resettlement of families (Jordan, 2023). This would seem like a perfectly appropriate solution to solve the issue of still recovering resettlement organizations attempting to process an even larger case load of refugees. However, this push to pass the job of resettlement to American families could be devastating for refugees, especially for their mental health. With greater numbers of individuals in need, providing less appropriate or formal resettlement has the potential to increase the health risks.

In this thesis I do not advocate for a return to pre-1980s resettlement tactics, because it is important to be critical of the shortcomings of resettlement focused on only European displaced peoples. Instead, I aim to show how those most vulnerable to the changing resettlement policies are being pushed further towards critical mental health conditions. These conditions are a cyclical extension of their previous traumatic experiences that forced them to leave their home countries in the first place. Additionally, I utilize critical medical anthropology to reflect on how this passive neglect by politically appointed resettlement agencies creates a narrative of blame and skepticism toward refugees neglected by an informalized and defunded resettlement system. These narratives add further to the everyday violence that these vulnerable populations must confront.

Resettlement Process

For reference, it is important to understand how refugee resettlement is supposed to work in order to understand why resettlement in Tampa is particularly dangerous to mental health care.

As these refugees are vetted through UNHCR, I will briefly describe in detail the process that each refugee goes through. In order to even be determined to be a refugee under the UNHCR mandate, an individual must fall under one of the following categories: "legal and/or physical protection needs, survivors of torture and/or violence, medical needs, women and girls at risk, family reunification, children and adolescents at risk, and lack of foreseeable alternative durable solutions" (UNHCR, 2023). Following a referral, the individuals are set up for an interview that includes all family members and translator, and can take anywhere from two to six hours (UNHCR, 2023). A form will be filed with UNHCR and they will determine a suitable country for resettlement, which can be determined by the individuals expressed wishes (UNHCR, 2023). Depending on the decision, the individual, and possibly their family, will begin preparations for travel. It should be noted that these individuals are provided with a loan for travel costs that they are expected to begin paying back beginning six months after their arrival (Bureau of Population, 2023a).

What happens once these refugees arrive? Refugees are supposed to be met by someone form the local resettlement agency, where they will then be taken to an initial housing area, which is supposed to have basic necessities such as "appropriate food" and other essential needs (Bureau of Population, 2023a). These resettlement agencies are then required to assist in initial resettlement, including:

> "…enrolling in employment services, registering youth for school, accessing medical care, applying for Social Security cards, and connecting them with necessary social or language services. In coordination with publicly supported refugee service and assistance programs, resettlement agencies focus on assisting refugees to achieve economic self-

> sufficiency through employment as soon as possible after their arrival in the United States." (Bureau of Population, 2023a).

This program is limited to the first three months after a refugee arrives in the United States (Bureau of Population, 2023a).

Anthropology, Refugees, and Mental Health

Because of the absolute necessity of cross-cultural understanding of mental health and care, I focus on the anthropology of mental health as a framework that utilizes cross cultural understandings of mental health, coping, and security (Drake, 2015; Kleinman, 2012; Westermeyer, 2011; Whitley, 2014). Employing this broader approach allows me to explore and utilize other frameworks such as critical medical anthropology, psychological anthropology, and medical anthropology in general (Bock, 1994; Joralemon, 2017; Singer & Baer, 2018).

Anthropological Theories in Use

In order to understand how I framed my research, I will discuss the theoretical frameworks that I utilized such as critical medical anthropology, structural violence, everyday violence, and practice theory. Through these frameworks and from my initial interaction with this community, I was able to figure out some of the structural causes for the inequities of mental health care for this population. Furthermore, by leveraging these frameworks I was able to formulate possible structural changes that would benefit this population, while keeping their cultural understandings of mental health in mind.

Critical Medical Anthropology is an ethnographic-focused approach that considers how the prevalent political nature can directly correlate to effects on the social and economic

inequalities of individual health within a health care system (Singer & Baer, 2018). Furthermore, while still recognizing and acknowledging the agency and role within an individual's experience, it focuses on how structural inequalities and factors have a direct consequence on the allocation and distribution of resources of care (Singer & Baer, 2018). This in turn can further constrain the available choices that an individual is able to make in regard to their own health care. This structural inequity has an overall negative impact on the health of those who have less privileged intersectional ties (Singer & Baer, 2018).

Structural violence (Farmer, 2016) and everyday violence (Schepher-Hughes, 1992) are similar concepts in the sense that they both examine how societal structures make it difficult for individuals of marginalized intersectional backgrounds to meet their basic life needs; however they differ in terms of individual agency. In structural violence, there is little to no consideration of how individual agency can combat some of the violence that is perpetrated by harmful social institutions (Farmer, 1996). However, the concept of everyday violence takes into account the social structures that can impede an individual, but it also focuses on the banal, everyday instances that people struggle against (Schepher-Hughes, 1992). These everyday instances of harm can inevitably be tied back to social institutional violence, but they allow for the agency of the individual to be considered, as they are not seen as just passive actors (Schepher-Hughes, 1992).

Theories in Practice

By pursuing critical medical anthropology, I utilize models of care that have recently shown promise in populations such as the one included in this study, such as collective or shared interventions (Animbom Ngong, 2017; Bosqui, 2020; Bryant et al., 2022; Bunn et al., 2021;

Esala et al., 2018; Koegler, 2019; Mels et al., 2010; Nuwer, 2020; Oppedal & Idsoe, 2015; Puffer et al., 2016). By leveraging pre-existing resources within the community, community-based approaches allow for a means of achieving positive change and care, specifically in terms of mental health (Bryant et al., 2022; Gone & Kirmayer, 2020; Kong et al., 2021; Mistry et al., 2021; Nuwer, 2020). Furthermore, I keep phenomenology and somatization, or the physical expressions of mental phenomena and people's understanding of mental health and illness, at the core of my research (Kleinman, 1977). This project brings forth the combined different perspectives on mental health and will hopefully help shape future methods of care that will be appropriate to this and similar populations (Kaiser & Jo Weaver, 2019; Kirmayer et al., 1952; Rohlof et al., 2014; Singer, 1977; Singer & Baer, 2018; Singer et al., 2011).

There is considerable research on mental health among refugees (Abu Suhaiban et al., 2019; Arnetz et al., 2020; Arnetz et al., 2013; Beiser, 2009; Berthold et al., 2014; Bosqui, 2020; Bunn et al., 2021; Charlson et al., 2019; Chung et al., 2021; Familiar et al., 2021; Fine et al., 2022; Hameed et al., 2018; Hecker et al., 2015; Ibrahim & Hassan, 2017; Lindert et al., 2009; Lokuge et al., 2013; Mels et al., 2010; Rohlof et al., 2014). There are clear findings that refugees coming from conflict ridden areas tend to have some trauma and underlying Post Traumatic Stress Disorder (PTSD) from events and situations that they experienced (Beneduce, 2008; Bosqui, 2020; Charlson et al., 2019; Familiar et al., 2021; Grasser & Javanbakht, 2019; Hecker et al., 2015; Ibrahim & Hassan, 2017; Lokuge et al., 2013; Miller & Rasmussen, 2017; Morina et al., 2018; Schubert & Punamaki, 2011; Song et al., 2015; Steel et al., 2017), and refugees from the DRC have received particular focus and concern (Familiar et al., 2021; Koegler, 2019; Lokuge et al., 2013; Mels et al., 2010; Steel et al., 2017; Steiner et al., 2009; Verelst et al., 2014; Wachter et al., 2018). However, very few studies have been done with the goals of creating new

methods of care through the merging of cross-cultural understandings of mental health and community interventions in the country of eventual resettlement.

Mental health care is approached differently in different parts of the world (Abu Suhaiban et al., 2019; Animbom Ngong, 2017; Berthold et al., 2014; Bosqui, 2020; Grasser & Javanbakht, 2019; Harms et al., 2009; Knettel et al., 2018; Kong et al., 2021; Marshall et al., 2009; Schubert & Punamaki, 2011) and it is a topic that has been steadily increasing throughout Africa despite differences in understandings of somatization and methods of care (Animbom Ngong, 2017; Knettel et al., 2018; Nuwer, 2020; Puffer et al., 2016; Ventevogel et al., 2013). Community interventions have generally been met with great success (Animbom Ngong, 2017; Bosqui, 2020; Bryant et al., 2022; Bunn et al., 2021; Esala et al., 2018; Koegler, 2019; Mels et al., 2010; Nuwer, 2020; Oppedal & Idsoe, 2015; Puffer et al., 2016) especially those that can create healing spaces through gathering and performance (Animbom Ngong, 2017; Roy-Omoni, 2022). This project aims to bring both methodologies to the forefront of current mental health care practices for this Central African refugee community living here in the Tampa Bay.

Refugee Mental Health

Recent studies have found that one in three asylum seekers or refugees globally have high rates of PTSD, anxiety, and depression (Association, 2020; Charlson et al., 2019; Chung et al., 2021). This can be due to experiences in war zones, including ethnic and gender-based violence (Abu Suhaiban et al., 2019; Arnetz et al., 2020; Association, 2020; Levy & Sidel, 2009). However, past traumatic experiences are not the only reasons for the continuation of adverse mental health experiences among refugees. Recent studies and my own experience working with Central African refugee populations confirm that the violence does not necessarily end after

refugees enter the country of resettlement (Baer et al., 2017; Beneduce, 2008; Dhalimi et al., 2018; Inks, 2021; Jansen, 2008; Lorenz, 2022; Mahoney et al., 2020a; Thomson, 2012; Wright et al., 2016). Rather, it changes to a more structural, everyday violence that includes racism, inequity, and neglect that can be explained through a lens of critical medical anthropology (Singer & Baer, 2018).

As others have found, the resettlement process can sometimes further intensify cycles of trauma on this population (Amos, 2018; Beiser, 2009; Mahoney et al., 2020a; Soifoine, 2022a), not because of physical violence, but due to blatant mistreatment by those entrusted to care for this population. The new experiences of further state-imposed limitations and the informalization of resettlement policies and procedures can subsequently increase the risk of further stress-induced mental health outcomes of refugees. Refugees are supposed to be 'resettled' with state-support, but in reality, they are continually overcoming and struggling against everyday, racially motivated, and state-sanctioned negligence that comes in the form of neoliberal ideologies of self-sufficiency.

For reference, neoliberalism is one of the dominant social theories that maintains that by reducing state interventions and responsibility of care, it will allow for the possibility of freeing up capital and the market, which will in turn allow for more of a buy in to social wellbeing and programs (Navarro, 2007). In the course of my work, it became especially clear that this passing of responsibility of care by the state onto volunteer run organizations and the other, further bureaucracy of resettlement further added to the stress and feelings of liminality within this community. It also subsequently furthered gendered violence and risks, in particular.

Concurrently with state-endorsed neglect, refugees are still dealing with the subsequent effects of being in a liminal place on camps for upwards of 20 years of their lives, or in the cases

of the children, their entire lives. In this sense, a lack of sufficient services in the United States retraumatizes the most vulnerable within refugee populations, lessens their own ability to have power and autonomy over their lives, and subjugates them to further violent, everyday lives (Arnetz et al., 2020; Beiser, 2009; Familiar et al., 2021; Hecker et al., 2015; Koegler, 2019; Levy & Sidel, 2009; Mahoney et al., 2020a; Pearlin, 2005; Posselt et al., 2019; Thomson, 2012; Wachter et al., 2018).

After resettlement, the continuation of this liminal legal status of refugees (still African, not yet American) makes it difficult to maintain cultural, familial, and community ties, which are important for dealing with traumatic incidents and maintaining overall wellbeing (Beiser, 2009; Lori & Boyle, 2015; Sidel, 2008). Central African refugees are also regularly generalized and grouped together as "Congolese Refugees", even though what it means to be "Congolese" is a colonial construction (Geenen, 2019; Gehrmann, 2009). This population of refugees, fleeing ethnic conflict and violence, carry an array of intersectional ties and identities related to their ethno-linguistic backgrounds and religious denominations (Mahoney et al., 2020a).

Issues while resettling in Tampa- (Housing, automobility, mental health care, etc.)

When refugees first enter the United States, their caseworkers at resettlement agencies are supposed to prioritize housing, appropriate food, and language barriers as primary concerns. In this thesis, I will discuss additional specifics around these issues that have become apparently normalized as part of resettlement within Hillsborough County, Florida. Further, as I have found, despite making claims to the contrary, resettlement services seemingly give little to no consideration to the mental wellbeing of refugees in resettlement, as not only is mental health generally not prioritized, but the impacts of other resettlement decisions (regarding housing,

transportation, and finances, for example) on mental health is generally ignored or misunderstood.

Housing in Tampa

With the dramatic, pandemic-related increase in the cost of housing in the Tampa Bay Area since 2020 (although the increases began earlier), it has not only been difficult to find housing for refugees, but once housing has been found, refugees are more than likely to be resettled in low-income neighborhoods that are already dealing with structural inequality and violence (Martin, 2018; Peace, 2022; Rodriguez & Ward, 2018; Schaul & O'Connell, 2022; Way, 2019). This becomes particularly hard on African refugee families, which tend to have larger numbers of children (eight is not uncommon). It has become standard practice for even large families of eight to be placed in a small, two-bedroom hotel for weeks before more permanent housing is found.

During this time, it is also standard practice for these families not to hear from their case workers for weeks at a time and not have access to money. According to the Department of State, the government provides a one-time payment of $2,375 per individual refugee to the local resettlement affiliates; by the time families leave the hotel, their resettlement funds allotted by the United States government are often almost or completely depleted from the hotel bills, and the family usually has little to no understanding of why their funds are gone despite having received no services (Bureau of Population, 2023a). Furthermore, resettlement agencies are required to provide "appropriate food" for the refugees (Bureau of Population, 2023a), but more often than not they have been provided with government subsidized foods that include cheese, milk, and bread. There have been numerous cases of families being provided with food that they

did not know how to eat or did not like (See Soifoine 2022). This single issue of housing and families being stuck in hotels for weeks upon arrival is readily acknowledged as the primary, current challenge by resettlement agencies, and it is directly related to the soaring cost of (and lack of) housing in Tampa since before the pandemic.

Automobility in Tampa

[2]Another issue with resettling within Tampa is how dependent residents within Tampa Bay are on automobility. This is a city that has little to no infrastructure for public transportation, is spread out over a vast geographical area, and frankly is the home of some of the worst drivers in the United States. Tampa was also the deadliest city for bicyclists in the United States as recently as 2018 (Calvert & Rust, 2018). According to the Florida Department of Highway Safety and Motor Vehicles (FHSMV) there were around 63,000 traffic crashes reported in the greater Tampa Bay area, which accounts for 16% of all car crashes that happen in the state of Florida. Just in 2021, Hillsborough County saw over 260 fatalities due to car accidents (FHSMV, 2023).

Tampa is a city that is heavily dependent on automobility, but is also extremely dangerous for people with cars, pedestrians, and bicyclists. It is no coincidence that the city has little reliable public transportation infrastructure. This makes reaching workplaces extremely difficult and time-consuming, which adds a further obstacle to achieving economic "self-sufficiency". Further, when refugees are resettled vast distances apart from each other with no support to maintain their communities, it strips them of their interpersonal networks of

[2] Everything in this paragraph is from Catania and Catania with statistics taken from the Florida Department of Highway Safety and Motors (FHSMV): https://www.cataniaandcatania.com/tampa-car-accident-lawyer/statistics/

reciprocity, and it leaves them isolated, culturally, and linguistically. This can further add to the cycles of trauma of an already vulnerable population.

Mental Health Care During Resettlement

Research has shown that a lack of consideration for mental health can be extremely detrimental to refugees' ability to resettle in a positive and well-rounded manner (Association, 2020; Bosqui, 2020; Hameed et al., 2018; Ibrahim & Hassan, 2017; Levy & Sidel, 2009; Posselt et al., 2019; Shannon et al., 2015; Song et al., 2015). It is difficult to devote time to positive thinking, mental health, and unpacking traumatic experiences, when you do not even have a stable roof over your head and are unsure of where to get food. While the struggles of resettlement organizations appear insurmountable, a lack of consideration for the impacts on refugee mental health has had very real consequences within the familial structures of resettled families in Tampa. There have been multiple, recent cases that reflect how this lack of mental health care and services have allowed for the emergence of gender-based violence, domestic violence and abuse, suicidal ideations and attempts of teenagers, and incarceration of refugee family members, all as crisis-outcomes of a situation that needed to be confronted immediately but could have been avoided completely.

