EXPLORING THE LIVED EXPERIENCES OF RWANDAN REFUGEES RESETTLED IN THE USA: A DESCRIPTIVE PHENOMENOLOGY STUDY

By

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Dedication

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Abstract

EXPLORING THE LIVED EXPERIENCES OF RWANDAN REFUGEES RESETTLED IN DALLAS FORT WORTH: A DESCRIPTIVE PHENOMENOLOGY STUDY

Betty Tonui, MSW

The purpose of this qualitative phenomenological study was to explore the lived experiences associated with (genocide, migration, resettlement) and socio/cultural factors that influenced Rwandan refugees' mental health in the United States (U.S.). In 2018, there were more than 25 million refugees displaced around the world, and more than 50,000 refugees were admitted to the United States in 2017 (UNHCR, 2019). Studies have shown that refugees are more likely to develop post-traumatic stress disorder (PTSD), depression, and anxiety than the general population (Bogic et al., 2015; Goodkind et al., 2017). Despite the prevalence of mental health concerns amongst refugees, minimal information is known about the experiences of genocide, migration, resettlement, and socio/cultural factors of Rwandan refugees resettled in the U.S. To capture these experiences, the study utilized the ecological systems theory to lend insight into how the mental experiences of Rwandan refugees are influenced by events that occurred during the Rwandan genocide (pre-migration) and resettlement. In doing so, the study utilized a descriptive phenomenological study to understand Rwandan refugees' experiences. This study used purposive snowball sampling to recruit thirteen individuals who self-identified as Rwandan refugees. Data were obtained through in-depth interviews and were analyzed using Colaizzi's (1978) five steps of descriptive phenomenological analysis. Four major themes and one sub-theme emerged from in-depth interviews. The identified themes and subthemes were as follows: 1) *Traumatic Experiences of Rwandan refugees:* 1a) *Effects of Trauma* 2) *Resettlement*

Experiences of Rwandan refugees in the U.S. 3) *Barriers to Mental Help-Seeking Among Rwandan Refugees in the U.S.* and 4) *Rwandan Refugee Coping and Help-Seeking Behaviors Differ in the U.S.* These findings extend the literature on how untreated traumas may be exacerbated by socio-cultural aspects or migration to produce lasting negative effects on survivors and refugees. Collectively, the challenges that Rwandan refugees face cannot be resolved by one-size-fits-all or a silver bullet but rather calls for the development and implementation of multi-level and multi-component culturally attuned interventions.

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Chapter One:

Introduction

In 2017, more than 50,000 refugees were admitted into the United States, some of whom were from Rwanda, Somalia, Ethiopia, and the Democratic Republic of the Congo (UHNCR, 2019). Other than the US, Rwandan refugees escaped to other countries following the Rwandan genocide of 1994. The genocide contributed to numerous social mayhem, destruction of property, looting, sexual violence, and brutal murders (Mutabaruka., 2012; Neugebauer et al., 2014). The associated post-traumatic stress disorder (PTSD), depression, and anxiety were exceedingly horrendous (Munyandamutsa et al., 2012; Neugebauer et al., 2009; Schaal & Elbert, 2006). By having a better understanding of experiences associated with genocide, migration, and mental health concerns are essential for researchers to gain a better understanding of the effects of violence, traumatization, and their cumulative impact on refugee resettlement (Banyanga et al., 2017). The research suggested that refugee post-migration experience challenges contribute to psychological concerns such as cultural and linguistic challenges, economic and social challenges, stigma and social isolation and difficulty adapting to different social roles (Espinoza, 2016; Yako, & Biswas, 2013: Li et al., 2016; Tingog et al., 2017: Bogic et al., 2015; Fazel et al., 2005; Fisher, 2013 and Turrini et al., 2017). Given the excess of stressors, mental health interventions for refugees are designed to target trauma experienced during the conflict, socio-cultural challenges specific to their new homeland, and daily stressors associated with resettlement (Bogic et al., 2015). The study aimed to discover the lived experiences (associated with genocide, migration, and resettlement) and socio/cultural factors that impact Rwandan refugee mental health and well-being.

Brief Rwandan History

The Rwandan genocide, it is argued, began when the colonial German (and later, Belgian) administrators allowed the Tutsis more political, educational, and economic privileges than the Hutu (Porter et al., 2006). The preferential treatment for Tutsis disfavored the Hutu, who were considered inferior and expected to perform hard labor jobs. In the 1950s, the Belgian political powers changed their allegiance from the ruling Tutsi minority to the Hutu majority, leading to ethnic tensions that culminated in the Hutu revolt of 1959 (Des Forges, 1999; Porter et al., 2006). Between 1960 and before Rwanda gained its independence in 1962, 10,000 Tutsis were murdered, and about 120,000 fled to the neighboring countries as refugees (Porter et al., 2006). Rwanda was then ruled by the Hutu political parties, but the Tutsis were marginalized and excluded from political power (Porter et al., 2006). Even so, power-sharing was initiated before the 1994 Rwandan genocide.

The 1994 genocide began on April 6, the night Juvenal Habyarimana—President of Rwanda, who was Hutu, was returning from Tanzania after attending meetings in Arusha (Des Forges, 1999). The purpose of these meetings was to structure and implement a shared governmental power between the Hutu and the Tutsi (Des Forges, 1999). As the Rwandan President prepared to land in Rwanda's capital city Kigali, the plane was shot down, killing both the Rwandan and the Burundian presidents and other military personnel (Des Forges, 1999; Hagengimana et al., 2003; Prunier, 1995). The Rwandan government blamed the Rwandan Patriotic Front (the ruling political party) and the Tutsi for killing their president (Prunier, 1995). In retaliation for President Habyarimana's death, the Hutu erected roadblocks in Kigali and initiated the mass slaughter of the Tutsis, opposing politicians, and moderate Hutus (i.e., Hutus who supported the Tutsi rebel groups) according to prepared death lists (Porter et al., 2006). The president's assassination provoked a campaign of genocide against the Tutsis and moderate

Hutus in which as many as one million people, or 11% of the country's total population, were murdered within 100 days (Des Forges, 1999; Hagengimana et al., 2003; Prunier, 1995). The genocide victims would include more than 84% of Rwanda's Tutsi population (Cohen, 2007; Porter et al., 2006).

Other atrocities during this time included the rape of more than 250,000 women and children by militia members, resulting in more than 70% of them becoming infected with human immunodeficiency virus (HIV; Cohen, 2007; Gourevitch, 1998; Human Rights Watch, 1996; Mullins, 2009; Zraly et al., 2011). The war led to four million internally displaced people (IDPs) and an additional 2.3 million people who fled the country and became refugees in other countries. The cumulative effect of the war, including the mass murders, contributed to a reduction in Rwanda's population by 50% (Cohen, 2007; Dyregrov et al., 2000; Hagengimana et al., 2003). In addition to the killings, millions of Rwandans. Many were tortured, branded with heated metal, sexually mutilated, hacked with machetes, orphaned, forced to witness or participate in the murder of family members, or killed by subsequent outbreaks of diseases such as cholera (Cohen, 2007; Neugebauer et al., 2009; Pham et al., 2004; Schaal et al., 2012; Schaal & Elbert, 2006).