An additional issue is that many of the mental health programs that cater to refugees take a biomedical approach to mental health and suffering – an approach that has been proven to have difficulty translating appropriately across cultures and languages (Beiser, 2009; Beneduce, 2008; Bunn et al., 2021; Dew, 2018; Familiar et al., 2021; Goździak, 2004; Harms et al., 2009; Hecker et al., 2015; Koegler, 2019; Lock & Nguyen, 2018; Mels et al., 2010; Pearlin, 2005; Wachter et al., 2018). Others have called for a broader shift to more contextualized, collaborative, and

community-based mental health programs for populations such as refugees (Abu Suhaiban et al., 2019; Animbom Ngong, 2017; Bosqui, 2020; Bryant et al., 2022; Bunn et al., 2021; Esala et al., 2018; Koegler, 2019; Kong et al., 2021; Mels et al., 2010; Nuwer, 2020; Oppedal & Idsoe, 2015; Posselt et al., 2019; Reyes, 2019). Research has also provided us with a greater understanding of how resilient refugee and survivor populations are and continue to be (Abu Suhaiban et al., 2019; Arnetz et al., 2013; Bosqui, 2020; Posselt et al., 2019; Shapiro & MacDonald, 2017; Soifoine, 2022a; Yu et al., 2021). Building on these studies, I call for a greater push to solidify the recovery capital and social envelope of refugees during initial resettlement (Lyons, 2010) while also having more formalized federal and state structures for mental health services for refugees upon arrival/early detection of mental health crises (Arnetz et al., 2020; Berthold et al., 2014; Bisson et al., 2013; Monson et al., 2012).

How does this translate to what is happening in Tampa? There are little to no mental health services available specifically for refugee populations, and if they exist, they solely focus on a biomedical approach. This biomedical approach is the belief that any mental health illness as directly and solely caused by a chemical imbalance in the brain and pays minimal attention to the impact social and cultural factors on mental health. Moreover, the other possible mental health care options in Hillsborough County that are not specialized in refugee mental health, which will be discussed later, are essentially incapable of providing care due to the lack of translation services and the subsequent cost of care. The one option in the county is a monthly clinic run by USF Health students. When I interviewed the mental health practitioner associated with the clinic, she clearly stated in her interview that her ability to provide care was grossly limited due to resources available, time and cultural nuances to mental health care.

Conclusion

Individual refugees in the population with which I work have had extremely rough patches in their lives. Some have seen the worst of humanity and still came out being able to smile, while some still bear the brunt of their scars. Refugee resettlement was supposed to be a vehicle for a humanitarian intervention, but in certain areas of the United States, we appear to have dropped the ball on appropriate care and support. The state-sanctioned neglect that is rampant in Tampa has compounded violence refugees have already endured, and further inaction could dangerously push individuals to a breaking point - something that has already happened numerous times. There is a direct correlation between inappropriate action and inaction by state sanction refugee resettlement agencies and further, negative mental health crises (Beiser, 2009).

So far, I have created a comprehensive approach that effectively reframes the mental health care of this population from a more structural and biomedical viewpoint, to one that takes a critical consideration of what some of the actual proximate, everyday issues are that shape the mental health of this community. This includes the process of becoming a refugee and living in a liminal space in camps, to again being in a liminal refugee status that excludes and even marginalizes here in the United States. This can be seen from the false promises of financial support, the inability to be mobile, the dearth of culturally appropriate resources and mental health services, subsequent and forced familial changes, overall lack of food security that leads to further malnutrition, and even in the long-term accumulation of mental and physical risk factors that stem from surviving deeply traumatic and deadly experiences. By focusing on the everyday experiences that directly contribute to mental health crises, it is a more effective and comprehensive approach to understanding the needs of this population and it further informs us on how best to provide culturally appropriate mental health care.

CHAPTER THREE:

METHODS

Introduction

To say that this project was completed without any hiccups would be a gross understatement. The project, as initially proposed, focused on understanding the coping mechanisms of the Central African Refugee population living in the Tampa Bay Area, while also evaluating whether the mental health care programs that were available to this population were appropriate either in times of crisis or for general, preventative mental health care. This project was structured as follows: to 1) conduct a mental health needs assessment of the community of Central African refugees (mainly Congolese and Rwandan) with which the local African-run, non-profit organization works, and 2) organize a culturally appropriate community event that would focus on shared interventions, community building, and celebration among recently resettled refugees.

The plan was to conduct multiple semi-structured interviews of key participants while simultaneously conducting focus groups that were separated by gender. Then, the plan was for the community event to be recorded collaboratively with the community and shared through social media and the Kiswahili-language YouTube Channel, Umoja wa Afrika – Tampa (Africa United – Tampa). This event is still to come due to delays with funding, community partners, and unexpected situations that resulted in the incarceration of numerous participants and family members, but it is expected to take place in July 2023.

Methods

Despite the many barriers that arose along the way, I focused on utilizing the frameworks of the anthropology of mental health, collective intervention, and critical medical anthropology (Bosqui, 2020; Drake, 2015; Joralemon, 2017; Kleinman, 2012; Singer & Baer, 2018; Westermeyer, 2011; Whitley, 2014). I employed a mixed methods design of semi-structured interviews, a focus group, and participant observation. My primary methods consisted of 1) community-based participant observation facilitated by my internship with AR4WRM, 2) one focus group with five recently resettled female heads of household, 3) five key informant interviews with stakeholders in refugee resettlement in Tampa Bay, and 4) a mapped survey of nine mental health care resources and therapist offices that are possibly accessible to this community.

I also engaged in countless hours of participant observation during regular house visits to families in need, a weekly driver's education program developed by a recent MA student of the Anthropology Department (Soifoine), crisis management for certain refugee families, and regular meetings (often online) among members of AR4WRM and the Tampa Bay Refugee Task Force. These respondents were sampled through expert referral and network selection from AR4WRM, the Refugee Task Force of the Tampa Bay Area, the driver's education program that I helped develop and conduct, and through an online resource platform of available mental health care resources within the Tampa Bay Area.

In phase one, participant recruitment and data collection occurred mainly in person, but due to COVID-19 and geographic location, some remote recruitment and data collection occurred, especially with refugee resettlement providers. To minimize the risk of being exposed to COVID-19, meetings and data collection occurred outside as much as possible, and social

distancing was practiced. Additionally, I was fully vaccinated and boosted, and wore a mask when conducting in-person activities until the mask enforcement was lifted in the State of Florida.

The director of the community based-non-profit AR4WRM, regularly does in-person and cellphone check-ins with the Central African refugee households in Tampa Bay. Last year, she was responsible for coordinating mobile units to provide COVID-19 vaccinations to members of this community at their residences. Therefore, she was also the expert referral in this project. She decided whether or not to describe the project to potential participants, as scripted in the recruitment materials, in-person or over the phone with members of the community. She then introduced me to members of the target population who had expressed interest in the project.

These introductions occurred in-person at the potential participants' residences or other spaces frequented by potential participants. More often than not, they happened at the AR4WRM office where the driver's education program was also held. After informal engagement through the driver's education program, I spoke to potential participants about the project. After expressing interest, verbal consent was asked for through both me and the director of AR4WRM. All participants were asked for additional verbal consent before the focus group.

Consecutively, through the director of AR4WRM, I was introduced to key informants who are involved in the Tampa Bay refugee resettlement services and mental health care of this population. Through informal and formal meetings, I was able to gain access to three stakeholders that worked within various refugee resettlement entities and were able to do a one-hour interview with me. Verbal consent was gained from all of those participating.

For phase two, the USF-sponsored community event will take place in the Summer of 2023. Through the USF Creative scholarship grant, there will be a space where research

participants and members of the community can come together to discuss the research findings, utilize the shared community interventions, and perform culturally appropriate and fictionalized skits that are focused on mental health care. Half of the grant money will go towards transportation of community members to this event, culturally appropriate food, and compensation for community members to cook aforementioned food.

Inclusion and Exclusion Criteria

For phase one, participants were five individuals who work directly within the refugee resettlement services for the Tampa Bay area and 40 individuals who self-identify as a Central African refugee or asylee living in Tampa Bay, FL. Five of the refugees participated in the focus group, while the rest of the participants were interacted with through house visits and other community events. Participants had to be at least 18 years of age, but there was no upper limit on the age range. Phase two included community members interested in participating in event planning and community outreach. The selection criteria for phase two is inclusive since it is a community building event.

Key Informant Interviews

Semi-structured and informal interviews occurred in-person or remotely over Zoom. Four of the five key informant interviews were with members of the Refugee Task Force (the resettlement community) who work with issues of mental health or run mental health programs. The purpose of the focus group interview with refugees was to gain an understanding of participants' access to mental health care, their experiences with mental health care in the US (if at all), and the knowledge and skills they draw upon to negotiate these experiences. In phase one,

no identifying personal information was collected and stored with the data, especially due to the nature of resettlement and the risk of retaliation by resettlement agencies.

During phase one, I used probes to ask follow-up questions based on participant answers. As everyone spoke English in these interviews, I had no need for a translator. There was no need for translation services with these five interviews. With permission from participants, the interviews were audio recorded. I also asked participants for permission to video record the final question in the interview script. This question asked participants to give mental health-related advice to future Central African refugees who will be resettled in Tampa Bay.

The purpose of audio recording was to capture and accurately portray the experiences of participants in data analysis and presentation. The purpose of video recording was to record participants answers visually and audibly for use in future educational skits for the community. Interviews were not recorded in either format without the permission of participants. Other than participants images and/or voices, no identifying personal information was collected and stored with the data that we will gain from Phase Two. Participants were able to review any final video production that includes them, if they wished to be edited or cut out. I was able to interview the following people: key personnel in the Tampa Bay Refugee Task force, a volunteer associated with USF that was known for working with this population, the head of the non-profit community partnership, a Congolese refugee that was resettled over five years ago, and finally a member of both the Tampa Bay Refugee Task force and USF Health.

Participant Observation

The number one research method of an anthropologist is participant observation and over the course of my master's education, I have been involved in this community in more ways than

one. For this project, I was an intern of the non-profit AR4WRM from the Fall of 2021 to the Spring of 2023, and I acted as a liaison between resettled families, local, state, and federal governments, and paid religious entities that were tasked with the resettlement of this population. There was even an instance, which will be described later in more detail, where I was one of the main crisis actors during a domestic abuse case, even though I was nowhere near qualified to be.

As an unpaid volunteer, it was clear that there was a heavy reliance on informalized volunteer work and the non-profit AR4WRM by paid, state sanctioned employees to be the on-the-ground eyes and ears of resettlement. Especially in the case of translation, since most of my team on the non-profit board have either experience in Central/East African cultures and languages, or they speak one or more of the languages spoken by the refugees in the area. I also participated in the development of a driver's education program for this population of refugees in order to combat immobility, malnutrition, and gender issues. This required multiple hours each week teaching Florida State Driving Laws, teaching the refugees how to drive in-practice and the unpaid transportation of numerous refugees to and from these lessons.

All these experiences allowed me to 1) improve my Kiswahili and communication skills, even with Kinyarwanda, 2) gain rapport with both new and old families in the community, 3) see first-hand what the households and families were dealing with. The third point is especially important since it is so rare for members of resettlement to actually conduct home visits to the families. This lack of visibility into the everyday lives of the families drastically impacted the agencies' abilities to have an empathetic mindset or even understanding of the everyday challenges that their refugees faced.

Focus Group

I conducted the sole focus group in collaboration with my community partner, AR4WRM. This group was sampled through a concurrent community-based project that was developed to combat mobility issues within the refugee community by providing a space to learn how to drive and translation services for the driver's test in Hillsborough County, known as the Drivers Education Program. The focus group had five participants (n=5), all female, and all the discussions were conducted in both Kiswahili and Kinyarwanda and then subsequently translated to English for me, although I am conversational in Kiswahili.

The focus group utilized anonymized and fictional vignettes to not only create a comfortable space for conversation of extremely sensitive topics, but it allowed the participants to exercise autonomy with their own stories that are more than likely traumatic in their own way. Instead of possibly adding further to the trauma by having them describe their own experiences, participants were asked to listen to a story of a fictionalized person dealing with situations that are very possible realities within the refugee community. They were then asked for their reactions and to provide advice to this fictionalized person. This method has been utilized on multiple occasions in refugee mental health care research and has been accepted as being less traumatizing (Barter & Renold, 2000; Crafter et al., 2014; Palaiologou, 2017). The only time that their own personal experiences were brought into question was when I had participants free lists things that they did in order to help them relax or get rid of stress.

My research goal had been to conduct two gender-separated focus groups to get the differing perspectives on mental health since it is a subjective and phenomenological thing that can be affected by differing, intersectional ties. By doing this, the goal of these focus groups, in particular, was to encourage participants to organize themselves into women's and men's

councils of elders to help advise struggling and newly arrived families in terms of mental health care. It should be added that much of this community organizing and self-help was already taking place and myself and the director of AR4WRM had already been involved in this process, but the goal was to be more collaborative and look for sustainable options of community healing. These meetings were initially the idea of the Central African household heads, and so the idea of using these to help them organize community interventions was not my own idea but that of the research participants.

However, due to the time constraints, delays with community partners and the development of some serious mental health crisis within the resettled community, my community partner and I were only able to find the five participants for the one focus group, and I found it prudent to focus more on the gendered expectations of female presenting, resettled refugees. Especially, since some of the main issues that arose during my research could have been prevented if there was a more concerted effort by refugee resettlement services to conduct their processes in a way that was not exclusionary to the women and focused on preventing mental health crisis instead of just reacting to them.

Survey of Mental Healthcare Providers

Finally, in order to understand mental health care, you need to know what resources are available in your geographic area. Using an online database of local mental health practitioners, I created a list of mental health care providers that specifically focused on “immigration/ acculturation techniques”. The goal was to create a visual aid of resources that could be handed out and utilized by refugees in the Tampa Bay Area if there ever was a want or need. As a sampling technique, I decided to specifically google “therapists that utilize Acculturation/

Immigration Therapy techniques" to imitate how someone might search for mental health care that was appropriate across cultures. It brought up a general hub of therapists in the Tampa Bay area that I could contact. For the purpose of this project, I decided to keep the scope to just Hillsborough County, as most of the refugees that are placed in the Tampa Bay Area are in that county, although there are refugees in Manatee, Pinellas, and Pasco Counties.

I then compiled all the data available online about each of the practitioners, there were nine, what sorts of insurance they accepted, their session rates, what further therapeutic skills they excelled in, and what languages they had a capacity to provide services in. I developed an interview guide that was used during the survey of the providers and/or their administrative staff. Some of the most important questions were whether they had ever provided care for a refugee, what language translation services they had available, accessibility in general, their understandings of cross-cultural mental health care, and their perceptions on the care that is available to vulnerable, minority populations such as this.

Based on the surveys conducted, I created a map of mental health services available in Hillsborough County, including the specific requirements of each service. This was intended to be a preliminary aid in creating a more formalized map of the entire Tampa Bay Area and the mental health services available. However, I instead ultimately created a visualization of how inaccessible and rare culturally appropriate mental health care is in the Tampa Bay area for this population and other refugees alike.

Data Analysis

The majority of this analysis relied on qualitative data which does not lend itself to numeric coding and further renders traditional quantitative methods ineffective and useless. The only time

that I could have possibly used quantitative methods of analysis was for the provider surveys, but due to the data set being completely homogenous, the only conclusion that came forth was that there were no resources available for refugees in the local therapy offices. In terms of qualitative methods of data analysis, I mainly relied on my ethnographic data that included field notes from my participant observation, interview transcripts, and field notes from the focus group that included free lists. I was able to become immersed in my data, which allowed for me to code and tease out themes that were integral to this research. Finally, I utilized spatial analysis while making the resource map of available services and locations of therapy offices within the Tampa Bay Area.

Ethnographic Sections: Positionality, reflexivity, bias, and ethics

Positionality

I am a master's student at the University of South Florida. I am a 26-year-old, white, female presenting individual. I had experience working with the community of refugees due to being a part of a local, community-based NGO, lived and travelled throughout East Africa for a year, and speak a Bantu language conversationally. All of these positionalities made negotiating this project easy at times and uncomfortable at others. It was easier in the sense that I understood Kiswahili and could speak to most of the participants in the community. I was unable to speak very well to those who mainly spoke Kinyarwanda, but I still had a cultural awareness for life in East Africa that afforded me understanding of cultural norms and practices from the geographical area.

It was more difficult in the sense that my whiteness made my participants and collaborators afford me more authority than was appropriate. Some specifics will be discussed

later in the next chapter, but the reactions that my skin color afforded me can be directly tied to the history of anthropology, colonialism, and the blatant, racist narratives that have been commonplace since the 15th Century.

My gender should also be reflected upon.

I am non-gender conforming, but I am female presenting. My gender presentation afforded me access to some but barred me from others. In a culture of gender inequality, it was easy to speak with other female presenting individuals, but many male participants did not care to speak with me or were clearly uncomfortable speaking with me. Or I was sexualized and immediately asked about my relationship status. This was not entirely unexpected either since it was commonplace during my travels in East Africa, but the difference was that I did not want to necessarily wear the fake wedding ring that I wore during my time in East Africa. However, I did take the precautions of setting up a google phone number in case any male participants asked for my phone number, which they did.

I also struggled during the survey of the providers as most of the providers were suspicious as to what the survey information would be used for, especially since I was not asking to be a patient myself, nor was I another qualified mental health care provider. In those cases, my positionality made the data gathering difficult. To navigate this, I attempted to assuage concerns by reiterating how the data would be used: as a guide of mental health resources that are available to the refugee population in the Tampa Bay Area. The data that I received from the survey was still limited due to the distrust.

Inescapable Structures

As stated above, I have experience working with East African communities and it was reflected in many of my actions throughout my research. I knew of some of the typical gender expectations, but I struggled with my need to be culturally reflexive with certain instances that happened and my own feminist rage. Instances where I was sexualized, observed gendered expectations and norms in play, or was forced to participate in these expectations would make me bite my tongue. More often than not, I experienced extreme exhaustion every time I was in the community. This was due to the need to mask as a gender conforming person, mask as a neurotypical individual, move past my social anxiety, and remember how to speak and act in a different language.

I am aware that all of this reflects in how I conducted my research, what I was able and unable to do, and my ability to have certain conversations. I also know that my feminist rage directly contributes to some of the harsh language that I utilize throughout this thesis. Due to that, I struggled with criticizing the social structures that affect this population with enough of the oomph that I felt it required, while struggling with the need to still be seen as a respected professional in an academic setting. Academia and anthropology itself are still struggling with the expectations of what researchers should and should not do or express, especially in terms of gender, race, and sexuality. I am not a cis, white, heterosexual man and there were numerous instances where I struggled against patriarchal notions or felt imposter syndrome due to the nature of academia. It was a careful line that I struggled with throughout this research process.

Risks to Population

Even though throughout this project, I did not question refugees directly on their own pasts and personal experiences with trauma, this project did pose some risk to this population due to the nature of the focus on mental health. These are very delicate topics since the project would be uncovering trauma, mental health illness, potential cultural and ethnic identity crises. Because of this myself, the academic advisor, and the director of AR4WRM developed a connection with USF Health (as well as with the non-profit RAMWI, Refugee and Migrant Women's Initiative) in order to have a licensed mental health practitioner be available in case any of the participants become distressed during this research. Participants were able to stop participating at any time. Participants in phase one were to be compensated with cassava flour, and/or other culturally appropriate foods, such as cassava leaves and mangoes, but due to the challenges in organizing the focus groups, the participants of the focus group will be compensated with the money that was allocated towards transportation rentals. The participants carpooled with each other, so we were able to compensate each participant up to $50 in visa gift cards. Participants in Phase Two, which is planned for the Summer of 2023, will be compensated with the community event in November which will include culturally appropriate food and activities.

CHAPTER FOUR:

A CASE STUDY

Please note that the situation described in this section contains themes of suicide, domestic abuse, and neglect.

Introduction

In this chapter, I focus on one specific situation that helps to illustrate the complex and intersecting challenges confronting refugees resettling in Tampa. As this case demonstrates, the pressure of resettlement, compounded by issues of structural and state-sponsored negligence, miscommunication, racism, gender insecurity, and lack of cultural awareness, can lead to extremely dangerous situations that directly impact the mental health of these refugees. This was one of several cases that appeared as a "perfect storm" for acute stress induced reactions, including, but not limited to, suicidal ideation and attempts by teenagers, gender-based violence and substance abuse. My goal is to not only illustrate how complex challenges intersect but focus on how many of the eventual "crisis" situations could have been prevented had the family in the example been provided with adequate resources.

A Case Study

One day at Driver's Education, the participants and I were casually chatting with the director of AR4WRM while they were waiting for their rides. It had been a long day of going

over Florida driving laws and the women just wanted to catch up socially. Many lived far from one another and rarely had time to chat in person.

At one point, the director mentioned casually that one absent family that day had been dealing with some serious issues with their oldest son. She described how the son was having issues in school, no longer wanted to attend, and that there had been some instances of petty theft. She described how she was trying to help the family, but that the situation was complicated. She had initially learned of the situation when she was called by the Tampa police, who showed up at her house unannounced and was asked to translate between the family and the officers. They told her that the son had tried to heat up a knife and cut the father and then later himself. She mentioned that this was not the first time that there had been an attempt by the boy to do self-harm. He had previously been found attempting to commit suicide by hanging in his room, but due to his slim stature from a lack of consistent diet, he was not heavy enough. In the more recent issues, the boy told AR4WRM's director that he was defending himself after being choked by his father during an alcohol induced rage.

However, in the confusion of interpretation during the investigation, the police misunderstood the situation (not knowing much of the background), and the boy was taken to a juvenile detention facility. He did not understand or speak English, was actively suicidal and had been trying to defend himself against his father's physical abuse toward him and his mother – a complex family dynamic that had not been revealed during the brief investigation. With the boy having been incarcerated for over a week, we decided to plan a strategy.

We considered several safety issues when deliberating a solution. If the household abuse was linked to the father's alcohol abuse, had the abuse shifted to another member of the household? How could we get the father to understand that in the United States, domestic abuse

was illegal and would lead to severe legal consequences? Should the father be entirely separated from the family? If we did nothing and the father was arrested, what would be the consequences for his immigration and work status? How could we get the father mental health services for his prior traumas, which were colliding with the pressures of resettlement?

This was not the first such domestic case that AR4WRM had tried to navigate with the help of the community and the state. The question of a proper procedure to follow as volunteers, however, was left unanswered, from either top officials within state refugee resettlement or among the volunteer practitioners who were working on the ground with this population. Another USF graduate student and I emphasized that this situation needed to be handled quickly, appropriately, and with the utmost caution. Not just because of the dangers to the son but also to the father snapping under the pressure and committing violence against the family.

In domestic abuse situations such as this, there can often be an acute stress reaction by the abuser when confronted with legal action that can result in the death of those they abuse (PBS, 2018). In fact in 2018, The Washington Post released a report that showed that nearly half of the women (50%) who were murdered in the past decade were killed by a current or former partner (Zezima et al., 2018). Additionally, as a Black family in urban Florida, there was the added risk of police instigated violence on the father that could also result in his injury or death (Bunn, 2022; Post, 2023). In another recent report by The Washington Post:

> "On average, police in the United States shoot and kill more than 1,000 people every year, according to an ongoing analysis by The Washington Post… Although half of the people shot and killed by police are White, Black Americans are shot at a disproportionate rate. They account for roughly 14 percent of the U.S. population and are killed by police at more than twice the rate of White Americans." (Post, 2023)

Since there are countless examples of the overuse of violence by law enforcement officers and rampant racism towards Black men, those of us wanting to intervene did not want to risk his life anymore either.

From a culturally relativist standpoint, this family came from a background where gender-based violence has been normalized (González-Brenes, 2004; Women, 2023). That is not to say that domestic violence and abuse should be condoned in any situation, but there was also a need to both recognize that 1) the father's abuse toward his family was normalized, to an extent, before their resettlement in the United States, and 2) the father was a refugee dealing with his own mental health (and substance abuse) issues. This does not mean that there should be specific legal or cultural accommodations made for the father, but there was a necessity to address the situation on a family level that provided services for everyone affected. This situation was extremely delicate and there was neither a clear, nor a formalized process of how to proceed.

Finding a Solution When There is No Clear Responsibility

Those of us in attendance of the driver's education program considered doing a community intervention with married men, the director of AR4WRM, and me and the other white graduate student from USF. The director suggested that the father might listen more seriously if there was a white person in attendance. In this case, our whiteness, despite our status as graduate students, deemed us as perceivable authorities.

This association of whiteness and power is a product of the historical and often violent power dynamics central to colonialism and imperialism that still have real ramifications today. In the case of AR4WRM's director, as a Black woman, she had repeatedly felt disregarded and used as an interpreter and community social worker due to her Blackness and status as a former

asylum seeker herself. She was well-aware of how race and status were intimately linked, not just among those working in resettlement but among newly resettled refugees themselves.

Despite our ostensible White authority, both the other graduate student and I expressed hesitation since we were not trained crisis workers nor mental health practitioners. In fact, we had no form of actual, tangible state power beyond advocacy for the refugees. We were both just graduate students conducting participant observation and volunteering with the community. We were also concerned that the father would act unpredictably in an intervention, which would be dangerous both for us and the family.

This was already a delicate situation and I felt that I was in an ethical minefield where there were very real lives at stake if this was not handled properly and swiftly. After a tentative plan of action was formed, as any graduate student would, I reached out to my advisor about the situation. After discussion, I was advised to reach out to another non-profit head who had experience working in situations such as this. A phone call ensued, and I was assured that there would be conversations with heads of the resettlement agencies in order to expedite any action for this family. I was also told to reach out to another top person in the Refugee Task Force to inform them of the situation. The next day, I had an online meeting with this individual, and it was clear from their reaction that they had not heard anything about this situation. They assured me that there would be some swift action taken. I did not hear anything from the officials or from the family for over a week.

"Official Action"

A week and a half later, I was invited to a meeting that had been scheduled by the head of the Task Force, which also included the director of AR4WRM, and a representative of the

refugee resettlement service that was handling this family's case. It was already an interesting meeting because I had been under the impression that my advisor and others, who had been involved with this community for longer, would also be present at the meeting. Apparently, they had never even been invited. The meeting only lasted an hour and there were little to no outcomes. The timing of the meeting was unfortunately also the day before the landfall of Hurricane Ian, which at that time was expected to directly hit the Tampa Bay area. Because of this, the social workers involved were understandably distracted.

When the meeting began fifteen minutes late, the primary discussion revolved around a back-and-forth exchange between the refugee task force attendant and the resettlement agent. They were discussing the fifteen-year-old teenager who was still in the juvenile detention center after nearly three weeks. There was no clear information on what was happening with this case other than the facts that he had a state-appointed lawyer, and no one knew when his court hearing was, including his case worker. I brought up that this was concerning considering that the teen already had a history of suicide attempts. This was met with shock by the task force attendant, who said she did not know about that component. Coincidentally enough, she and I had discussed this in length the week prior, after which she had stated that this was a delicate case that needed to be handled quickly.

When the representative from the resettlement agency was asked why they had no information on the son’s court date, she mentioned that there was a tier system within refugee resettlement and that there was a singular case worker that handled “special, level 3 cases” such as this. She said that she would inform this case worker about the situation and move the family from level one to level three so that they would get more focused case work. Both the director of

AR4WRM and I expressed shock that this family was not already a level three case since they had been notified about this family's issue more than a week prior.

As the meeting continued, the director of AR4WRM then went on to question the resettlement agent about what she perceived to be their policy of only finding employment and setting up bank accounts for refugee men, leaving many wives and daughters unable to be financially independent. The agent responded by saying that they needed to make sure that there was a parent available for when the children came home from school. She then went on to explain how in her own family her husband was the breadwinner, leaving her the responsibility to be present and available for the children.

While AR4WRM's director (a single mother of three children) would later express great disdain at this part of the meeting, it was another example of how those in the resettlement agency have their own gender biases, norms, and expectations that they inadvertently or quite intentionally place on newly arriving refugees. While it may appear that previous refugees and immigrants would make the best resettlement staff, without formal training in social work, public health, or even anthropology, these individuals bring many of their own cultural, racial, and class-based biases. While the state places much faith and resettlement money into the hands of religious organizations and affiliated non-profits (Soifoine, 2022a), religious expectations of gender and family dynamics can cause problematic issues for newly arriving families.

The task force agent decided to get the conversation back on track and switched to asking why the father was still in the house with the family. It was clear that most of us in the meeting wanted to separate the father from the family, although the resettlement agency representative disagreed. There was then discussion about what steps were needed to relocate the father from the house. In the end, it depended upon whether or not the mother would be willing to file an

injunction, or restraining order against the father. The director of AR4WRM confirmed that in a recent conversation, the mother had said she was ready to take legal action against her husband because she was afraid that she was "going to have a dead child on her hands soon if something did not change."

To our surprise, no one at the meeting knew how to begin the process of filing an injunction. Finally, the representative from the resettlement agency said that the mother would need to go to her local police station. The head of the task force then asked the director of AR4WRM and me to take the mother to the police station and to help the mother call Child Protective Services (CPS) to get protection for the children. Because it was now 5pm, she no longer had time to discuss this topic and the call soon ended.

After the call ended, the director of AR4WRM and I called each other. We were both upset at the lack of action from the resettlement agency and for the clear gender expectations that were being projected. We planned to take the mother to the police station as soon as we could, but it was unclear when we could. This was due to the impending hurricane and the fact that the two of us were just volunteers who had other, time demanding obligations. It was also unclear what would happen after the restraining order was filed. There were no plans for the relocation of the father, for the actual serving of the restraining order, or how we would protect the mother and children, during and afterwards. Despite these questions, we decided to try for Saturday, four days from then. In actuality, we were unable to take her for another week and a half.

At the police station, we were told that we were at the wrong place and that we needed to take the mother to the courthouse in downtown Tampa. Furthermore, we would have to wait until Monday since they were closed on the weekends. We were given the case number of the teenager's case, since he was still in juvenile detention, and planned to try to take the mother on

Monday. Scheduling, however, was difficult not only because we both had busy schedules, but because our schedules needed to align together. I did not speak Kinyarwanda, the language of the mother, and the director of AR4WRM once again felt more comfortable if I was there to act as a liaison between them and the police. We were unable to take her that entire week due to schedule conflicts.

Inaction to Reaction

That next Sunday, I received a text message from the non-profit head at 9pm asking if I was awake. I was, and she immediately called me. Apparently, the father had once again been drinking, was heard physically abusing the family and the police had been called. She was acting as translator, but there was not that much to be done. We had not been able to take the mother to get a restraining order yet, so it seemed in the mother and children's best interest if the father was taken away and separated for the time being. The father was then taken by the police. I notified my advisor and things became very tense over the next few days between those who volunteered with the refugees, including myself, my advisor, and the director of AR4WRM, and those within the resettlement agency and the task force.

There were questions as to why such a critical task of getting a restraining order and calling CPS was directed at two volunteers. But there was also a question of why the injunction had never been filed. There were questions as to why there was little to no involvement by the case worker at the resettlement agency. There were questions as to why the task force leader, who was a mandated reporter, had not reported the child and domestic abuse herself but instead pushed the task onto volunteers. There were questions as to why there was still no resolution on

the teenager, who was still wrongly imprisoned, and was still known to have a history of mental health challenges, including suicidal ideation and attempts.