During the genocide, Rwandans were impacted by the devastation of their schools, businesses, and churches (Eftekhari, 2004; Schaal et al., 2012). Rwanda's infrastructure was left in shambles, and its political and economic systems were in disarray. Healthcare facilities were demolished, and services were stopped (Rugema, 2016). Healthcare services were disrupted by the murder or flight of providers (Logie et al., 2008). During the four months after the genocide, when the Tutsi-led RPF had regained control of the country, an estimated two million Hutus fled Rwanda to take refuge in Burundi, Tanzania, Uganda, and Zaire (now known as the Democratic Republic of Congo), due to fear of retaliation. Soon after the RPF took power, the United

Nations (UN) troops and international organizations helped to restore order and basic services (United Nations, 1996).

Despite international assistance, physical and mental health needs were not met based on the acute shortage of medical professionals, facilities, and services (Binagwaho et al., 2013). Additionally, Rwanda faced political instability and a crippled economy, resulting in high unemployment rates and financial difficulty in meeting their basic needs (Richmond & Galgano, 2019; Mbanjumucyo et al.,2015). Two and a half decades after the genocide, Rwanda recovered economically and improved its infrastructure; however, the genocide left Rwandans with mental health concerns that are well-documented in the literature (Mahr & Campbell, 2016). After the genocide, these same mental health issues affected the Rwandans who resettled in the United States (Goodkind et al., 2014).

Definition of Terms

Genocide. United Nations' Office of the High Commissioner of Humans Rights ([OHCHR], 2018, para. 10), genocide is described as "acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, such as (a) Killing members of the group; (b) Causing serious bodily or mental harm to members of the group; (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part; (d) Imposing measures intended to prevent births within the group; (e) Forcibly transferring children of the group to another group."

Mental health. The World Health Organization (WHO), mental health is defined as "a state of well-being in which every individual realizes his or her potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community" (2014, para. 1).

Refugee. A refugee, as defined by the UNHCR, is a person who is forcibly displaced outside their native country, who demonstrates that he or she has been persecuted or has a reason to fear persecution on the grounds of religion, race, political opinion, nationality, and membership in a particular social group, or who experiences hardships such as famine, violence, and genocide (UNHCR, 2018c).

Resettlement "the transfer of refugees from an asylum country to another State that has agreed to admit them and ultimately grants them permanent settlement" (UNHCR, 2019, para. 2).

Trauma. A deeply disturbing experience that elicits an emotional response (American Psychiatric Association [APA], 2018). Typically, shock and denial are two common outcomes of trauma. Additionally, the list of long-term effects may also encompass unpredictable emotions, flashbacks of traumatic events, stressful relationships, and even physical symptoms, such as headaches or nausea (APA, 2018).

Well-being. A general state of happiness (APA, 2019). This includes generally low levels of stress in an individual's life (APA, 2019). According to the American Psychiatric Association (2019), well-being ideally includes a life that is free from trauma, pain, or stress.

Problem Statement

By 2018, there were 68.5 million forcibly displaced individuals throughout the world, of which 25.4 million were refugees, 40 million were internally displaced, and 3.1 million were asylum seekers (United States Department of State, 2018). Genocide contributed to human displacement and associated consequences. Researchers reported that these numbers would continue to rise, requiring successful resettlement of refugees in new host countries (Dunn, 2016; Esses et al., 2017; Simich et al., 2003) and the United States has the largest and oldest refugee resettling history around the globe (UNHCR, 2019).

Successful resettlement partially depends on the mental health status of refugees (Esses et al., 2017; Ibrahim & Hassan, 2017; King et al., 2017). The general problem is that refugees are ten times more likely to develop PTSD and four to five times more likely to develop depression and anxiety than the general population (Turrini et al., 2017; Morina et al., 2017). People who face wars and atrocities experience tremendous health and psychological problems. The poor mental health of refugees is associated with other factors that influence refugees' ability to thrive, such as gaining employment or housing, learning a new language and culture, and navigating foreign healthcare services (Cengiz et al., 2019; Ibrahim & Hassan, 2017; Kim & Kim, 2014; Kim, 2016). The experience of trauma does not resolve when refugees leave their conflict-ridden home; the immigration process and adapting to new social, environmental, and cultural contexts of life can itself be challenging and stressful (Aoun et al., 2018; Bogic et al., 2015; King et al., 2017). This is factual in scenarios where the receiving country does not have a supportive infrastructure to handle the incoming refugee population. Because of the variations in the socio-economic environment where refugees resettle, their resettlement process will equally differ (Aoun et al., 2018; Ibrahim & Hassan, 2017; Mahr & Campbell, 2016).

Refugees have experienced extremely stressful events related to their refugee status. Because of political or cultural oppression and war migration and resettlement, refugees, suffer tremendous trauma. For example, Rwandan refugees are resettled in the U.S. following the Rwandan genocide. Even though the 1994 Rwandan genocide happened two and a half decades ago, longitudinal studies have documented that individuals exposed to trauma such as the genocide frequently report PTSD symptoms, which may emerge soon after the exposure while others may experience chronic PTSD symptoms (Shalev, 2009). In this case, the 1994 Rwandan genocide survivors may re-experience traumatic memories of the war during their resettlement. Studies that have examined the long-term mental health consequences of the 1994 Rwandan

genocide suggest that survivors continued to report PSTD symptoms two decades later (Eytan et al., 2015; Munyandamutsa et al., 2012). The most-reported symptoms include the following: flashback memories, avoidance, anger, persistent crying, and fear, which is often exacerbated by different events in one's life, such as migration (Banyanga et al., 2017). As earlier mentioned, sexual abuse during the genocide was used as a weapon inflicted on women leaving a lasting psychological effect both for the victims and the perpetrators (African Rights, 2004). Genocide rape survivors have reported carrying a permanent mark of their experiences on their minds (Banyanga et al., 2017).

Furthermore, evidence suggested that children born as a result of rape suffer from depression, anxiety, and social stigma (Banyanga et al., 2017). Further, evidence also indicates that exposure to trauma can be intergenerational meaning it can be transmitted from one generation to other (Betancourt et al., 2015; Neuner et al., 2004) and migration has been cited worsen mental health especially for refugee (Betancourt et al., 2015). It is imperative to explore the experiences of Rwandan refugees given that this population has endured myriads of challenges and their experiences are not well understood during resettlement and to the researcher's knowledge, no evidence describes their experiences following their resettlement in the U.S. The purpose of the current study was to gain an understanding of the lived experiences (associated with genocide, migration, and resettlement) and socio/cultural factors that impact their mental health and well-being. By understanding this phenomenon, it may assist in informing health care providers on resettlement policies on more effective integration and healing practices for this vulnerable population.

Importance to Social Work

Social workers strive to be culturally competent in delivering services to individuals from other cultures. Cultural competence is the provision of pertinent, effective, and culturally

responsive services to individuals of diverse backgrounds (Weaver, 1999). This competence can assist in bridging the gap between minority group disparities in healthcare settings, for example, and improve healthcare quality, patient contentment with care, and health outcomes (Shen, 2015). Cultural competence necessitates acting respectfully and effectively to address the needs of diverse populations, recognizing their worth and their uniqueness, and becoming aware of the cultural values of other groups (National Association of Social Workers [NASW], 2008). Understanding clients' cultures tend to enhance the practice and outcomes of social work; for this reason, participating in diverse practices and developing culturally competent practices and services is considered an integral part of social work (NASW, 2008).