My main question was why it had to get to this point for any tangible action to come from those who had state sanctioned power in refugee resettlement. Why were we all reacting and pointing fingers when this could have been prevented weeks prior when this was first reported? Why were there no standards of conduct for dealing with a domestic abuse case such as this? It was not the first time, nor the first family. Numerous working relations were strained to a breaking point in the aftermath of the father's arrest and yet there were no clear answers from anyone.

However, within a day or two, the head of the resettlement agency personally made a visit to the mother and children, which was out of the norm, the agency helped the mother get a job at a local McDonalds, she was given her own bank account, and the son was released from juvenile detention. Little to no information was given about the status of the father, but recently I was notified that the father was released and was once again living with the rest of the family. He had been in jail since early October 2022 and was released in early January 2023. There have been no protections put in place for the mother or the children, no word as to what is happening behind closed doors, and no word on whether any mental health care has been made available to anyone in the family.

Conclusion

This stark vignette clearly shows not only how complicated resettlement can be, but also how inaction and lack of preventative care or policy can lead to serious consequences. This case study was a perfect storm. There was 1) a lack of preventative health/mental care for all

members of the family, 2) a lack of good resettlement support, including employment and separate bank accounts, 3) communication and translation issues, 4) gender/family issues and expectations that differ between the refugees and the resettlement agencies, and finally 5) state sanction employees with power and money waiting to react to this family's needs until they were already in a crisis. This was a clear example of utilizing response rather than prevention as an approach to care.

Some of the main themes that were clearly there throughout this entire situation was the over-reliance of volunteer time, or the informalization of refugee resettlement. This can be tied back to the overuse of neoliberal politic machines and the passing of responsibility onto the state, and then further into non-profit, religious, and volunteer platforms. However, because this responsibility of care is passed, the care gets passed through more and more informal channels and is funneled down into smaller organizations. This care is eventually bureaucratically disintegrated and the protections and support that were originally designated for individuals such as refugees, are no longer even possible to offer due to the lack of state and federal power and funding.

The United States' 'democracy' has historically and systematically created, promoted, and protected systems and structures of power that benefit only those with social and racial hierarchical privileges that the structures afford. It is a cyclical effect that keeps those in power, and with privilege, in positions that allow them to defend these self-promoting structures. Refugees and lower U.S. citizens alike are continually struggling against these imposed structures, and narratives of personal responsibility and self-sufficiency as the only methods of self-actualization and success. This is the anthropological notion of practice theory at work since

they are using their agency to fight against structures that affect them (Ortner, 2006; Shapiro & MacDonald, 2017).

We can also utilize critical medical anthropology as a framework to understand how these political structures and narratives have a direct and syndemic effect on the mental health of this population (Willen et al., 2017; Willen et al., 2022). Due to the power structures that have been superimposed by institutions that are funded with a capitalist dogma, care has been turned into a profit scheme. To put this claim into context, resettlement organizations, who are more often than not religious, must lobby for the number of refugees that are resettled in their territory; the more numbers of refugees granted, the more funding that these organizations receive from the federal office of refugee resettlement.

This would not be an issue necessarily if the care that was then supposed to be provided through the funds was utilized appropriately, or even at all. Instead, especially in the case of Tampa, refugees have gone without financial support for upwards of months. Where did their allotted funding go? Refugee resettlement needs to be a funded enterprise that is monitored carefully, not crowd sourced, and there needs to be a better oversight and consequences to the wrongful use of funds that are supposed to be designated to resettled families. Without it, there will be more and more dangerous and possible deadly cases of families struggling to survive while being neglected.

CHAPTER FIVE:

FOCUS GROUP

Introduction

"As long as you stay, adapt to it." - Congolese woman, roughly 50s

"If you are still thinking about the past, you can't think about the future." - Congolese woman, mid 30s

Thus far, we have covered the major issues of refugee resettlement and how the neglect of resettled individuals can have clear and dangerous consequences as best understood using the theoretical frameworks central to my project, such as critical medical anthropology and the anthropology of mental health. In this chapter, I utilize the method of focus groups to connect some of the issues within resettlement to the overarching themes of everyday violence, agency, gender insecurity, and community healing. The use of focus groups has been a proven method for conducting qualitative research with various populations (Bernard, 2018). It has also been a useful tool when conducting research on populations that are vulnerable, children, have a history of mental illnesses or trauma, or are from communities and cultures that value community networks over individualized care (Bosqui, 2020; Bunn, 2022).

Fictionalized vignettes have also been a proven method of data collection when researching sensitive topics such as this, with vulnerable populations, and for populations from Central and East Africa (Barter & Renold, 2000; Bryant et al., 2022; Crafter et al., 2014). I include some of the fictionalized vignettes I created based on scenarios possibly encountered as a refugee in Tampa. These were used during the course of the focus group and each vignette was

discussed in length. While these vignettes were fictionalized, they were based upon very real situations that refugees in Tampa have experienced in the past ten years.

The main goal of these vignettes was to elicit responses from the participants that would allow me to learn more about their coping strategies. By focusing on the coping strategies, I avoided possibly re-traumatizing participants, and allowed participant agency to enter into the discussion. Everyone has mental health, but they understand it and cope with it differently. By giving voice to the participants, it was the first movement in developing collaborative and community based mental health care (Beiser, 2009; Hoewe, 2018; Holmes & Castañeda, 2016; Kappeler, 2020; Syvertsen et al., 2017).

Focus Group

The focus group's participants were five Congolese women who all had Rwandan or Ugandan connections. The director of AR4WRM and I had planned to do this focus group for quite a few weeks, but there were numerous other issues that came up within the community that kept us from holding it. We were able to hold this focus group in the first week of November 2022 after one of the driver's education sessions.

These women had been meeting with us since August of 2022 with the goal of preparing them and others in the community to get their Florida Driver's license. This driver's education program was the product of another colleague's work with this population with the goal of combating mobility issues that exasperated food insecurity, gender inequality and feelings of isolation from the community (Soifoine, 2022a). All of these issues could be attributed to further mental health issues, stress, and high levels of blood pressure. This program entailed numerous

Saturdays spent with community members teaching them the rules of the road, Florida driving laws and road signs.

While the driver's education program was moderately successfully at our final goal – getting everyone driver's licenses – it was unexpectedly successful at creating a shared and safe space for community members to ask questions about resettlement, share trials and errors, share triumphs, and quick problem solving for situations that resettlement offices were silent on. I conducted the focus group interview after a few months of attending the driver's education program to allow for the women to grow comfortable with each other and for them to be more comfortable with me.

Background of the Participants

The five focus group participants were all women who had been in refugee camps throughout East Africa for anywhere from 5 to 20 years. Their ages ranged from 28 to 62. All of them had anywhere from one to five kids and two of them had husbands. Three of the women had been in the United States for less than one year, while the other two had been in the country between one and two years. Two of the women could only speak Kinyarwanda, while the other three could also converse in Kiswahili as well. AR4WRM's director, who speaks both languages, acted as translator for the focus group, and she frequently switched among English, Kinyarwanda, and Kiswahili. She also has knowledge of numerous other similar Bantu languages.

Focus Groups- In Practice

At the beginning of the focus group, I asked what the participants tended to do when they encountered difficult situations that they had never encountered before or had little to no support on, effectively asking the participants to free list their coping strategies. The answers varied from listening to music, to praying, to being with other people. They each discussed how whenever they felt a huge pressure in their chest, they tried to employ one or multiple of these techniques. One coping strategy that all of them agreed upon was leaning on family or friends in their community to talk to. All of them maintained community networking, both for practical and social purposes, was the best way to help ease some of the stresses with resettlement or with what they dealt with in the past.

I then utilized four fictionalized vignettes to present fictive, but very possible situations that refugees in Tampa might, and in some instances, have faced in their day-to-day lives. By not directly asking about the participants own experiences, but rather asking for their insight on what they would do or how they would support this fictional person allowed participants to focus on their coping strategies. It also avoided any further traumatic recollections or forcing them to dwell on their own past experiences. They were structured as the experts in the conversation, and the goal was to collect their culturally appropriate coping strategies when faced with stressful situations, not to provide therapy myself since I do not claim to be qualified enough for that. This approach allowed a focus on the assets they brought or had developed during resettlement. The following are some of the vignettes that I utilized and the responses that they elicited.

Vignette #1

Endesh: "37-year-old woman living in Tampa with her husband, and her four children. Two young adults and two are under the age of 18. This family lives in a one-bedroom apartment in East Tampa. Through resettlement agencies, her husband has been able to acquire a minimum wage job in South Tampa, but he doesn't have a car or a driver's license. They pay every morning to have someone drive there each morning and back each evening. She stays home with the kids and tries to make extra money as a tailor. Money from food stamps runs out quickly and there is a minimal budget for food. She says that she has lots of pressure in her chest when she thinks about it. "

Participants were then asked, "Do you have any suggestions for coping with that pressure that she talks about?" Responses focused on experience sharing, leaning on their community, that they need to lower their expectations for resettlement services because they were "lied" to by UNHCR when they were in the camps applying to be a refugee in the U.S., and that they needed to act with courage.

> "She needs to talk to her neighbors. There is no smooth life on Earth. There will be both good and bad. Her neighbors would share their experiences of when they arrived since it was similar. As long as she stays in the US, she will need to adapt to the life here."

> "Instead of paying for the driver, ask their supervisor to see if anyone that lives in the same area would be able to carpool."

> "Because the money isn't going back to the wife, even though she is helping, she needs to save money for herself and the household. Her husband will spend it all on himself."

While these suggestions were useful, some proved impractical because of the distance between families and the lack of a social envelope. There were even suggestions to re-establish a women's group to provide support for such cases, but transportation and networking would still be issues.

Vignette #2

> "Endesh's children are now attending school here in Tampa. One of her children seems to be acting differently all of a sudden and does not want to go to school anymore. Endesh is not sure why this is happening, and the child does not seem to want to discuss what is happening at school. Another of her older children has stopped going to school all together and will argue with Endesh about going. Endesh's husband is gone all week at work and does not have time to deal with these minor issues. Endesh is feeling quite a few emotions and does not know how to calm herself down.

Participants were then asked the following questions: 1) Do you have any suggestions for Endesh to calm down? 2) Do you have any suggestions for her dealing with her children not wanting to go to school? 3) Do you have any suggestions for Endesh if she was to encounter a difficult situation like this again that does not have an easy resolution?

This vignette was specifically focused on some of the stressors that can come from the uncertainties and pressure of resettling other family members in the local school system. There has been recent research done in the local Hillsborough County school districts that focused on some of the difficulties that refugee children can experience when resettling into the local school

systems, such as bullying, difficulties with language learning, and lack of specialized care for these children who were more than likely born in the refugee camps (See Inks 2021). These difficulties have resulted in multiple cases of children that do not even want to attend school, which in turn can also add more stress to the parents.

All of them women discussed how they would first go to the school to see if they had seen anything specifically concerning happening, in terms of bullying. They wanted to even ask if they could sit in their child's class to watch over them and make them comfortable. Unfortunately, the director and I had to tell them that this would not be possible in the U.S. school system. They replied that they think the children are being intimidated because of language issues and that "their kids are shy". So, they would use their community as a resource, the director of AR4WRM and even myself. That they were "lucky to have [us]" as a resource because "school is so important for these children".

Vignette #3

> "Every once in a while, Endesh will remember something that happened to her a long time ago before she had to flee to the refugee camps. Sometimes she remembers vividly the situation. She feels lots of emotions when this happens and sometimes it can make her feel different for the rest of the day. She sometimes finds her normal daily tasks to be difficult to complete when this happens. "

Participants were then asked the following questions: 1) Do you have any suggestions for coping when a situation like this happens again? 2) How would you help a friend who told you of a situation like this?

This was the first of the four vignettes that specifically focused on mental health and trauma. Again, the goal of this focus group was to not retraumatize the individuals, but there was still a very real possibility that it would happen either way. Traumatic responses can be triggered by the smallest things, and they can be so nuanced that it can be unpredictable. I had been prepared in case there was an acute stress reaction by one of my participants by having a connection with a USF health therapist who had worked with this population before. Luckily, all of the participants consented to continue and focused on how they coped.

All the women maintained that "you could forgive, but not forget," and that you had "to go forward as that past is the past." They all maintained that every single one of them was struggling, which brings them together, but that they were also divided due to their different experiences. These differences meant that they had to work together so that they could appropriately help everyone. They went on to describe how their community is broken now and that it is harder to maintain these relationships that help. Finally, they all agreed that they would tell "Endesh" that they would encourage her to try to move on. That, "If you are still thinking about the past, you cannot think about the future. If she is remembering where they came from, she needs to think about and compare how it was. This is better." – Congolese woman, mid 50s.

Vignette #4

> "Endesh recently found out that her mother had passed away in her home country. She does not have the money or resources to return to grieve her mother. She does not know what to do and has many emotions. She cries a lot and sometimes she does not want to get out of bed. Even when she does get up out of bed, she still has days where she has

many emotions and days where she does not feel any emotion and feels like she is not even present. “

Participants were then asked if they had any suggestions for Endesh in terms of dealing with grief or sadness. Before they gave their coping strategies, I was asked if this person was real. I said no, and they all looked relieved. They started laughing because this person seemed to have extraordinarily bad luck if all these experiences were about one person. It was a good moment that lifted the heaviness in the room.

They still had some suggestions. They would of course offer condolences and be a shoulder to cry on if the person needed it. They would, however, remind her that the mother was gone and that there was nothing that could be done to bring them back. “All you can do is pray.” They would offer money to help with the cost of the funeral if they could, sit with them, cry with them, and emotionally support her. They would also talk about their similar experiences so that they could remind them to focus. That they also knew how painful it was to lose a loved one, but that they would help find a solution.

Outcomes

The main outcome of the focus group is that the use of the community is the number one resource that this population relies on when encountering difficult situations. Some of the main themes that emerged in the discussion were ‘community,’ ‘unite,’ ‘support,’ and ‘shared experiences.’ Across the board, it was clear that some of the main recommendations for these fictionalized vignettes were to lean on your family and community. Time and time again, the participants said that they would provide a “shoulder to cry on,” provide monetary support, or

someone to just listen to this fictionalized refugee's problems since they themselves are going through some similar issues.

Across the board, participants agreed that resettlement was extremely stressful due to lack of support, but that it could be manageable if support from their cultural and linguistic community was present to lean on. This data confirms the validity of community interventions and shared community experiences as a form of mental health care that could be utilized for this population (Abu Suhaiban et al., 2019; Animbom Ngong, 2017; Bosqui, 2020; Bryant et al., 2022; Jager, 2016; Miller & Rasmussen, 2017; Nuwer, 2020). They maintained that they had to rely on themselves, but that they would seek out formalized mental health care if there ever became a need for it.

These findings were not entirely unexpected. I lived and traveled throughout East Africa for over a year, and it was clear that interpersonal networks of reciprocity are crucial to community survival. However, the specified goal of refugee resettlement in the United States is framed around personal responsibility and self-sufficiency (Soifoine, 2022a). This goal is based on a fundamental, classist assumption that it is even possible to successfully achieve self-sufficiency in our society. For refugees and lower income Americans alike, this can be wholly unattainable. However, it is clearly much harder if there is not a community of support for refugees during resettlement.

We see these realities in effect during resettlement when newly arrived Central African refugees are continually resettled separately from their cultural and linguistic support groups, more often than not in low income, minority communities that are overpoliced, are given no community connections and then are disparaged for not settling into the American way within 3 months. In a city that is heavily dependent on auto mobility and lacks good public transportation,

families are resettled too far away to regularly interact, and their possible interpersonal networks of reciprocity are effectively cut off (Bosqui, 2020; Yu et al., 2021).

Considering the previous chapter's case study and the themes that came up consistently in the focus groups, it is not necessarily hard to understand then why there have been multiple cases of acute stress reactions from this population. The lack of care and collaboration have clear, negative consequences to this population's ability to resettle without furthering, exasperating, or triggering previous trauma.

CHAPTER SIX:

KEY INFORMANTS AND PROVIDERS SURVEY

Introduction

The primary purpose of the key informant interviews and survey of mental healthcare providers for refugees was to "study up" to see how those working in refugee resettlement and healthcare understand the challenges facing Central African refugees. My key informants included: a member of Tampa Bay's refugee task force who is also a state employee (Department of Children and Families, DCF); a former asylee/refugee (now US citizen) who works as a community volunteer; a long-time volunteer based at USF; and the only licensed clinician in the Tampa Bay Area I could find who had experience with refugee mental health care.

I also conducted a survey to understand what more broad-based mental health care services were available to refugees. I contacted local mental health clinics that were listed as providers of "Immigration/Acculturation Therapy" to see if they have ever worked with anyone from the refugee population. I was interested in the services they provided, the types of therapy they employed, and requirements for new patient intake. From the survey, I created a map of mental health services available in Hillsborough County, including the requirements of each service, while also showing the general geographical areas that these refugees are resettled. While the mapping component was initially intended to facilitate access to healthcare, the map ultimately served as a stark visualization of the lack of - or inaccessibility of - appropriate mental

healthcare for this and other populations in need. Below, I will discuss the outcomes of the survey before discussing the implications within the context of the key informant interviews.

Survey

Using an online database of local mental health practitioners, I created a list of mental health care providers that specifically focused on "immigration/ acculturation techniques" as a sampling method. This was an attempt to emulate how someone might search for mental health care that was appropriate across cultures. It brought up a general hub of therapists in the Tampa Bay area that I could contact. For the purpose of this project, I decided to keep the scope to just Hillsborough County.

After the mental health professionals who advertised multicultural, cross-cultural, or immigration/acculturation related care in the area were identified (n=9), I contacted each of their offices and expressed an interest in an interview to discuss mental health services for refugees. When initially contacting the providers, I primarily reached their voicemail systems rather than being able to express my interest and explain the research intentions directly. Whether because of this or not, the majority of the voicemails left went unreturned. Despite this, four mental health providers did return the call and agreed to an interview. For the offices where I was able to directly reach individuals upon initial contact, the interview was conducted with the secretary in the provider's absence.

My four main questions that I asked were: 1) Did they have experience working with refugee populations? 2) What specific services were they able to provide? 3) What did their services look like in practice? 3) What were their requirements for new patient intake? My first impression was that most of the providers took wide varieties of health insurance, promised

compassionate care, and focused on cross cultural mental health care. Most of the offices tended to be along major roadways such as Dale Mabry, Busch Boulevard, and other high-traffic areas (this would be helpful to refugees who would be using public transportation). Most offered bilingual translation of English and Spanish, but no other advertised languages or translation services were available from these providers. Fifty-five percent (5 out of 9) of the providers offered online therapy options.

Through these interviews, I was able to understand the requirements of establishing care, the availability of services (with and without insurance), estimated costs of services, and the availability of language resources to make services accessible to non-English speaking refugees. During interviews, it quickly became apparent that one of the biggest barriers to mental health care of these refugees is that there were essentially no resources for non-English speakers to receive mental health services, specifically in the form of quality interpretation services. Of the four providers I interviewed, while all provided Spanish-language translation, no interpreting or translation services were available to bridge other language gaps. The other four offices identified were later contacted and it was confirmed that they were generally the same in terms of language translation services being one of the main barriers to care.

I created a map of these services with each of their requirements for patient intake, including out of pocket costs, and overlayed it with the local bus routes to visualize how refugees might be able to access the care without a car (See Figure 1). This was intended to be a preliminary aid in creating a map of the entire Tampa Bay Area and the mental health services available, but ultimately demonstrated, visually, the broader lack and inaccessibility of culturally appropriate mental health care in the Tampa Bay area for this population and other refugees alike.

Looking at the map (see Figure 1), the orange dots are the locations of therapist offices. The white text boxes next to the orange dots offer the cost of the sessions, and if they took insurance or no insurance. ‘I’ is insurance taking, while ‘N’ means no insurance taken. The red areas all over the map are the general geographical places where refugees from this population are resettled in the Tampa Bay Area. Finally, I overlayed the Hillsborough County bus lines onto this map to visualize how accessible the offices would be from public transportation.

For those not familiar with Florida, one of the largest issues with transportation in Tampa is that it is very hard to move East to West across North Tampa. This is particularly an issue with

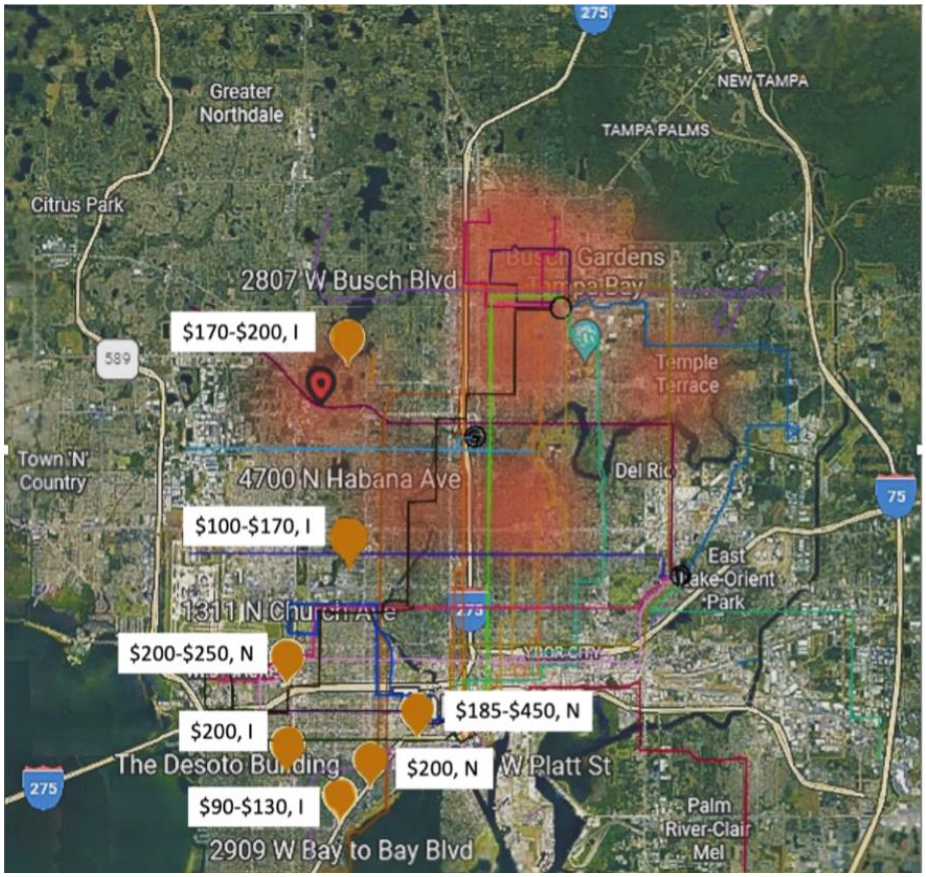

Figure 1: Map of Resources Available.
The Orange dots are the locations of therapist offices. The white text boxes next to the orange dots offer the cost of the sessions, and if they took insurance or no insurance. ‘I’ is insurance taking, while ‘N’ means no insurance taken. The red areas all over the map are the general geographical places where refugees from this population are resettled in the Tampa Bay Area. Finally, I overlayed the Hillsborough County bus lines onto this map to visualize how accessible the offices would be from public transportation. Map by Author.

refugees since most of the refugees are resettled in Eastern parts of Tampa. Coincidently, Eastern Tampa is where most of the light industry and chemical plants are located and there are numerous cases of minority communities being affected by airborne particulate matter, and water and soil contamination (Arradondo, 2022; Ordway, 2022; Registry, 2018; Woolington & Murray, 2022). Furthermore, as can be seen on the map, there is a lack of services North of Interstate 4 and East of Highway 275. Due to the services being in the Southern and Western portions of Tampa, refugees are required to utilize public transportation, something that refugees have expressed they find confusing, unreliable, and uncomfortable to use – the only other alternative being to ask for a ride from another community member with access to a car.

Key Informant Interviews

Task Force Member

I was able to gain access to one of the main power players of the Tampa Bay Refugee Task Force in early August of 2021. I was not able to interview them until later in the year of 2021, and it was not until the case discussed in Chapter 4 that I was able to schedule this interview. This interview was an hour long and was conducted over Teams. The interview was recorded with the consent of the participant. Throughout the interview, few answers went beyond the surface level, and there seemed to be a lack of willingness to discuss certain sensitive topics. Questions ranged from generalized topics such as their role in refugee resettlement, to more specific questions on what gaps in care they are currently aware of and are working on. In general, the tone was very positive; the only negative comment I heard regarded budget cuts, which I was told left resettlement, “Not what it used to be.” This and other comments also left the impression that this person was tired and generally burnt-out from working in resettlement.

This white woman had been with resettlement for the past 20 years and considered themselves to be the person that forces collaboration and discussion between the multiple facets and programs that are utilized during resettlement. The Refugee Task Force does have a special "mental health sub-committee," although those meetings focus on and are for service providers, not for refugees themselves. During those meetings, providers do discuss specific cases among refugees and how to best handle them. More often than not, such cases are filtered to one of the case workers at the resettlement agency to handle and are not given to a licensed mental health practitioner. Furthermore, there is a tendency to give all these intensive cases to one specific case worker at one of the main resettlement agencies. This case worker is usually the only case worker for this third tier of care, and their workload includes all refugees from all populations - not just Central Africans. Because Tier One is usually for simple cases such as SNAP or food stamps and Tier Three is reserved for highly intense cases that require an enormous amount of time and energy to support these cases, it is counter-intuitive to assign only one case worker to handle all Tier Three cases. This is hard on both refugees in need and the overworked caseworker.

Besides learning that resettlement is very bureaucratic and underfunded, my main takeaway from the one-hour interview was that there is a lack of understanding of the everyday struggles that refugees face. My subsequent interaction with this individual further solidified these points, and anecdotal comments from other community volunteers stated that higher-ups in the resettlement system rarely actually visit refugees' homes or neighborhoods. This creates a disconnect between the realities of refugees' struggles during resettlement and those in charge – something, I believe, many understand to be a fundamental issue in refugee resettlement. Furthermore, there appeared to be an attitude of complacent acceptance that the system was

underfunded, bureaucratic, and beyond repair or improvement. While the impact of the budget cuts and funding issues is undeniable, complacency appeared to be only leading to the type of defensive inaction that reproduces the continued neglect of recently resettled refugees.

USF Licensed Therapist

The second key informant interview I will discuss at length was with a licensed therapist to whom I was referred by the task force member discussed above. This interview was held over zoom and lasted for an hour. It was recorded with the permission of the participant and questions focused on their role in the mental health care of refugees in Tampa, how they conducted care, gaps in care, and their understanding of cross-culture mental health care. This USF psychologist and psychology professor works with the refugee populations within the Tampa Bay Area through a free refugee-focused clinic run by USF Health. This clinic, however, is only held once a month for three hours. Because of this, she confirmed that she does not get to work with many clients due to the lack of time and the nature of the screening process. The screening process for mental health care is conducted by volunteers from USF's medical school. She stated that she only works with refugees who are ready and want to talk to her. Even then, she said that nine of ten (90%) refugees she has seen only met with her once for a single 30-minute session with no follow-up. She had only seen about three clients 'regularly', or every few months; otherwise, the care they have offered has been limited. She also admitted that she "was experienced in refugee mental health, but not an expert." I found this an interesting and humble admission from an "expert."

Due to the lack of time at the clinic, in her sessions she focused more on coping strategies and breathing exercises to avoid pathologizing her clients or diagnosing with little to no ability to

fully unpack past experiences. She also bridged the language gaps by utilizing a service, paid for by USF Health, called Cyracom, which provided translators over the phone. Having access to a translation service was an incredible strength for the care that they could provide, but she relented that it could also be limiting in the sense that it cut the already limited time of care in half with the translator. There have also been some concerns about translators being unable to correctly translate certain culturally appropriate mental health ideas.

When I asked further about the strengths and weaknesses of the form of limited therapeutic care she could offer through the refugee clinic, she maintained that one of the program's biggest strengths was being there at all for refugees. However, she admitted that having the clinic and resources available did not necessarily matter if refugees did not know the clinic existed or had no way of getting to the clinic. Although she felt they had great translation services, the amount of care that she could provide was greatly limited due to the time constraints.

When asked further about other practitioners that she knew were available, the USF psychologist admitted that she did not know anyone outside of the task force that provided refugee-specific care and that it was a goal of the task force to create a network of practitioners who might be able to provide such care. She seemed both surprised and not surprised to hear that I had done a survey of the available care networks in the Tampa Bay area, but had found no available resources specific to refugees. She was interested in further discussing and investigating with me how those barriers to care could possibly be bypassed, but it was clear that the state needed to provide more resources, support, and incentives for practitioners to bridge the gaps in care. I do plan to follow up with her again after the community event in Summer 2023.

Conclusion

From the beginning of my study, it was clear that there was a severe lack of appropriate mental health care resources for Central African refugees. My survey confirmed this, and the key informant interviews spoke to a general complacent acceptance that the resettlement system "is not what it used to be." Throughout my research, it has been repeatedly described as broken, overly bureaucratic, and underfunded. My interviewees also highlighted how they continued despite known problems. This attitude of perseverance brings me to the main issue: that everyone working with refugees, while passionate about providing the best care, is severely limited in what they can offer due to their labor largely being uncompensated, volunteer, or pro bono work. The primary issue appears to be that resettlement relies heavily on informal labor, or formalized volunteerism.

Refugees struggling with resettlement must accept an informalized system that makes them continually turn to volunteers or whatever personal networks they may have (usually other refugees). An increasing dependence on community or other volunteers does little to build trust between refugees and resettlement services – or those who are being paid to manage resettlement (this is also not good for the trust between volunteers and resettlement staff either). While there is a monthly refugee clinic and a case worker assigned to Tier Three cases, this is not appropriate care, nor is it seen as appropriate care by those in need.

Below are some of the most powerful quotes from the refugees themselves when discussing how their resettlement was going. One woman was promised everything:

> "We had no idea that we wouldn't be saved. We were promised that 'everything will be given to you once you come to America'. That 'every single family member would have

their own bedroom'. We were even promised cats and dogs." - Congolese women- mid 50s

Another woman was clear about the lack of support during resettlement:

"We were told that we would be helped. We haven't been." - Congolese woman- mid 40s

A third woman was describing how hard it is to resettle in the United States:

"There's so much pressure here." - Congolese woman- mid 40s

Finally, another summed up how different their resettlement in the United States has been as compared to what they were promised:

"This is the 'Country of Opportunity'. What opportunity?"

- Congolese woman- late 20s

Overall, it is clear from these powerful quotes that these women all felt that their resettlement process was the opposite of what they were promised. That they were not receiving care, but more having to rely on themselves to persevere.

CHAPTER SEVEN:

CONCLUSIONS AND RECOMMENDATIONS

Introduction

Throughout this thesis, I worked to bring the reader from the typical individualist, structural approach of mental health care issues, to a more contextualized approach that recognizes the daily hardships that effectively catalyze mental health crises within this population. Furthermore, I worked to bring the reader from the broader issues of resettlement and mental health to show how the two issues are deeply embedded and connected to each other. There are other factors that contribute to negative experiences of both separately, but the historical separation of the two has allowed for neglect and victim blaming to run rampant in refugee resettlement. Not only that, but due to religious organizations being given the power of resettlement by the state, refugees experience gender expectations that are inappropriate and further act as an excuse for inaction by resettlement organizations. Furthermore, through the continuous informalization that we see with the defunding and subcontracting/outsourcing of resettlement, the responsibility of care for this population is being pushed further and further aside.

The main finding of this research is that the mental health care of these populations needs to be made a higher priority during resettlement because there is practically no preventative or early intervention mental health care programming available for them. The mental health care for refugees that does exist is admittedly inadequate (in volume and cultural appropriateness) and

thereby reactionary to crises. This reactive care can reproduce dangerous ideologies of refugee over-neediness, lack of "deservingness", and deficiency that have unfortunately become mainstream, instead of rare (Holmes & Castañeda, 2016).