Cultural competence in social work requires a combination of knowledge, skills, and values (Weaver, 1999). By having knowledge and skills to provide culturally competent care has been argued to be a challenge for practitioners, it is not conceptualized for practitioners (Kleinman & Benson, 2006). Tervalon and Murray-Gracia (1998) alluded that there is growing evidence of diverse groups represented in the U.S. can increase compromise in the socio/cultural inconsistencies among health care professionals and clients. Such disparities often emerge through health care provider's lack of understanding regarding their clients' health beliefs (Kleinman & Benson (2006) as well as racism, social class, age, and fear that impede effective care (Tervalon & Murray-Gracia (1998). To improve cultural competency in practice, Ortega and Coulborn Faller (2011) suggest having a sense of cultural humility an ability to acknowledge that one cannot fully be knowledgeable and competent in one's culture. Being culturally modest means creating an awareness of personal biases and engaging in a continuous reflection of those biases and perceptions about others (Tervalon & Murray-Gracia,1998). For example, a culturally humble practitioner views clients as experts in their own cultures and experiences. It is with this approach that social workers can access clients humbly and minimize service provision barriers.

As such, social workers to provide culturally competent care for this vulnerable population, having knowledge on genocide, migration, resettlement, and socio/cultural factors that influence mental health and well-being of Rwandan refugees in the U.S. is important, however, working from a cultural humility perspective would be beneficial to this population.

Summary

Refugees have experienced extensive stressors from the turmoil in their homeland, and often, their mental health symptoms are exacerbated during resettlement because the process brings added stress (Li et al., 2016). The mental health of refugees remains important after resettlement because concerns are related to other factors that influence refugees' ability to thrive such as gaining employment or housing, learning the new language and culture, and navigating healthcare services (Cengiz et al., 2019; Ibrahim & Hassan, 2017; King et al., 2017). Because the risk and protective factors related to trauma differ according to socio-cultural contexts within the host country, emerging research suggests exploring stress-inducing socio-cultural differences between refugees' place of origin and host country to improve the resettlement process and support long-term acculturation (Aoun et al., 2018; Ibrahim & Hassan, 2017; Mahr & Campbell, 2016)There is no known research, to date, that has explored the mental health challenges faced by Rwandan refugee who settled in the U.S. The purpose of this qualitative descriptive phenomenological study was to explore the lived experiences associated with (genocide, migration, and resettlement), and socio/cultural factors influence Rwandan refugees' mental health.

Chapter Two:

Literature Review

In recent years, more than 50,000 refugees were admitted into the United States, some of whom were from Rwanda (UHNCR, 2019). Many Rwandans sought refuge in other countries following the Rwandan genocide in 1994, and some made their way to eventual resettlement in the U.S. Experiencing or witnessing the destruction of property, looting, sexual violence against men, women, and children, and murder that occurred during the genocide caused psychological distress in a majority of Rwandan people (Joseph, 2018; Ng & Harerimana, 2016). For example, several studies found PTSD, depression, and anxiety as some of the mental health concerns resulting from the genocide (Joseph, 2018; Munyandamutsa et al., 2012; Ng & Harerimana, 2016; Rieder & Elbert, 2013; Roth et al., 2014). Understanding mental health concerns are important because, for refugees who have experienced mass violence, traumatization is often an enduring, cumulative process that continues during resettlement (Banyanga et al., 2017). Research indicated that refugees experience post-migration challenges that exacerbate psychological concerns including cultural and linguistic challenges (Espinoza, 2016; Yako & Biswas, 2013), economic challenges (Li et al., 2016), the stigma of mental health and social isolation (Espinoza, 2016; Tingog et al., 2017), and difficulty adapting to different social roles (Bogic et al., 2015; Fazel et al., 2005; Fisher, 2013; Turrini et al., 2017).

Chapter 2 will synthesize relevant literature and introduce ecological systems theory, which is the theoretical framework that informed the research questions. Relevant literature was organized in categories, progressing from the Rwandan genocide towards its relationship with mental health, refugee status, resettlement, and mental health barriers and interventions. The conclusion of this chapter describes the gap in the literature and how the current study will attempt to address it.

History of the 1994 Rwandan Genocide

Rwanda is in central east Africa in the African Great Lake Region (the Republic of Rwanda, 2015). This region consists of the following nine African countries: Angola, the Central African Republic, Burundi, the Democratic Republic of the Congo (DRC), Kenya, Rwanda, Sudan, Tanzania, Uganda, and Zambia (African Center for the Constructive Resolution of Disputes [ACCORD], 2016). Rwanda is bordered by the DRC to the west, Tanzania to the east, Uganda to the north, and Burundi to the south (the Republic of Rwanda, 2015). Rwanda was colonized by Belgium and had three ethnic identities prior to the genocide: the Hutu (84%), Tutsi (15%), and Twa (1%) (Des Forges, 1999; the Republic of Rwanda, 2015).

On April 6, 1994, an airplane carrying the Rwandan President was shot down near the Rwandan capital city of Kigali while returning from peace negotiation for the Rwandan Patriotic Front (RPF), a Tutsi-led political party to included power (Human Rights Watch, 2003). The death of Rwanda's President was used as the initiation of massive killings. In point of fact, within just 36 hours of the President's assassination, violent attacks began (Eftekhari, 2004). Initiated by Hutu nationalists, military forces armed local young men and carried out the initial wave of violence in the capital, Kigali, then eventually spread throughout the surrounding rural communities. Systematic killings took place from house to house, focusing first on eliminating Tutsis (Des Forges, 1999) and the Hutu people who shared the physical features of Tutsis (Prunier, 1995). By mid-July 1994, the RPF finally gained control and, in doing so, killed thousands of Hutus (Eftekhari, 2004). Consequently, 2,000,000 Rwandans, one-quarter of the total population, most of whom were Hutu, fled the country due to fear of reprisal from the RPF (Eftekhari, 2004). The mass slaughters lasted for 100 days before the genocide was ended by the RPF (Human Rights Watch, 2003).

Psychological Effects of the 1994 Rwandan Genocide

In the aftermath of the genocide, Rwanda encountered the long, arduous process of rebuilding the country and attending to the Rwandan people, as many of the survivors had experienced major physical, emotional, and psychological effects from the genocide. Recognizing the influence that this event had on the Rwandan people is important to understand the state of mental health and healing within the Rwandan population. The following sections synthesize the literature related to the psychological effects of the Rwandan genocide.

Post-traumatic stress disorder. The 1994 Rwandan genocide left Rwandans to face multiple mental health concerns, with PTSD being one of the most reported mental health issues in the literature (Fodor et al., 2015; Munyandamutsa et al., 2012; Neugebauer et al., 2014; Schaal et al., 2014). Evidence suggested that the psychological consequences of genocide are profound and last a lifetime (Schaal et al., 2012). However, such effects of trauma may vary depending on one's length of exposure to the violence (Dyregroy et al., 2000). Furthermore, the influence of genocide disrupts basic psychological needs. For example, genocide survivors' way of viewing the world, sense of identity, and spiritual lifestyles are vulnerable to negative influence based on traumatic experiences. These experiences can influence a person's ability to regulate their emotions, and eventually, give rise to profound trauma symptoms (Staub et al., 2005). The myriad of complications relating to the Rwandan genocide provides validity to the pressing question as to how the mental health needs of this population can be met, almost a quarter of a century after the event has occurred.

Several studies have been conducted to examine the post-genocide psychological status of Rwandans. For example, one study among 3,000 children reported that 80% had experienced the death of a loved one, 70% saw killings, 35% witnessed other children's murders, 61% were threatened with being killed, and 90% thought they would die (Human Rights Watch, 2003).

Additionally, research conducted among Rwanda children and adolescents' post-genocide established that over 75% of children met the criteria for PTSD (Neugebauer et al., 2009; Dyregov et al., 2000).