This project focused on the refugee community from the Democratic Republic of Congo (DRC) who had been forcefully displaced due to ethnic and gender-based conflicts and violence. It is therefore ironic that the few Central African families that do not move away from Tampa are generally either those who are quite wealthy or those who have the least money and connections elsewhere. Many of the families that are still in Tampa have expressed feelings of being stuck and that they are "still suffering".

Many studies, including a 2020 American Psychiatric Association report, have found that roughly one in three asylum seekers or refugees have high rates of post-traumatic stress disorder, anxiety, and depression (Association, 2020). Recent studies and my own experience working with this population confirm that the violence does not necessarily end after refugees enter the country of resettlement (Beiser, 2009; Bosqui, 2020; Chung et al., 2021; Familiar et al., 2021; Soifoine, 2022b). Rather, they experience a different sort of violence – to use Nancy Schepher-Hughes' classic term, an everyday sort where they must navigate within the broader structural inequalities and bureaucracy in an effort to maintain their agency (Schepher-Hughes, 1992).

With national refugee resettlement budget cuts that are still affecting staffing of national and local resettlement agencies, and thus the subsequent push by federal and state governments to informalization and reliance on volunteer time, the effectiveness of the available programing for refugees, such as housing, employment, and language development, is limited, and often non-existent. Still, refugees are expected to be completely self-sufficient within three months of

arrival. This pressure combined with essentially state sponsored neglect can be the perfect storm for acute stress induced reactions, such as the situations that I discussed in chapter four.

I have discussed how this is not due to these individuals' lack of agency or being unable to utilize culturally relevant self-care techniques. Due to different cultural understandings of mental health, one of the main aims of this study was to collect information about coping techniques that members of this community are already utilizing in hopes of developing health care professional's knowledge of appropriate mental health care and to widely disseminate to newer and recently entered refugees. This would then allow for the implementation and development of mental health care and social programming that would work with this specific community's cultural understandings of mental health, instead of blaming the population for struggling with the inadequate and inappropriate resources 'provided' to them. The care would then be more preventative, instead of reactionary. This transition would take care away from ineffective, state sanctioned programming to a more collaborative and community based mental health care system, something that has been shown to be effective in East African communities.

I discussed how over the course of the past year and a half, I conducted multiple interviews with state sanctioned resettlement agents, held a focus group with members of the community itself, surveyed local mental health care providers, and was involved in countless hours of participant observation by volunteering with a local community-based non-profit. I also discussed how one of the more important research methods that was employed was the focus group that was conducted after the driver's education program.

The main outcome of the focus group is that the use of the community is the number one resource that this population relies on when encountering difficult situations. Interpersonal networks of reciprocity are crucial to individual and community survival within this culture, but

this goes directly against the resettlement goals of personal responsibility and self-sufficiency. For refugees and lower income Americans alike, this can be unattainable. Despite these realities, newly arrived Central African refugees are continually resettled separately and in a city that is heavily dependent on automobility and lacks good public transportation, making it next to impossible for families to interact on a regular basis.

It is not necessarily hard to understand then why there have been multiple cases of acute stress reactions from this population. With the stark example of a situation that could have easily been prevented that I discussed in chapter four, it showed how complicated situations such as those were a product of numerous previous (in)actions that built to a boiling point. It was a clear example of the reliance of reactionary care instead of preventative care.

Scholarly Contributions

This thesis expands the literature on US-based refugees, especially those from Central Africa. Furthermore, this research is a continuation of a partnership with the central African refugee community within Tampa. USF's Anthropology department has been broadly working with refugees in this area since the early 2000s (Baer & Nichols, 2001). This research also contributes to the critique of the for-profit medical system and the overuse of neoliberal politics that are commonplace in the United States. With the American mental health care crisis in general as an example, it is both real and can be used as an excuse for inaction by national and local governments.

The state of refugee resettlement here in Tampa, Florida is another example of how the state has abandoned responsibility and its role as a provider of care for this vulnerable population. However, due to the nature of accepting global refugees through UNHCR, it is still a requirement

that the national government is still heavily involved. This concurrent acceptance of bureaucracy and funding cuts, simultaneously, speaks to disfunction and allows for numerous types of contradictory, state sponsored (in)actions. This research contributes a significant voice to the argument that there needs to be crucial and systemic change in the policies and execution of refugee resettlement because the current system is effectively broken and is creating situations that can further break people.

I have spoken up about the current resettlement situation in Tampa, FL at two national conferences and the created visibility of this situation has increased awareness and discussion of the inadequacies of state and federal resettlement that have been commonplace and accepted for far too long. I am also in the process of submitting articles about my work on this project and with the driver's education program to scholarly journals as a way to bring even further visibility to the inadequacies of resettlement, easy recommendations to implement to bypass certain bureaucratic stalemates, and promote faster, critical, and positive change.

Applied Outcomes

The findings of this project have already been used by AR4WRM as a vehicle to advocate for better, more contextualized, and community-based mental health care for this population. The situation that happened in Chapter 4 was not necessarily an unheard-of situation within the community, but it had one of the worst outcomes. This situation is already being used as a blueprint for policy creation on what not to do because it was clear that all of the powerful stakeholders involved failed this family. It is also being used as an illustration of what can happen if there is not a more concerted effort for effective, preventative care and early detection.

I am also discussing how I might disseminate my findings from this project with AR4WRM and the USF anthropology research team. I would like to be able to present my findings to the Tampa Bay Mental Health Task force in order to spark conversation about how their current models of mental health care for this population is dangerous, inappropriate, and unethical. There needs to be more of a collaborative approach to this sort of care, and there needs to be greater respect for the position that the director of AR4WRM holds as a liaison between the community and resettlement agencies.

Furthermore, there is budding discussion with other non-profits within the city of Tampa and Tampa General Hospital to discuss how might medical and mental health care become more accessible in terms of language translation, cultural understandings of health and wellness, and cultural understandings of gender expectations. With better digital approaches to language translation, there is a greater chance of portable and effective translation services that could even be useful in emergency situations. Furthermore, this dialogue will hopefully bring about modules that can be disseminated to medical staff as a reference guide for future, culturally appropriate guided care.

This research was funded through a Creative Scholars grant through USF and one of the main applied outcomes is going to be a culturally appropriate community building event that will take place this Summer. The community will come together to sing, dance, and a goat roast. We will provide resources and people will be given space to bring forth their concerns about resettlement. State resettlement actors will be invited, but the point of this event is not for PR for them. It is to help bridge the gaps in community that have been forced on this population through the state sanctioned neglect of resettlement in Tampa.

As I strive to continue into the Applied Anthropology Ph.D. program at the University of South Florida, I will continuously advocate for the mental health of the Central African refugee community, other refugee communities alike, and AR4WRM. I am planning to help foster more partnerships based on my initial study between mental health practitioners and the communities that will be beneficial to both.

Recommendations

How can we avoid instances like what we saw in chapter four in the future? A few thoughts. Combating this lack of care will be no easy task.

First, there needs to be more community-based programs that allow refugees to continue to build their community ties that they can rely on in times of stress. It was stated in the focus group that programs such as the driver's ed program made the women feel better. That it not only acted as a vehicle to gain mobility, but it also solidified friendships within the community and allowed them to do something that felt tangible and a step forward towards the better life that they were promised. So, more community programs that help them gain autonomy and build their social envelope is imperative.

Second, there needs to be a more concerted effort by resettlement agencies to build and maintain community ties when they resettle new families. However, this will have to be done carefully due to the gender and ethnic politics of what it means to be Congolese. Without change, we will see the continuation of the structural and gender inequalities that seem to be continually reproduced during resettlement for this population.

Third, there also needs to be a concerted effort to solidify the formalized mental health care of this population in terms of more accessibility to language translation services and more

accessibility to practitioners in general. This move towards a more formalized translation program and services will make care accessible to broader audiences, even beyond refugees.

Fourth, there needs to be more state involvement in the mental health care of this population because their lack of support during resettlement has created or compounded multiple mental health crises. More specifically, the state needs to provide subsidized mental healthcare services to those who are in great need but lack access due to either financial or transportation issues. This would be beneficial to the public in general.

Fifth, mental health care for this population needs to be approached with preventative measures in mind, instead of only being reactionary to state-created crises. While it is important to acknowledge the current realities of an underfunded resettlement system, complacency, or defensive inaction, allows only for reactive rather than the necessary preventative care. We must harness and utilize state resources to create better, preventive models and methods of screening and care – something important for both refugees and the general public.

Conclusion

It will take a village to do it, but what does that look like? Tampa resettlement will need more formal funding, but even refugee resettlement organizations can do some of these things that do not cost as much, such as resettle refugees closer to each other, provide them with culturally appropriate food, more language translation and transportation services, and focus more on preventative mental health care, instead of waiting to act until the families are already in crisis. By studying the structural inequities that are hyper prevalent in the health care system and socio-economic structures of the United States through critical medical anthropology, structural violence, everyday violence, and practice theory, I believe that I got to the heart of some of the

major issues that are barring Central African refugees from resettling in a positive manner with appropriate and preventative mental health care. It is my hope that by bringing these concerns more to light, focusing on having a more collaborative approach to this population's mental and health care, that resettlement will be drastically overhauled in Florida.

REFERENCES

Abu Suhaiban, H., Grasser, L. R., & Javanbakht, A. (2019). Mental Health of Refugees and Torture Survivors: A Critical Review of Prevalence, Predictors, and Integrated Care. *Int J Environ Res Public Health*, *16*(13). https://doi.org/10.3390/ijerph16132309

Alvarez, P. (2018, Sept. 9, 2018). America's System for Resettling Refugees is Collapsing. *The Atlantic*. https://www.theatlantic.com/politics/archive/2018/09/refugee-admissions-trump/569641/.

Amos, D. (2018, Jan. 1, 2018). *The Year the Refugee Resettlement Program Unraveled*. National Public Radio.

Andersson, R. (2018). The price of impact: reflections on academic outreach amid the 'refugee crisis'. *Social Anthropology*, *26*(2), 222-237. https://doi.org/10.1111/1469-8676.12478

ANI. (2022). UN chief warns of 'global mental health crisis'. *Khaleej Times*. https://www.msn.com/en-ae/news/world/un-chief-warns-of-global-mental-health-crisis/ar-AAYBmGX

Animbom Ngong, P. (2017). Therapeutic theatre: an experience from a mental health clinic in Yaoundé-Cameroon. *Arts & Health*, *9*(3), 269-278. https://doi.org/10.1080/17533015.2017.1296007

Arnetz, B. B., Sudan, S., Arnetz, J. E., Yamin, J. B., Lumley, M. A., Beck, J. S., Stemmer, P. M., Burghardt, P., Counts, S. E., & Jamil, H. (2020). Dysfunctional neuroplasticity in newly arrived Middle Eastern refugees in the U.S.: Association with environmental exposures and mental health symptoms. *PLoS One*, *15*(3), e0230030. https://doi.org/10.1371/journal.pone.0230030

Arnetz, J., Rofa, Y., Arnetz, B., Ventimiglia, M., & Jamil, H. (2013). Resilience as a protective factor against the development of psychopathology among refugees. *J Nerv Ment Dis*, *201*(3), 167-172. https://doi.org/10.1097/NMD.0b013e3182848afe

Arradondo, B. (2022). *Tampa neighborhood on alert after lead warning* https://www.fox13news.com/news/tampa-neighborhood-on-alert-after-lead-warning

Association, A. A. P. (2020). *Mental Health Facts on Refugees, Asylum-seekers, & Survivors of Forced Displacement*.

Baer, R. D., Mahoney, D., Holbrook, E., Inks, M., Obure, R., Bomboka, L., & Benton, K. (2017, July 30, 2017). School Harassment/Bullying Among Congolese Refugees in the Tampa Area— Part 1. Tampa Bay Refugee Task Force Meeting, Tampa, FL.

Baer, R. D., & Nichols, J. (2001). Ethnic Issues. *Handbook of Rural Health*, 73-102.

Barter, C., & Renold, E. (2000). 'I wanna tell you a story': Exploring the application of vignettes in qualitative research with children and young people. *International Journal of Social Research Methodology*, *3*(4), 307-323. https://doi.org/10.1080/13645570050178594

Beiser, M. (2009). Resettling refugees and safeguarding their mental health: lessons learned from the Canadian Refugee Resettlement Project. *Transcult Psychiatry*, *46*(4), 539-583. https://doi.org/10.1177/1363461509351373

Beneduce, R. (2008). Undocumented bodies, burned identities: refugees, sans papiers, harraga — when things fall apart. *Social Science Information*, *47*(4), 505-527. https://doi.org/10.1177/0539018408096444

Bernard, H. R. (2018). Text Analysis I: Interpretive Analysis, Narrative Analysis, Performance Analysis, and Conversation Analysis. In *Research Methods in Anthropology : Qualitative and Quantitative Approaches* (6th ed.). Lanham, Maryland : Rowman & Littlefield.

Berthold, S. M., Kong, S., Mollica, R. F., Kuoch, T., Scully, M., & Franke, T. (2014). Comorbid mental and physical health and health access in Cambodian refugees in the US. *J Community Health*, *39*(6), 1045-1052. https://doi.org/10.1007/s10900-014-9861-7

Billingsley, K., & Mahoney, D. (2021). Engaged Research in a Hurry: The Case for and Complications of Immediate Anthropology. *Human Organization*, *80*(Summer 2021), 117-127.

Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post‐traumatic stress disorder (PTSD) in adults. *Cochrane database of systematic reviews*, *12*.

Bock, P. K. (1994). *Psychological Anthropology*. Praeger Publishers/ Greenwood Publishing Group.

Bosqui, T. (2020). The need to shift to a contextualized and collective mental health paradigm: learning from crisis-hit Lebanon. *Glob Ment Health (Camb)*, *7*, e26. https://doi.org/10.1017/gmh.2020.20

Bryant, R. A., Bawaneh, A., Awwad, M., Al-Hayek, H., Giardinelli, L., Whitney, C., Jordans, M. J. D., Cuijpers, P., Sijbrandij, M., Ventevogel, P., Dawson, K., Akhtar, A., & Consortium, S. (2022). Effectiveness of a brief group behavioral intervention for common mental disorders in Syrian refugees in Jordan: A randomized controlled trial. *PLoS Med*, *19*(3), e1003949. https://doi.org/10.1371/journal.pmed.1003949

Bunn, C. (2022). *Report: Black people are still killed by police at a higher rate than other groups*. https://www.nbcnews.com/news/nbcblk/report-black-people-are-still-killed-police-higher-rate-groups-rcna17169

Bunn, M., Marsh, J., & Haidar, A. (2021). Sharing Stories Eases Pain: Core Relational Processes of a Group Intervention with Syrian Refugees in Jordan. *The Journal for Specialists in Group Work*, 1-23. https://doi.org/10.1080/01933922.2021.2000084

Bureau of Population, R., and Migration (PRM). (2023a). *U.S. Refugee Admissions Program: Reception and Placement*. U.S. Department of State. https://www.state.gov/refugee-admissions/reception-and-placement/

Bureau of Population, R., and Migration (PRM). (2023b). *U.S. Refugee Admissions Program: Overseas Application and Case Processing*. U.S. Department of State. https://www.state.gov/refugee-admissions/application-and-case-processing/

Cabot, H. (2019). The business of anthropology and the European refugee regime. *American Ethnologist*, *46*(3), 261-275. https://doi.org/10.1111/amet.12791

Calvert, S., & Rust, M. (2018). The Most Dangerous Place to Bicycle in America: Pinellas County, Fla., has the highest cyclist death rate in the Tampa Bay metro area—which has the highest rate of any metro region in the U.S. *The Wall Street Journal*. https://www.wsj.com/articles/the-most-dangerous-place-to-bicycle-in-america-1537867800

CDC. (2023). *About Mental Health*. https://www.cdc.gov/mentalhealth/learn/index.htm#:~:text=More%20than%201%20in%205,a%20seriously%20debilitating%20mental%20illness.&text=About%201%20in%2025%20U.S.,bipolar%20disorder%2C%20or%20major%20depression.

Center, C. (2014). *Refugees from the Democratic Republic of Congo*. http://www.culturalorientation.net/learning/backgrounders

Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *The Lancet*, *394*(10194), 240-248. https://doi.org/10.1016/s0140-6736(19)30934-1

Chung, M. C., AlQarni, N., AlMazrouei, M., Al Muhairi, S., Shakra, M., Mitchell, B., Al Mazrouei, S., & Al Hashimi, S. (2021). Posttraumatic stress disorder and psychiatric co-morbidity among Syrian refugees: the role of trauma exposure, trauma centrality, self-efficacy and emotional suppression. *J Ment Health*, *30*(6), 681-689. https://doi.org/10.1080/09638237.2020.1755023

Council, N. R. (2021). *The World's Most Neglected Displacement Crises*. https://www.nrc.no/resources/reports/the-worlds-most-neglected-displacement-crises-in-2020/

Crafter, S., de Abreu, G., Cline, T., & O'Dell, L. (2014). Using Vignette Methodology as a Tool for Exploring Cultural Identity Positions of Language Brokers. *Journal of Constructivist Psychology*, *28*(1), 83-96. https://doi.org/10.1080/10720537.2014.923354

Dew, A. S., Louisa; Collings, Susan; Dillon Savage, Isabella. (2018). Complexity Embodied: Using Body Mapping to Understand Complex Support Needs. *Forum: Qualitative Social Research*, *19*(4), 4-24. https://ro.uow.edu.au/ahsri/924/

Dhalimi, A., Wright, A. M., Yamin, J., Jamil, H., & Arnetz, B. B. (2018). Perception of Discrimination in Employment and Health in Refugees and Immigrants. *Stigma Health*, *3*(4), 325-329. https://doi.org/10.1037/sah0000068

Drake, R. E. (2015). Anthropology and mental health care. *Epidemiol Psychiatr Sci*, *24*(4), 283-284. https://doi.org/10.1017/S2045796015000402

Eaton, D. (2006). Diagnosing the Crisis in the Republic of Congo. *Africa*, *76*(1), 44-67.

Esala, J. J., Vukovich, M. M., Hanbury, A., Kashyap, S., & Joscelyne, A. (2018). Collaborative care for refugees and torture survivors: Key findings from the literature. *Traumatology*, *24*(3), 168-185. https://doi.org/10.1037/trm0000143

Familiar, I., Muniina, P. N., Dolan, C., Ogwal, M., Serwadda, D., Kiyingi, H., Bahinduka, C. S., Sande, E., & Hladik, W. (2021). Conflict-related violence and mental health among self-settled Democratic Republic of Congo female refugees in Kampala, Uganda - a respondent driven sampling survey. *Confl Health*, *15*(1), 42. https://doi.org/10.1186/s13031-021-00377-2

Farmer, P. (1996). On Suffering and Structural Violence: A View from Below. In A. D. Kleinman, V.; Lock, M. (Ed.), *Issues on Social Suffering* (pp. 261-276, 278-283). Daedalus, Journal of American Academy of Arts and Sciences.

Farmer, P. (2016). Structural Violence and Clinical Medicine. In P. J. Brown & S. Closser (Eds.), *In Understanding and Applying Medical Anthropology: Biosocial and Cultural Approaches* (3rd Edition ed.). Left Coast Press.

FHSMV, F. H. S. a. M. V. (2023). *Florida Crash Dashboard*. https://www.flhsmv.gov/traffic-crash-reports/crash-dashboard/

Fine, S. L., Kane, J. C., Spiegel, P. B., Tol, W. A., & Ventevogel, P. (2022). Ten years of tracking mental health in refugee primary health care settings: an updated analysis of data from UNHCR's Health Information System (2009-2018). *BMC Med*, *20*(1), 183. https://doi.org/10.1186/s12916-022-02371-8

Fisse, D. (2023, April 26, 2023). 5 Proven Strategies for Addressing the Global Human Energy Crisis. *Workplace Wellbeing*. https://www.springhealth.com/blog/5-proven-strategies-for-addressing-the-global-human-energy-crisis

Force, T. B. R. T. (2021). Tampa Bay Refugee Task Force Meetings. In.

Forum, N. I. (2023, November 5, 2020). Retrieved 06/11/2023 from https://immigrationforum.org/article/fact-sheet-u-s-refugee-resettlement/

Geenen, K. (2019). Categorizing colonial patients: segregated medical care, space and decolonization in a Congolese city, 1931–62. *Africa*, *89*(1), 100-124. https://doi.org/10.1017/s0001972018000724

Gehrmann, S. (2009). Remembering Colonial Violence: Inter/Textual Strategies of Congolese Authors. *Tydskrif vir letterkunde*, *46*, 11-27.

Glasman, J. (2017). Seeing Like a Refugee Agency: A Short History of UNHCR Classifications in Central Africa (1961–2015). *Journal of Refugee Studies*, *30*(2), 337-362. https://doi.org/10.1093/jrs/few044

Gone, J. P., & Kirmayer, L. J. (2020). Advancing Indigenous Mental Health Research: Ethical, conceptual and methodological challenges. *Transcult Psychiatry*, *57*(2), 235-249. https://doi.org/10.1177/1363461520923151

González-Brenes, M. (2004). *Domestic violence and household decision-making: Evidence from East Africa* Univeristy of California, Berkely]. Berkely, CA.

Goździak, E. M. (2004). Training Refugee Mental Health Providers: Ethnography as a Bridge to Multicultural Practice. *Human Organization*, *63*(Summer 2004), 203-210. https://www.jstor.org/stable/44127296

Grasser, L. R., & Javanbakht, A. (2019). Treatments of Posttraumatic Stress Disorder in Civilian Populations. *Curr Psychiatry Rep*, *21*(2), 11. https://doi.org/10.1007/s11920-019-0994-3

Hameed, S., Sadiq, A., MBChB, MRCPsych;, & Din, A. U., M.D. (2018). The Increased Vulnerability of Refugee Population to Mental Health Disorders. *Kansas Journal of Medicine*, *11*, 1-23. https://doi.org/https://doi.org/10.17161/kjm.v11i1.8680

Harms, S., Kizza, R., Sebunnya, J., & Jack, S. (2009). Conceptions of mental health among Ugandan youth orphaned by AIDS. *Afr J AIDS Res*, *8*(1), 7-16. https://doi.org/10.2989/AJAR.2009.8.1.2.715

Hecker, T., Fetz, S., Ainamani, H., & Elbert, T. (2015). The Cycle of Violence: Associations Between Exposure to Violence, Trauma-Related Symptoms and Aggression--Findings from Congolese Refugees in Uganda. *J Trauma Stress*, *28*(5), 448-455. https://doi.org/10.1002/jts.22046

Hoewe, J. (2018). Coverage of a Crisis: The Effects of International New Portrayals of Refugees and Misuse of the Term “Immigrant”. *American Behavioral Scientist*, *62*, 478-492.

Holbrook, E. B., R; Mahoney, D; Obure, R; and Ackey, F. (2019). Applying Applied Anthropology: A Project with Applied Anthropologists, Congolese Refugees, and Refugee Service Providers in West Central Florida. *Practicing Anthropology*, *41*(Winter), 15-19. https://meridian.allenpress.com/practicing-anthropology/article/41/1/15/9672/Applying-Applied-Anthropology-A-Project-with

Holmes, S. M., & Castañeda, H. (2016). Representing the "European refugee crisis" in Germany and beyond: Deservingness and difference, life and death. *American Ethnologist*, *43*(1), 12-24. https://doi.org/10.1111/amet.12259

Ibrahim, H., & Hassan, C. Q. (2017). Post-traumatic Stress Disorder Symptoms Resulting from Torture and Other Traumatic Events among Syrian Kurdish Refugees in Kurdistan Region, Iraq. *Front Psychol*, *8*, 241. https://doi.org/10.3389/fpsyg.2017.00241

IDMC. (2021). *Internal Displacement in a Changing Climate* (Global Report on Internal Displacement, Issue.

Inks, M. (2021). *Educational Experiences of Congolese Refugees in West-Central Florida High Schools* University of South Florida]. Tampa, FL.

Jager, A. d. T., Anna; Ludlow, Bryn; Boydell, Katherine. (2016). Embodied Ways of Storying the Self: A Systematic Review of Body-Mapping. *InForum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *17*.

Jansen, B. J. (2008). Between Vulnerability and Assertiveness: Negotiating Resettlement in Kakuma Refugee Camp, Kenya. *African Affairs*, *107*(429), 569-587.

Joralemon, D. (2017). *Exploring Medical Anthropology*.

Jordan, M. (2023, Jan. 19, 2023). Biden Administration Invites Ordinary Americans to Help Settle Refugees: The program to speed up refugee arrivals will allow private citizens to sponsor families in their communities after raising funds and undergoing training. *The New York Times*. https://www.nytimes.com/2023/01/19/us/refugee-resettlement-policy-biden.html?unlocked_article_code=BRJFGRyYgBLe1Ou9Sth4EE4vK5ISzaEmX7GVBTWFA6ZdGIFUalk7IbxafEok8Sw1lPkKD8OC_de13kDqCaOZMutOjlo4oWt48FxVbHaNQv8V3uarn08R-BeVFarAlvfJKS4LHYbD5eWLsGMsTDISXCtMV3hG9LE72G6k0YCe5B9JH4J5sP23Lv_OZQqn5um22VCD5KwxF0-SB2_Sk4lvGmoOj9BeK5K_V5C_mNDT6-aXPi2im0emKU5Hwi2wNfIPXBH-gT02uIo3AzHUmgPA-y3BigvhJsXhc-BCjx2HGROU-gcINEXHdEavBSag6633zoK2UxrpiurzEWKqz3NFeVhrkYmokA

Kaiser, B. N., & Jo Weaver, L. (2019). Culture-bound syndromes, idioms of distress, and cultural concepts of distress: New directions for an old concept in psychological anthropology. *Transcult Psychiatry*, *56*(4), 589-598. https://doi.org/10.1177/1363461519862708

Kappeler, T. (2020). *Framing Refugees: Swiss Asylum Reform Discourse During the 'Refugee Crisis' 2015-2016* International Institute of Social Studies]. The Hague, The Netherlands.

Kerwin, D., & Nicholson, M. (2021). Charting a Course to Rebuild and Strengthen the US Refugee Admissions Program (USRAP): Findings and Recommendations from the Center for Migration Studies Refugee Resettlement Survey: 2020. *Journal on Migration and Human Security*, *9*(1), 1-30. https://doi.org/10.1177/2331502420985043

Kirmayer, L. J., Lemelson, R., & Cummings, C. A. (1952). *Re-visioning psychiatry: cultural phenomenology, critical neuroscience, and global mental health*. Cambridge University Press. https://usf-flvc.primo.exlibrisgroup.com/permalink/01FALSC_USF/8i1ivu/alma9937993274090659 9

Kleinman, A. (2012). Medical Anthropology and Mental Health: Five Questionss for the next fifty years. In *Medical Anthropology at the Intersections: Histories, Activisms, and Futures* (pp. 116-128).

Kleinman, A. M. (1977). Depression, somatization and the "new cross-cultural psychiatry". *Social Science and Medicine*, *11*, 3-9.

Knettel, B. A., Rugira, J., & Cornett, J. A. (2018). Mental Health Diagnostic Frameworks, Imputed Causes of Mental Illness, and Alternative Treatments in Northern Tanzania: Exploring Mental Health Providers' Perspectives. *Cult Med Psychiatry*, *42*(3), 483-503. https://doi.org/10.1007/s11013-018-9565-z

Koegler, E. (2019). Understanding How Solidarity Groups—A Community-Based Economic and Psychosocial Support Intervention—Can Affect Mental Health for Survivors of Conflict-Related Sexual Violence in Democratic Republic of the Congo. *Violence Against Women*. https://advance-lexis-com.ezproxy.lib.usf.edu/api/document?collection=news&id=urn:contentItem:60MS-RCP1-JBMY-H3XD-00000-00&context=1516831.

Kong, C., Campbell, M., Kpobi, L., Swartz, L., & Atuire, C. (2021). The hermeneutics of recovery: Facilitating dialogue between African and Western mental health frameworks. *Transcult Psychiatry*, 13634615211000549. https://doi.org/10.1177/13634615211000549

Levy, B. S., & Sidel, V. W. (2009). Health Effects of Combat: A Life-Course Perspective. *Annual Review of Public Health*, *30*, 123-136. https://doi.org/10.1146/annurev.publhealth.031308.100147

Lindert, J., Ehrenstein, O. S., Priebe, S., Mielck, A., & Brahler, E. (2009). Depression and anxiety in labor migrants and refugees--a systematic review and meta-analysis. *Soc Sci Med*, *69*(2), 246-257. https://doi.org/10.1016/j.socscimed.2009.04.032

Lock, M. M., & Nguyen, V.-K. (2018). *An Anthropology of Biomedicine* (Second Edition ed.). Wiley Blackwell.

Lockhart, C. (2008). The life and death of a street boy in East Africa: everyday violence in the time of AIDS. *Med Anthropol Q*, *22*(1), 94-115. https://doi.org/10.1111/j.1548-1387.2008.00005.x

Lokuge, K., Shah, T., Pintaldi, G., Thurber, K., Martinez-Viciana, C., Cristobal, M., Palacios, L., Dear, K., & Banks, E. (2013). Mental health services for children exposed to armed conflict: Medecins Sans Frontieres' experience in the Democratic Republic of Congo, Iraq and the occupied Palestinian territory. *Paediatr Int Child Health*, *33*(4), 259-272. https://doi.org/10.1179/2046905513Y.0000000098

Lorenz, M. L. (2022). U.S. Refugee Resettlement Is in Ruins-It Is Our Duty to Rebuild It. *J Gen Intern Med*, *37*(4), 940-943. https://doi.org/10.1007/s11606-021-07373-5

Lori, J. R., & Boyle, J. S. (2015). Forced migration: health and human rights issues among refugee populations. *Nurs Outlook*, *63*(1), 68-76. https://doi.org/10.1016/j.outlook.2014.10.008

Lyons, T. (2010). Recovery Capital, drug policy and the cycle of incarceration. *Practicing Anthropology*, *32*, 41-44.

Mahoney, Baer, R. D., Wani, O., Anthony, E., & Behrman, C. (2020a). Unique Issues for Resettling Refugees from the Congo Wars. *Annals of Anthropological Practice*, *44*(1), 77-90. https://doi.org/10.1111/napa.12137

Mahoney, D. (2017). *The art of connection: risk, mobility, and the crafting of transparancy in coastal Kenya*. University of California Press.

Mahoney, D., Obure, R., Billingsley, K., Inks, M., Umurutasate, E., & Baer, R. D. (2020b). Evaluation Understandings of State and Federal Pandemic Policies: The Situation of Refugees from the Congo Wars in Tampa, Florida. *Human Organization*, *79*, 271-280.

Mahoney, D., & Wright-Soifoine. (2021). *AR4WRM. org Critical Case Profiles: Gender Equity, Maternal Health, and Mental Health Challenges*.

Marshall, G. N., Schell, T. L., & Miles, J. N. (2009). Ethnic differences in posttraumatic distress: Hispanics' symptoms differ in kind and degree. *J Consult Clin Psychol*, *77*(6), 1169-1178. https://doi.org/10.1037/a0017721

Martin, S. T. (2018, Feb. 21, 2018). Tampa Bay Homes Prices Soar by Double-digits in January. *Tampa Bay Times*. https://www.tampabay.com/news/business/realestate/Tampa-Bay-homes-prices-soar-by-double-digits-in-January_165661316.