Furthermore, ten years after the Rwandan genocide, Schaal and Elbert (2006) conducted a qualitative study among 68 orphaned survivors in Rwanda. Every child who participated in the study had been exposed to genocidal violence. Forty-one percent of the total sample had directly witnessed the murder of their parents. Additionally, using the diagnostic criteria of *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV), the authors observed a prevalence of PTSD among Rwandan children and found an estimated 44% of the Rwandan children in the study had a PTSD diagnosis (Schaal & Elbert, 2006). In adults, 73% reported to have had relatives murdered during the 1994 genocide, and roughly 25% met the criteria for PTSD (Pham et al., 2004).

Hagengimana et al.'s (2003) study conducted in Rwanda in 2002 involved 100 Rwandan widows who had lost their husbands during the genocide and were not receiving mental health services. Using four different scales to determine the rates of anxiety attacks and symptoms of PTSD, the authors reported that 87% of those who had anxiety attacks at some point suffered from panic disorder, raising the rate of panic disorder for the entire sample to 35%. Furthermore, 40% of women continue to suffer from anxiety attacks (Hagengimana et al., 2003). Finally, to assess the level of trauma exposure and prevalence of PTSD, a multi-stage stratified cluster sampling method was used among 2,091 adults in Rwanda in 2002 who met study criteria. Using the PTSD Checklist-Civilian Version, the researchers found that 28% of the participants had PTSD symptoms, and the prevalence of PTSD was higher for women compared to men (Pham et al., 2004).

One study used a national representative sample to determine the prevalence of PTSD and major depressive episodes among the Rwandans (Munyadamusta et al., 2012). This study used a sample size estimation method before the study to administer a mini-international neuropsychiatric interview and medical outcome study (36 item short-form), which was translated into Kinyarwanda among 1,000 participants (Munyadamusta et al., 2012). Participants were predominantly female (58.9%) and between the age of 16 to 34 years. The survey indicated that 26.1% of the sample reported they met the diagnostic criteria of PTSD, while 22.7% reported major depression (Munyadamusta et al., 2012). One important factor is that not all diagnoses in this study were directly related to the Rwandan genocide because some participants were not born until after the event.

A community-based study was conducted in southern Rwanda among the genocide survivors (n=90), former prisoners accused of participating in the genocide (n=83), and their children to examine the level of trauma exposure, psychopathology, and risk factors for PTSD. It was reported that survivors predominantly witnessed violence during the genocide, while former prisoners were subjected to physical attacks. The findings of this study revealed that parents had lower rates of PTSD compared to their children (16% to 25%, respectively), suggesting the long-term psychological effects of the Rwandan genocide are evident within generations, albeit at different rates (Rieder & Elbert, 2013).

Depression. Depression is a common mental health concern that has been well-documented among the Rwandan population (Bolton et al., 2002). Research indicates that when a community experiences trauma, it often infiltrates many aspects of society, and sometimes the children of trauma-sufferers may display mental health symptoms (Rieder & Elbert, 2013).

Five years after the Rwandan genocide, Bolton et al. (2002) conducted a quantitative community-based survey with a random sample of 368 adults in rural Rwanda to assess the

mental health of the survivors. The findings of this study revealed that the prevalence of depression was 16%, which was associated with functional impairment among participants. In another study conducted in Rwanda, this study examined the rates and risks of Prolonged Grief Disorder (PGD) among orphaned and widowed survivors 12 years after the genocide found that participants displaying symptoms such as feeling numb, shocked, astonished, and yearning for their deceased loved ones. Prolonged grief disorder was associated with depression and other mental health concerns (Schaal et al., 2012). Furthermore, there is evidence suggesting the comorbidity of PTSD and major depressive episodes (MDE; Eytan et al., 2015).

With a similar goal as Eytan et al. (2015), Brouneus (2010) conducted a study 14 years after the Rwandan genocide to examine long-term effects on mental health in 962 participants. The author reported that PTSD and depression co-occurred among 51% of the participants (Brouneus, 2010). Another study investigated the levels of trauma and the rates of mental health among the Rwandan widows (n=194) and orphans (n=206). It used the Depression Hopkins Symptoms Checklist to assess depression and other mental health issues. The results of the study suggested that widows in the study had severe mental health problems compared to orphans, and a substantial number of widows suffered from depression (48% versus 34% orphans; Schaal et al., 2011).

Additional evidence suggests that many Rwandan people have an increased prevalence of mental health problems due to their genocide exposure (de Jong et al., 2000; Rugema et al., 2015). Furthermore, experiencing sexual violence (as many people did) has been associated with an increased prevalence of mental health concerns. Research results estimated that rape survivors have higher rates of HIV infection and mental health concerns compared to the rest of the Rwandan population (African Rights, 2004; Hagengimana et al., 2003; Neugebauer et al., 2009; Zraly et., 2011). An estimated 250,000 Rwandan women were raped during the genocide,

infecting many with HIV/AIDS, and resulting in the birth of approximately 20,000 babies (Palmer & Firmin, 2011).

Rwandan Displacement

The Rwandan genocide caused a crisis of human displacement. An estimated two million people were refugees in countries neighboring Rwanda by late August 1994 (United Nations, 1996). Approximately 1.2 million people fled into the Democratic Republic of Congo (DRC), 580,000 to Tanzania, 270,000 to Burundi, 10,000 to Uganda, and some 1.5 million people were internally displaced (United Nations, 1996). It is not unusual for refugees to resettle in refugee camps prior to resettlement in a host country. The living conditions within the refugee camps, however, are often crowded, deplorable, and insecure (Wright & Moorthy, 2018). The refugees experienced difficult conditions in their first asylum refugee camps. Many people were faced with unhealthy and unsafe environments, chaos, the lack of water supply. Women were exposed to gender-based violence because women travel far to find water and inadequate humanitarian assistance, which could result in refugees spending years in refugee camps waiting for resettlement (Cultural Orientation Resource Center, 2014). According to Dryden-Peterson (2015), refugee children experienced limited access to schools and frequent disruptions. Language barriers within the school settings and low quality of education compound this, making it almost impossible for the refugee children to catch up with their counterparts in terms of their education. On-going migration, discriminatory laws, and spending time trying to learn a new language of instruction all contribute towards the late or no entry of refugee children in schools (Themner & Wallensteen, 2013).

Migration to the U.S.

Prior to migrating to the United States, refugees may have experienced traumatic conditions, such as war, rape, murder, and other forms of violence, in addition to spending long

periods in refugee camps, which may have lasted for years depending on the availability of humanitarian help (Ramsden & Taket, 2013). Resettlement is a process organized by the UNHCR, an agency established in 1950 by the United Nations General Assembly to protect the rights and well-being of refugees and displaced persons worldwide ([UNHCR, 2018a). The UNHCR protects refugees who cannot return to their home countries because their fundamental human rights are at risk. The process usually begins when refugees were transferred from their country to another country that agreed to give them permanent resident status (UNHCR, 2018a). The process of resettlement begins in refugee camps where refugees are housed prior to migrating to their destined host country (UNHCR, 2018a).

When refugees migrate to their host culture, they face potentially unique challenges such as adapting to a new language, constructing an identity in a new social context, and securing a new home. In the United States, refugees are resettled in over 190 communities across 50 states. The United States has a long and rich tradition of welcoming immigrants and refugees for resettlement. Since the 1990s, the United States has resettled refugees from the African Great Lakes Region (Boise et al., 2013). In 2018, 22,491 refugees were resettled in the United States, with Texas relocating the highest number of refugees of all states. These refugees were from various regions, including Africa, with the most significant number in 2018 from the Democratic Republic of Congo (DRC) (UNHCR, 2019). Of the 22,491 refugees resettled, DRC accounted for 7,878, followed by Burma and Ukraine (UNHCR, 2019). In 2017, the United States resettled 53,716 refugees, 104 of whom were from Rwanda, with the largest percentage being from the Democratic Republic of Congo, which accounted for 17.5% (Refugee Processing Center, 2018). It is worth acknowledging that most refugees who were considered for resettlement from the DRC were ethnically diverse. These individuals have different backgrounds, including those

with a history of persecution, such as the Hutu and the Tutsi (Cultural Orientation Resource Center, 2014). Whatever their ethnic identity, this process is never easy for refugees.

Resettlement Experiences for Rwandan Refugees

The United States resettlement programs have helped resettle thousands of refugees from various countries over the years. However, these programs have not been without their difficulties, including structural barriers such as language barriers, economic challenges, and socio-cultural barriers consisting of social isolation and differing social roles of refugees, and health challenges. The following sections summarize the literature related to the analysis and study of these various challenges.

Language barriers. When a refugee is resettled within the United States, the state provides them with temporary service assistance. However, service is available for the first eight months, after which the refugees are expected to become independent and self-sufficient. In a study on the outcomes of the United States refugee program, Capps et al. (2015) posited the main challenge to the success of the resettlement program is most refugees arrive with deficient levels of education and knowledge of the English language. As a result, the eight months provided to them is barely enough to get them on par with the English and educational skills needed to acquire meaningful employment. A lack of English proficiency, therefore, impedes the refugee's ability to obtain employment (Kiselev et al., 2020; Yako & Biswas, 2013), communicate with healthcare providers (Habeeb-Silva, 2016; Kiselev et al., 2020; Kohlenberger et al., 2019), and integrate socially (Coughlan et al., 2016; Kiselev et al., 2020). The lack of proficiency in English hinders acculturation, as the individuals are unable to communicate with other individuals or pursue opportunities such as employment that would have improved the acculturation process (Kohlenberger et al., 2019; Lee et al., 2015). Many Rwandans are not English speakers, as their

native language is Kinyarwanda, followed in prevalence by French and Kiswahili (the Republic of Rwanda, 2015).

Economic challenges. Most refugees were forced to wait months before they approved for resettlement in the United States. Warfa et al. (2012) stated that most refugees depleted their resources and savings during this waiting period, arriving in the United States in a financial crisis. Factors, such as financial security, are associated with the mental health of a resettled person. Many refugees may experience financial strains in their host countries, and finding appropriate employment may be difficult (Li et al., 2016). For example, the refugee's poverty situation is made worse by the difficulties experienced in obtaining employment. Among those that do, it is often impossible to get the same career level one had in their country of origin (Nsonwu et al., 2013). As a result, most of the employees end up being unemployed or underemployed, a situation that continually places a burden on their already troubled financial positions. The security of employment opportunities is highly dependent on the beliefs and attitudes of the host community towards the refugees living amongst them. According to Capps et al. (2015), some host employers recognize refugees as fellow working group individuals who require employment opportunities to sustain themselves. In such cases, the refugees have an easier time securing jobs as well as earning a little more than the average wage. However, limited work opportunities can worsen the mental health status of a person compared to those who have access to economic opportunities (Sangalang et al.,2019). Therefore, a lack of employment can expose a refugee person to depression and anxiety (Kim, 2016).

Social isolation. The process of displacement in which refugees are compelled to move into unfamiliar cultures presents significant social challenges for them. The Rwandan family social support system may be disrupted because of family separation or death and could lead to social isolation and the loss of familiar cultural ties and community. Such experiences are

associated with anxiety amongst refugees (Tingog et al., 2017). A study of Iraqi refugees in Austria suggested that refugees who were separated from their families suffered from higher rates of PTSD and depression symptoms compared to those who remained with their families (Nickerson et al., 2010). Social isolation was linked to poor mental health outcomes for refugees (Li et al., 2016), social support within their familiar communities has been seen to improve psychological well-being (Joyce & Liamputtong, 2017; Schweitzer et al., 2006).

Social roles. The change in social roles in the host country is also associated with depression. A qualitative study exploring the experiences of refugees suggested that social roles are tough to alter and can severely impact psychological well-being (Colic-Peisker & Walker, 2003). For example, refugees from Africa who resettled in Australia explained that men losing their opportunities to become breadwinners in the family and having to depend on their female spouse financially impacted the relationship dynamics within the family, resulting in decreased well-being (Fisher, 2013). This evidence suggests that post-resettlement experiences are complex and multidimensional, meaning that every experience contributes significantly to the mental health status of refugees.

The refugee's ability to secure employment is associated with positive health outcomes. This is supported by a study in that author considered the effects of volunteering and employment on the health of African refugees who had settled within Western countries (Wood et al., 2019). The results of the study established that those refugees who managed to acquire employment or volunteer opportunities within their area of resettlement tended to have a greater sense of self-fulfillment and belonging, which are factors that contribute towards effective integration into a new community. By having and sustaining an employment opportunity, refugees can maintain an adequate standard of living that makes it possible to promote healthy behaviors by improving their healthcare access. Having employment opportunities places a

refugee in a position where they can afford healthcare, thus significantly improving their health outcomes. Volunteering opportunities have considerable contributed to the promotion of community connections and a feeling of positive self-worth that helped to prepare the refugees for the eventual integration into the community as well as the workforce (Capps et al., 2015).

Hauck et al. (2014) established that most refugees were forced to work long hours or take on multiple jobs to afford basic amenities such as healthcare. By working long hours, refugees lack free time for their families, a situation that causes the development of familial difficulties (Phillimore, 2011). Extensive work hours can inhibit community integration as refugees do not have time to engage socially with other individuals in the community, further exacerbating their socially isolated state. Furthermore, language barriers aggravate a refugee’s efforts in seeking healthcare services as they lack the skills necessary to communicate with healthcare providers.

Healthcare. As a result of the difficulties experienced in obtaining jobs, refugees often settle for low-paying part-time jobs. With this, social services reduce the aid for which they are eligible to receive, thereby increasing the refugees’ financial troubles (Kiselev et al., 2020; Warfa et al., 2012). A limited flow of income affects a refugee’s access to healthcare because other basic amenities, such as food and clothing, are considered more urgent than healthcare outside of extreme cases. When faced with a choice between buying food and going to therapy, most refugees would settle for putting food on the table and sidelining the need for mental health care services (Cox et al., 2012).

Psychological Conditions Faced by Rwandan Refugees

Apart from the physical and survival challenges, refugees face unique psychological issues that arise as a result of the traumatic experiences they encountered, which is frequently elevated post-resettlement. As noted earlier, refugees were faced with numerous challenges, including changes in culture. Compared to the predominant western way of describing mental

health with its assumption of a mind-body dichotomy, a refugee person is likely to describe somatic symptoms instead of psychic symptoms (Robertson et al., 2019). Due to the widespread stigma that is associated with mental health issues, it is common for a person to deny psychic symptoms. People obtain non-medical support for their suffering, as Somali refugees turn to God instead of professional mental health service providers for solutions (Robertson et al., 2019).

Li et al. (2016) highlighted that resettlement has adverse effects on the mental health of the displaced individual regardless of the traumatic histories that may have driven them from their countries of origin. Exposure to an entirely new physical environment and having to navigate through an unfamiliar cultural context requires refugees to endure emotional stabilization before the situation returns to normal. Koh et al. (2013) established that the removal of an individual's socio-cultural and interpersonal support system and the severing of family and community networks often brings up adverse psychological and social health outcomes among refugees. Fazel et al. (2005) posited that refugees have a higher prevalence of mental disorders as compared to individuals within non-war affected areas because of war and migration experiences.