Mels, C., Derluyn, I., Broekaert, E., & Rosseel, Y. (2010). Community-based cross-cultural adaptation of mental health measures in emergency settings: validating the IES-R and HSCL-37A in Eastern Democratic Republic of Congo. *Soc Psychiatry Psychiatr Epidemiol*, *45*(9), 899-910. https://doi.org/10.1007/s00127-009-0128-z

Miller, K. E., & Rasmussen, A. (2017). The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. *Epidemiol Psychiatr Sci*, *26*(2), 129-138. https://doi.org/10.1017/S2045796016000172

Mistry, S. K., Harris-Roxas, B., Yadav, U. N., Shabnam, S., Rawal, L. B., & Harris, M. F. (2021). Community Health Workers Can Provide Psychosocial Support to the People During COVID-19 and Beyond in Low- and Middle- Income Countries. *Front Public Health*, *9*, 666753. https://doi.org/10.3389/fpubh.2021.666753

Monson, C. M., Macdonald, A., Vorstenbosch, V., Shnaider, P., Goldstein, E. S., Ferrier-Auerbach, A. G., & Mocciola, K. E. (2012). Changes in social adjustment with cognitive processing therapy: effects of treatment and association with PTSD symptom change. *J Trauma Stress*, *25*(5), 519-526. https://doi.org/10.1002/jts.21735

Morina, N., Akhtar, A., Barth, J., & Schnyder, U. (2018). Psychiatric Disorders in Refugees and Internally Displaced Persons After Forced Displacement: A Systematic Review. *Front Psychiatry*, *9*, 433. https://doi.org/10.3389/fpsyt.2018.00433

Navarro, V. (2007). Neoliberalism as a class ideology; or, the political causes of the growth of inequalities. *International Journal of Health Services: Planning, administration, Evaluation*, *37*, 47-62. https://doi.org/10.2190/AP65-X154-4513-R520

NCTTP. (2018). Descriptive, inferential, functional outcome data on 9,025 torture survivors over six years in the United State. *Torture Journal*, *25*(27), 34-60. https://doi.org/10.7146/torture.v25i2.109673

Nuwer, R. (2020, 27th May 2020). How a bench and a team of grandmothers can tackle depression. *BBC*. https://www.bbc.com/future/article/20181015-how-one-bench-and-a-team-of-grandmothers-can-beat-depression

Oppedal, B., & Idsoe, T. (2015). The role of social support in the acculturation and mental health of unaccompanied minor asylum seekers. *Scand J Psychol*, *56*(2), 203-211. https://doi.org/10.1111/sjop.12194

Ordway, D.-M. (2022). How they did it: Tampa Bay Times reporters expose high airborne lead levels at Florida recycling factory. *The Journalist's Resource*. https://journalistsresource.org/health/lead-air-recycling-factory-investigation-tampa-bay-times/

Ortner, S. B. (2006). *Anthropology and Social Theory*. Duke University Press. https://doi.org/https://doi.org/10.1515/9780822388456

Palaiologou, I. (2017). The use of vignettes in participatory research with young children. *International Journal of Early Years Education*, *25*(3), 308-322. https://doi.org/10.1080/09669760.2017.1352493

PBS. (2018). *Disturbing data shows how often domestic violence turns deadly* https://www.pbs.org/newshour/show/disturbing-data-shows-how-often-domestic-violence-turns-deadly

Peace, L. (2022, Feb. 2, 2022). Florida Renters Scramble for Shelter as Affordable Housing Erodes. *Tampa Bay Times*. https://www.tampabay.com/news/pinellas/2022/02/02/florida-renters-scramble-for-shelter-as-affordable-housing-erodes/

Pearlin, L. I. S., Scott; Fazio, Elena M.; Meersman, Stephen C. . (2005). Stress, Health and the Life Course: Some Conceptual Perspectives. *Journal of Health and Social Behavior*(2), 205-219. https://doi.org/10.1177/002214650504600206

Posselt, M., Eaton, H., Ferguson, M., Keegan, D., & Procter, N. (2019). Enablers of psychological well-being for refugees and asylum seekers living in transitional countries: A systematic review. *Health Soc Care Community*, *27*(4), 808-823. https://doi.org/10.1111/hsc.12680

Post, T. W. (2023). *1,066 people have been shot and killed by police in the past 12 months* (Fatal Force, Issue. https://www.washingtonpost.com/graphics/investigations/police-shootings-database/

Prunier, G. (2009). *Africa's World War: Congo, the Rwandan Genocide, and the Making of a Continental Catastrophe*. Oxford University Press.

Puffer, E. S., Green, E. P., Sikkema, K. J., Broverman, S. A., Ogwang-Odhiambo, R. A., & Pian, J. (2016). A church-based intervention for families to promote mental health and prevent HIV among adolescents in rural Kenya: Results of a randomized trial. *J Consult Clin Psychol*, *84*(6), 511-525. https://doi.org/10.1037/ccp0000076

Registry, A. f. T. S. a. D. (2018). *Public Health Assessment: Former Inco-Increte Facility*. https://www.floridahealth.gov/environmental-health/hazardous-waste-sites/_documents/inco-increte-final-01-25-2018.pdf

Reyes, C. C. (2019). Practicing "unsettled listening" to the migration narratives of young adolescent refugees. *Middle School Journal*, *50*(4), 16-25. https://doi.org/10.1080/00940771.2019.1650546

Riaño-Alcalá, P. (2008). Journeys and landscapes of forced migration: Memorializing fear among refugees and internally displaced Colombians. *Social Anthropology*, *16*(1), 1-18. https://doi.org/10.1111/j.1469-8676.2008.00036.x

Rodriguez, C., & Ward, B. (2018). Making Black Communities Matter: Race, Space, and Resistance in the Urban South. *Human Organization*, *77*, 321-322.

Rodriguez, D. X., McDaniel, P. N., & Tikhonovsky, M. (2020). Human Services Providers' Perspectives on Refugee Resettlement in the United States before and after the 2016 Presidential Election. *Journal of Immigrant & Refugee Studies*, *18*(4), 448-466. https://doi.org/10.1080/15562948.2019.1702749

Rohlof, H. G., Knipscheer, J. W., & Kleber, R. J. (2014). Somatization in refugees: a review. *Soc Psychiatry Psychiatr Epidemiol*, *49*(11), 1793-1804. https://doi.org/10.1007/s00127-014-0877-1

Roy-Omoni, A. (2022). Orality and Healing in the Stand-up Comedy Performance of Selected Niger Delta Comedians. *international Review of Humanities Studies*, *7*(1).

RPC. (2022). *Refugee Arrivals by State and Title* Refugee Processing Center (RPC). https://data.progress-index.com/refugee/florida-tampa/dem-rep-congo/all/

Schaul, K., & O'Connell, J. (2022, Feb. 16, 2022). Investors Bought a Record Share of Homes in 2021. See where. *Washington Post*.

Schepher-Hughes, N. (1992). *Death Without Weeping: The Violence of Everyday Life in Brazil*.

Schubert, C. C., & Punamaki, R. L. (2011). Mental health among torture survivors: cultural background, refugee status and gender. *Nord J Psychiatry*, *65*(3), 175-182. https://doi.org/10.3109/08039488.2010.514943

Shannon, P. J., Wieling, E., McCleary, J. S., & Becher, E. (2015). Exploring the mental health effects of political trauma with newly arrived refugees. *Qual Health Res*, *25*(4), 443-457. https://doi.org/10.1177/1049732314549475

Shapiro, S., & MacDonald, M. T. (2017). From Deficit to Asset: Locating Discursive Resistance in a Refugee-Background Student's Written and Oral Narrative. *Journal of Language, Identity & Education*, *16*(2), 80-93. https://doi.org/10.1080/15348458.2016.1277725

Sidel, B. S. L. a. V. W. (2008). *War and Public Health*. https://doi.org/10.1093/acprof:oso/9780195311181.001.0001

Singer, K. (1977). *Depression, somatization, and the "New Cross-Cultural Psychiatry". A Comment* (Vol. 11). Social Science & Medicine https://usf-flvc.primo.exlibrisgroup.com/permalink/01FALSC_USF/un0hgn/cdi_proquest_miscellaneous_83996989

Singer, M., & Baer, H. (2018). *Critical Medical Anthropology*.

Singer, M., Herring, D. A., Littleton, J., & Rock, M. (2011). Chapter 8. In *Syndemics in Global Health* (pp. 159-179).

Soifoine, S. (2022a). *"Even if You Have Food in Your House, It Will Not Taste Sweet": Central African Refugees' Experiences of Cultural Food Insecurity and Other Overlapping Insecurities in Tampa, Florida* University of South Florida]. Tampa, FL. https://www.proquest.com/docview/2696881899/419C0A9763F74935PQ/1?accountid=14745

Soifoine, S. (2022b). *"Even if You Have Food in Your House, It Will Not Taste Sweet": Central African Refugees' Experiences of Cultural Food Insecurity and Other Overlapping Insecurities in Tampa, Florida* ProQuest Dissertations Publishing].

Song, S. J., Kaplan, C., Tol, W. A., Subica, A., & de Jong, J. (2015). Psychological distress in torture survivors: pre- and post-migration risk factors in a US sample. *Soc Psychiatry Psychiatr Epidemiol*, *50*(4), 549-560. https://doi.org/10.1007/s00127-014-0982-1

Southhall, A. W. (1970). The illusion of tribe. In *Passing of Tribal Man in Africa* (pp. 28-50). Brill.

Stearns, J. (2012). *Dancing in the Glory of Mosters: The Collapse of the Congo and the Great War of Africa*. PublicAffairs.

Steel, J. L., Dunlavy, A. C., Harding, C. E., & Theorell, T. (2017). The Psychological Consequences of Pre-Emigration Trauma and Post-Migration Stress in Refugees and Immigrants from Africa. *J Immigr Minor Health*, *19*(3), 523-532. https://doi.org/10.1007/s10903-016-0478-z

Steiner, B., Benner, M. T., Sondorp, E., Schmitz, K. P., Mesmer, U., & Rosenberger, S. (2009). Sexual violence in the protracted conflict of DRC programming for rape survivors in South Kivu. *Confl Health*, *3*, 3. https://doi.org/10.1186/1752-1505-3-3

Syvertsen, J. L., Bazzi, A. R., & Mittal, M. L. (2017). Hope Amidst Horror: Documenting the Effects of the "War On Drugs" Among Female Sex Workers and Their Intimate Partners in Tijuana, Mexico. *Med Anthropol*, *36*(6), 566-583. https://doi.org/10.1080/01459740.2017.1317770

Tempany, M. (2009). What research tells us about the mental health and psychosocial wellbeing of Sudanese refugees: a literature review. *Transcult Psychiatry*, *46*(2), 300-315. https://doi.org/10.1177/1363461509105820

Thomson, M. J. (2012). Black Boxes of Bureaucracy: Transparency and Opacity in the Resettlement Process of Congolese Refugees. *PoLAR: Political and Legal Anthropology Review*, *35*(2), 186-205. https://doi.org/10.1111/j.1555-2934.2012.01198.x

Turrini, G., Purgato, M., Ballette, F., Nose, M., Ostuzzi, G., & Barbui, C. (2017). Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies. *Int J Ment Health Syst*, *11*, 51. https://doi.org/10.1186/s13033-017-0156-0

UNHCR, T. U. R. A. (2023). *Information on UNHCR Resettlement*. https://www.unhcr.org/us/information-unhcr-resettlement

Vail, L. (1991). *The Creation of Tribalism in Southern Africa* (Vol. 43). University of California Press.

Ventevogel, P., Jordans, M. J. D., Reis, R., & de Jong, J. (2013). Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. *Conflict and Health*, *7*(3), 1-16.

Verelst, A., De Schryver, M., De Haene, L., Broekaert, E., & Derluyn, I. (2014). The mediating role of stigmatization in the mental health of adolescent victims of sexual violence in Eastern Congo. *Child Abuse Negl*, *38*(7), 1139-1146. https://doi.org/10.1016/j.chiabu.2014.04.003

Vinck, P., & Pham, P. N. (2010). Association of Exposure to Violence and Potential Traumatic Events With Self-reported Physical and Mental Health Status in the Central African Republic. *JAMA*, *304*, 544-552. https://jamanetwork.com/journals/jama/article-abstract/186341

Wachter, K., Murray, S. M., Hall, B. J., Annan, J., Bolton, P., & Bass, J. (2018). Stigma modifies the association between social support and mental health among sexual violence survivors in the Democratic Republic of Congo: implications for practice. *Anxiety Stress Coping*, *31*(4), 459-474. https://doi.org/10.1080/10615806.2018.1460662

Way, U. (2019). *Alice Report, Florida Suncoast Region*. https://unitedwaysuncoast.org/what-we-do/alice-suncoast-2019/

Westermeyer, J. (2011). *Anthropology and Mental Health: Setting a New Course*.

Whitley, R. (2014). Beyond critique: rethinking roles for the anthropology of mental health. *Cult Med Psychiatry*, *38*(3), 499-511. https://doi.org/10.1007/s11013-014-9382-y

WHO. (2021). The Mental Health Atlas 2020. In (pp. 135).

Willen, S. S., Knipper, M., Abadía-Barrero, C. E., & Davidovitch, N. (2017). Syndemics 3-Syndemic vulnerability and the right to health. *Lancet*, *389*, 964-977.

Willen, S. S., Williamson, A. F., Walsh, C. C., Hyman, M., & Tootle, W. (2022). Rethinking flourishing: Critical insights and qualitative perspectives from the U.S. Midwest. *SSM Ment Health*, *2*, 100057. https://doi.org/10.1016/j.ssmmh.2021.100057

Women, U. (2023). *Gender-Based Violence: Women and girls at risk*. UN Women. https://www.unwomen.org/en/hq-complex-page/covid-19-rebuilding-for-resilience/gender-based-violence?gclid=EAIaIQobChMIxfi2poSM_wIVmiyzAB0RLgwNEAAYASAAEgISVfD_BwE

Woolington, R., & Murray, E. (2022). Dozens of workers file suit against Tampa lead factory: Sixty-four workers allege they were exposed to dangerous levels of lead and other toxic chemicals at Gopher Resource. *Tampa Bay Times*. https://www.tampabay.com/investigations/2022/11/04/dozens-workers-file-suit-against-tampa-lead-factory/

Wright, A. M., Dhalimi, A., Lumley, M. A., Jamil, H., Pole, N., Arnetz, J. E., & Arnetz, B. B. (2016). Unemployment in Iraqi refugees: The interaction of pre and post-displacement trauma. *Scand J Psychol*, *57*(6), 564-570. https://doi.org/10.1111/sjop.12320

Yu, M., Reyes, L., Malik, S., Khetarpal, R. M., & Steiner, J. J. (2021). Reciprocity among forced migrants: refugees and asylees as agents of facilitating integration and community-building for self and others in the United States. *Journal of Ethnic and Migration Studies*, *49*(7), 1648-1666. https://doi.org/10.1080/1369183x.2021.1953377

Zezima, K. M., Paul, D., Rich, S., Tate, J., & Jenkins, J. (2018). *Domestic Slayings: Brutal and foreseeable* (Murder with Impunity, Issue. https://www.washingtonpost.com/graphics/2018/investigations/domestic-violence-murders/

APPENDICES

Appendix A: IRB Approval

UNIVERSITY of SOUTH FLORIDA

APPROVAL

July 22, 2022

Caitlin Ruszczyk
[redacted]

Dear Caitlin Ruszczyk:

On 7/22/2022, the IRB reviewed and approved the following protocol:

Application Type:	Initial Study
IRB ID:	STUDY004449
Review Type:	Expedited 6 and 7
Title:	Participatory Capacity Building and Community Development among Central African Refugees
Funding:	USF Internal Awards Programs
IND, IDE, or HDE:	None
Approved Protocol and Consent(s)/Assent(s):	• Protocol- Ruszczyk- Clean; • Ruszczyk- Verbal Consent for Phase ONE; • Ruszczyk- Verbal consent for Phase TWO; Approved study documents can be found under the 'Documents' tab in the main study workspace. Use the stamped consent found under the 'Last Finalized' column under the 'Documents' tab.

Within 30 days of the anniversary date of study approval, confirm your research is ongoing by clicking Confirm Ongoing Research in BullsIRB, or if your research is complete, submit a study closure request in BullsIRB by clicking Create Modification/CR.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

Andi Encinas
IRB Manager

Institutional Review Boards / Research Integrity & Compliance
FWA No. 00001669
University of South Florida / 3702 Spectrum Blvd., Suite 165 / Tampa, FL 33612 / 813-974-5638