Research has also indicated that refugee populations report a higher prevalence of psychological issues compared to the general population (Fazel et al., 2005; Li et al., 2016). Growing evidence suggests that refugees undergo stressful experiences during forced migration, and the resettlement process, making them vulnerable to mental health concerns, including higher rates of PTSD, depression, and anxiety symptoms (Bogic et al., 2015; Fazel et al., 2005; Steel et al., 2009; Turrini, 2017) aside from the trauma that forced their resettlement.

More specifically, there have been several systematic reviews reporting the prevalence of PTSD, depression, and anxiety symptoms among refugees in Western nations. One of those systematic reviews examined 17 studies describing that Afghan refugees reported higher rates of

depression from 55%-57% than in the general population (Alemi et al., 2014). Similarly, Robjant et al. (2009) included ten studies stating that out of the total population of asylum seekers and refugees resettled in Australia, the U.K., and the U.S., 59%–100% were reported to have depression, 27%–50% reported to have PTSD, and 77% reported to have anxiety issues. Furthermore, Slewa-Younan et al. (2015) included eight studies examining resettled Iraqi asylum seekers or refugees and found that depression rates among this population were at 43%, and the rate of PTSD was 25%. Similarly, Bronstein and Montgomery (2011) included 22 studies in their systematic review and reported an average rate of 18% for depression and 36% for PTSD. These comparatively elevated rates from recent studies, however, were inconsistent with an earlier study by Fazel et al. (2005), who reported lower rates of mental health issues among refugees (PTSD 9%, depression 5%, anxiety 4%). Fazel et al. (2005) suggested the lower rates in mental health issues drawn from their meta-analysis possibly relate to the fact that three-quarters of participants in the review were from Southeast Asian countries.

Financial instability, inability to provide basic needs for families, and the lack of employment are critical reasons cited by the refugees as reasons for their depression (Jancin, 2017). Other refugees confirmed that they experienced depression as a result of unfulfilled expectations and hopes regarding their employment and their children’s education (Bryant et al., 2018). The constant worry over what their children would eat or how they would attend school were the self-reported explanations for depression. In other cases, a lack of proficiency in the English language contributed to depression as the refugees were worried about how to communicate with people within the U.S. (Fazel et al., 2012).

Additionally, some refugees migrate to the U.S. and leave their families behind in their country of origin either as a result of the separation during the migration process or as a personal decision to establish themselves before going back for them (Phillimore, 2011). The separation

that arises from this brings about anxiety and stress as they have to cope with the loss of both the immediate and extended family. In addition, most countries of origin for the refugees are usually in a state of unrest, implying that their families are subjected to dangerous environments. Among some Rwandans, the whereabouts and well-being of loved ones were often unknown for some time and, in some cases, even after decades, remains so. Anxiety occurs during resettlement; therefore, fear arises because family members are left behind, causing concern for their safety (Nsonwu et al., 2013). Rwandan refugees who resettled in the U.S. may experience the same challenges and mental health issues as those reported in the literature; however, no research has been conducted to support this assertion. As such, the current study aims to discover whether Rwandan refugees' mental health experiences differentiate from what is known about other resettled refugees.

Rwandan Refugee Experiences of Mental Health Care

Refugees can receive health assistance in their host country, including in the U.S. Specifically, the Office of Refugees Resettlement in the U.S. Department of Health and Human Services has policies in place to ensure the health and well-being of refugees' post-resettlement (Office of Refugee Resettlement, 2015). For example, refugees are eligible for Refugee Medical Assistance (RMA) for eight months upon arriving in the U.S., as well as Medicaid or the Children's Health Insurance Program (CHIP), which is available for children who qualify (Office of Refugee Resettlement, 2015). Soon after the RMA expires, most refugees can apply for health insurance through the marketplace of the Patient Protection and Affordable Care Act (ACA; Office of Refugee Resettlement, 2015).

Further evidence suggests that some refugees remain uninsured due to a lack of knowledge about enrolling in the ACA. Nevertheless, the ACA may not be sufficient to cover the refugees' health conditions (Morris et al., 2009; Yun et al., 2012). In a mixed-method study

sampling of 56 Africans from 14 different countries (including Rwanda's Great Lakes region), researchers gathered data regarding the refugees' health needs and the barriers they encountered as they resettled in the state of Oregon. Participants shared that, in light of economic struggles to meet their basic needs, healthcare became a lower priority for them (Boise et al., 2013). Despite the partial availability of ACA, barriers remain among the refugee population in the U.S., including, but not limited to, stigma, lack of awareness, and cultural/linguistic challenges (Espinoza, 2016). There is minimal information about Rwandan refugee experiences of mental health care in the U.S., which is another gap in the literature that the current study aims to fill.

Stigma. The stigma associated with mental illness can be defined as negative attitudes or perceptions of being flawed due to personal traits seen as socially unacceptable (Sartorius, 2007). Stigma can be public, meaning individuals may have negative perceptions toward individuals with mental illness (Vogel et al., 2006). The mental health stigma is generally one of the most cited obstacles among refugees seeking mental healthcare (Boise et al., 2013), marginal data has been documented on the lived experiences of the Rwandan refugees in the U.S. As noted, mental health issues are stigmatized in the Rwandan culture, and that likely reduces help-seeking behaviors.

Moreover, it has been argued that there are cultural differences that exist in stigma-related attitudes and behaviors, depending on one's conceptions of healthy and unhealthy behaviors (Shannon et al., 2015). Stigmatization is harmful as it often leads to discrimination, stereotyping, and prejudice toward persons seeking mental healthcare (Sartorius, 2007; Vogel et al., 2006). As a result, many people avoid seeking psychological care to avoid the consequences of public stigma. In one qualitative study that used focus groups with 111 refugees from Burma, Bhutan, Somalia, and Ethiopia to explore the refugees' perceptions in discussing mental health

concerns, the participants shared that it was difficult to discuss mental health issues because of the fear of being labeled as “crazy” (Shannon et al., 2015).

Additionally, stigma can also exist within families, such that if an individual that attains psychological services, their family may shun him or her (Piwowarczyk, Bishop, Yusuf, Mudymba, & Raj, 2014). Based on the existing literature, it seems that the Rwandan genocide survivors share a collective experience with other refugees in their sense of stigmatization toward mental illness and mental health services.

Culture. According to Kleinman (2006), culture is an embodiment of meanings through psychological responses, evolving relationships, religious beliefs, values, explanations, attitudes, and accumulated experiences. These factors may vary based on race, ethnicity, social class, sex, and generation, and these underlying tenets of cultures are behind every individual’s determining factors towards illness, attribution of an illness, and help-seeking behaviors (Kleinman, 2004). Additionally, unlike individualistic culture such as the United States, collective cultures like East African, emphasize interconnection and social conformity with each other and every person is essentially interrelated in a large social group consequently coping approaches also vary based on these differences (Mojaverian et al., 2013; Schlaudt et al., 2020). For example, cultural differences have been noted to have different implications for mental health interpretation. In Chinese culture, individuals may perceive mental health concerns such as depression as worry and uncontrolled anger, while Western culture would consider symptoms as depression (Kleinman, 1997), suggesting that culture influences people’s understanding and expression of illness. Concerning migration, Morris et al. (2009) established that factors such as misunderstanding of Western medicine, beliefs regarding preventative care, in addition to stigma associated with mental health, prevented some refugees from seeking healthcare services. Hauck and colleagues(2014) indicated that some cultures are less receptive to care as they have been

accustomed to visit the hospital only when they were feeling sick. In this case, individuals would not be open to carrying out procedures such as therapy sessions as they consider it a waste of money and will not make an appointment to visit a doctor when they are not physically sick (Hauck et al., 2014).

Specifically, among resettled African refugees, disclosing personal information to someone from a different culture is difficult, frowned upon, and out of alignment with the traditional practices (Piwowarczyk et al., 2014). In a qualitative study using focus groups about Congolese and Somali beliefs about mental health services, Piwowarczyk et al. (2014) discovered that participants in the study often turned to family members, friends, and religious leaders for help first, as mental health services were not routinely sought in their culture. In those same circles, prayer and waiting for God to work was, highlighted as a healthy way of coping and accepting trauma in one's life (Piwowarczyk et al., 2014).

Language and communication. The majority of mental health service information in the U.S. is in English, which may not be understood by refugees (Boise et al., 2013). Certainly, translating services may be available, but often, the initial points of contact for these organizations may not speak their language of origin (Morris et al., 2009). This communication barrier between the healthcare provider and the patient may seriously impede the healthcare provider from offering adequate services. Worabo et al. (2016) posited that because of the language differences, refugee patients lack the necessary vocabulary to describe their concerns and medical history, a situation that makes it difficult for healthcare providers to offer appropriate diagnosis and treatment.

The problem is heightened for sensitive mental health concerns, such as the complex trauma experienced by Rwandans. When a third-party interpreter is involved, patients are most likely to withhold some information for fear of judgment and ridicule. This situation results in a

less adequate quality of care. Refugees admitted to having missed appointments with healthcare personnel or left a health problem untreated as a result of a lack of understanding and comprehension of the English language (Worabo et al., 2016). The patients who expressed hesitation in making use of interpreters to communicate with the healthcare providers as these providers reported they did not make full use of the assigned professional interpreters as a result of their limited availability and the inconvenience of using these services (Fazel et al., 2005).

Lack of awareness. Another fundamental barrier regarding mental health services among refugees is that they are unfamiliar with the services available to them. Specifically, refugees who are being acclimated to their host countries may be unaware of their mental health problems and the services their communities provide (Yun et al., 2012). As previously mentioned, refugee people often experience illiteracy around mental health issues or are discriminated against, stigmatized, and shunned for pursuing them (Erinkveld, 2016). Therefore, there is a need to increase educational programs on mental healthcare among Rwandans resettled in the U.S. to improve their familiarity with and attitudes toward such services.

Mental Health Intervention for Rwandan Refugees in the U.S.

Refugees develop different coping mechanisms as they adapt to their new host countries. In one study, the refugees' coping mechanisms for torture were considered with a specific emphasis on religious behaviors (Leaman & Gee, 2012). Leaman and Gee (2012) reported that one main form of torture, sexual torture, was highly associated ($\beta = 0.25$, $t(128) = 2.64$, $p < .05$). In such cases, informal religious coping habits (e.g., trauma is a punishment from God for wrongdoing) were found to be used by refugees with symptoms of both depression and post-traumatic stress disorder. Refugees made use of private religious habits as a coping mechanism for torture experiences that were more mental than physical (Leaman & Gee, 2012).

Spirituality, religion, and income-earning activities were identified as coping mechanisms applied by refugees in a study within a settlement of Liberian refugees (Dako-Gyeke & Adu, 2015). In this study, the majority of the participants reported taking part in religious activities such as prayer, as this was perceived as a strategy that would strengthen them to face their current situations. Others opted to engage in income-earning activities such as selling purified water and vending food to prevent themselves from being idle and worrying about issues (Dako-Gyeke & Adu, 2015).

When it comes to making mental healthcare accessible, APA has guidelines for competent multicultural care (2017). Unfortunately, while competent multicultural interventions are an ethical mandate, historically, mental health interventions in the U.S. have focused primarily on the therapeutic needs of the upper- and middle-class Americans, leading to an increased reliance on more individualistic, Westernized paradigms (Griner & Smith, 2006). Despite such a heavily Westernized framework, interventions continue to be developed and tested with diverse populations.

During a systematic review of therapeutic interventions in resettlement contexts, about 22 studies were selected for review, but only 12 of these studies provided descriptions of how cultures informed the implementation of the interventions (Murray et al., 2010). Scholars continually suggest a need for clinical professionals to emphasize the meaning that is ascribed to the lived experiences of refugees and immigrants faced with distress and trauma (Bartholomew et al., 2015). Despite such recommendations, a narrative review of mental health interventions for refugee children states that refugee interventions are still limited (Fazel, 2018).

While there are mental health interventions for refugee communities, refugee faces unique traumas that vary based on levels of trauma exposure to add to resettlement stressors and create multifaceted challenges worth considering (Goodkind et al., 2014). Again, refugees

struggle to engage productively with any existing mental health resources, at least in part, due to the stigmatization associated with seeking mental health treatment (Shannon et al., 2015). While there is limited intervention research with Rwandan refugees, numerous studies have suggested that despite the stigma around mental health services, promising treatments are being used specifically for treating refugee populations. The best evidence for reducing mental health issues in refugees can be found for trauma-focused interventions, such as narrative exposure therapy (NET; Gwozdziewycz & Mehl-Madrona, 2013; McPherson, 2012; Neuner et al., 2004), interpersonal therapy (IPT; Meffert et al., 2014), support groups (Ley, 2006; Mitschke et al., 2016), and eye movement desensitization and reprocessing (EMDR; Acarturk et al., 2015; Ament-Lemke, 2018; Ter Hiede et al., 2011). These interventions have been used with increasing regularity among the refugee community discovered to be helpful for individuals who underwent exceptionally traumatic experiences.

A recent study conducted among 72 refugees to determine the safety and efficacy of EMDR among refugee adults with PTSD. Participants were assigned a 12-hour EMDR session, where the Harvard Trauma Questionnaire was used as a measure. The study's findings suggested that EMDR was effective; however, a limited number of EMDR sessions may not reduce the PTSD symptoms (Ter Heide et al., 2016).

Evidence suggests that NET and IPT (Meffert et al., 2014) are effective for reducing PTSD symptoms among refugees, as are support groups in reducing resettlement stress (Ley, 2006; Mitschke et al., 2016). Additionally, NET's ability to be productive while remaining affordable, teachable, time-efficient, and informal adds to its attractiveness in the mental health field (Goodkind et al., 2014). While there are strengths evident with these interventions, it is essential to note that refugees are exposed to prolonged trauma experiences, and it is suggested

that their symptoms of PTSD may increase when these individuals are exposed to new stressors during resettlement (Kirmayer et al., 2007).

There is a need for interventions that focus on the different stages of refugee migration: before resettlement, during resettlement, and post-resettlement, especially as it could prove beneficial to their mental health. Focusing on refugees' experiences more comprehensively is beneficial in identifying interventions that are culturally sensitive but also target their needs (Purgato et al., 2017). However, evidence examining holistic experiences for the refugee populations is limited. It also seems that the goals of NET, IPT, and support groups have been to reduce specific mental health concerns, suggesting that these interventions are not as comprehensive in assessing and treating each stage of migration risks and challenges (Kirmayer et al., 2007).

Critique of the Studies

Kleinman (1997) suggested that culture has a critical impact on determining how a person interprets their health symptoms, and therefore, their health concerns should be understood from a cultural, individual, and interpersonal level as earlier mentioned. However, studies reviewed above regarding Rwanda and mental health employed individualistic Western diagnostic methods. The adequacy or the psychometric properties of an instrument in one culture may not necessarily guarantee consistency and validity among people from another culture, despite the translation (Canino & Alegria, 2008). For the instrument to show adequate reliability and validity, it requires comprehensive adaptations to capture the same phenomena in populations and cultures different from the original population (Canino & Alegria, 2008) and for all of the studies reviewed in this section that is not the case. Most of the studies used surveys and Western criteria to examine mental illness and examined Western psychological approaches for reducing PTSD. Most research studies utilized measures that were not validated for the Rwandan population.

While the results clarify the psychological effects experienced by survivors and developing interventions, there is controversy associated with labeling Rwandan mental health issues using the Western medical model, as it may not be sufficient for understanding the Rwandan refugees (Ray, 2008). Furthermore, Rwandan ideas of sickness and healing are not the same as Western biomedical models and do not easily map onto them (Ray, 2008). As previously mentioned, for example, their local perceptions of mental health, and suffering are often not represented in the narratives of another culture. In other words, sickness is an experience that is culturally shaped and an integral part of a social system suggesting that emotions and behaviors are guided by culture and, in turn, culturally constructed (Kleinman et al.,1978; Otake, 2018). Finally, Western diagnoses have been questioned due to the emphasis on individual symptoms rather than collective suffering, which is arguably more consistent with Rwandan culture (Ray, 2008).

In keeping with this perspective, it is vital to capture the interpretation of mental health as expressed within diverse populations such as Rwandans. For example, Scorza et al. (2017) conducted a study with the aim of determining the culturally appropriate protective factors relevant to reducing mental health concerns among 367 Rwandan youth. To do so, the authors used locally derived constructs, which were then combined with an existing scale. The authors of the study identified the factor structure of the expanded range using exploratory factor analysis. The scale displayed excellent internal consistency reliability, suggesting that it was appropriate for measuring the protective factors: perseverance, sense of self-worth, self-efficacy, and social interactions related to preventing mental health issues among the Rwandan youth (Scorza et al., 2017). Because it is important to identify culturally appropriate measures for developing cross-cultural interventions, more evidence with regards to mental health instruments is needed to develop interventions for Rwandan communities in the U.S. This is especially

important as evidence indicate that the 1994 Rwandan genocide survivors continue to suffer prolong psychological concerns such as PTSD (Banyanga et al., 2017; Eytan et al., 2015) and these concerns are often reported to transfer from a different generation (Rieder & Elbert, 2013), and for refugees who have endured different challenging experiences, new stressors post resettlement exacerbated their mental health concerns (Li et al., 2016). Therefore, before culturally appropriate mental health interventions can be developed for the Rwandan refugee population in the U.S., more needs to be known about the social-cultural factors that influence their mental health and well-being in addition to their lived experiences associated with genocide, migration, resettlement in the U.S., and the effects of those experiences on mental health need to be explored.

Theoretical Framework

The current study was framed using Bronfenbrenner's (1981) ecological systems theory. According to ecological systems theory, multiple factors, personal, situational, and sociocultural, interact to shape our life experiences (Eriksson et al., 2018). Given that the Rwandan genocide occurred 26 years ago, research indicates that this population continued to suffer from the psychological consequences (Neugebauer et al., 2014). Therefore, it is essential to understand these experiences using a framework that underscores the different interrelated factors that have shaped Rwandan refugees' experiences prior to migration and post-migration. Furthermore, the ecological theory posits that individual development occurs within the context of interrelated systems that form the environment (Drozdek, 2015). These systems include the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. These systems of ecological systems theories are relevant to this study as they consider the multiple variables and transitions that refugees encounter during their displacement.

Microsystem. A microsystem comprises relationships between the individual and factors of the immediate environment such as family, peers, school, jobs, neighborhood housing, food, beliefs, and others that consistently interact with the individual (Bronfenbrenner, 1983, Drozdek, 2015). Bronfenbrenner (1979) defined microsystems as relationships between an individual and their surrounding environment, which includes environmental school, a neighborhood, the home, and other relevant environmental factors, such as the immediate family. A microsystem is considered as a relationship, or bond, between the immediate individuals within their microsystem (Bronfenbrenner, 1979; Drozdek, 2015). These environmental bonds lead to direct influences based upon these interactions. In terms of a refugee, the surrounding microsystem is considered a vital component that can guide their experiences after their traumatic experiences (Drumm et al., 2004). Microsystems are relevant to this study as they consider an individual's different life trajectories, persona, beliefs, job, housing, and school (Bronfenbrenner, 1979). These are impactful as they are bonded relationships that may impact their ability to respond to their experiences related to their refugee status (Drumm et al., 2004).

Mesosystem. The mesosystem includes individuals group membership such as a church and community support groups and how all these factors interact together (Bronfenbrenner, 1979; Drozdek, 2015). Mesosystems are considered vital as they can impact the relationship within the microsystem and inhibit the individual ability for positive progress with their microsystem supports (Bronfenbrenner,1979). Mesosystem was necessary for this study as it considers other elements within refugee's lives, such as their families and communities (e.g., churches) that may assist refugees (e.g., providing support).

Exosystem. This system comprises the relationships to the outside world that an individual is not directly involved within, such as displacement due to war or natural disasters (Bronfenbrenner, 1979; Drozdek, 2015). The exosystem may also include relationships between

the individual and society, including mass media and public relations (Bronfenbrenner & Evans, 2000; Drozdek, 2015). For example, for refugees, the social relationship within the exosystem may result from displacement, the family separation that can impact their well-being. As such, the exosystem is important to consider when examining refugees as it may impact their overall well-being. Exosystem is relevant to this study as it considers the relationship that a refugee has with their external world. This includes the relationships that a refugee may have with their external world (e.g., the media) in light of displacement or family separation (Esses et al., 2013). This relationship can be negative or positive and have lasting results in their life.

Macrosystem. This system represents the relationships between the individual and culture, laws, regulations, belief systems, and ideologies (Bronfenbrenner, 1979; Drozdek, 2015). These include the interaction between culture and belief systems that may guide Rwandan refugees' mental health towards positive or adverse effects. Additionally, the belief systems which exist within the macrosystem of this theory are noted to be elements that may guide coping strategies for refugees in light of their displacement (Brune et al., 2002). In the macrosystem, the relationships that an individual has within their unique socio-culture system impacts their progression within their host communities in the U.S. This includes how Rwandan refugees belief systems may guide their positivity towards a displacement, or towards contextualizing their situation within their ideological belief system (Brune et al., 2002). In terms of help-seeking behaviors, cultural attitudes around mental health may have a significant influence on refugee's access to mental health care (Shannon et al., 2015).

Chronosystem. This system consists of all the systems looking at the different life transitions that significantly influence a person as a whole (e.g., displacement, resettlement for a refugee person) (Bronfenbrenner & Ceci,1994). This is relevant to this study because it informs how we look at different transitions that refugees endure during and after their displacement.

This can include the transition from their original home, to refugee specific camps, and transitions to the host countries. These transitions are often considered contributors to the mental health of refugees due to the traumatic nature of displacement events (Hall & Olff, 2016; Silove et al., 2017). Chronosystems are essential to consider as it contextualizes the transitions that an individual can experience during their refugee experiences. These experiences include traumatic events that are associated with these displacement events and resettlement experiences (Hall & Olff, 2016; Silove et al., 2017).

The internal and external influences are bidirectional, where conflict or change in one system causes conflict or change in other systems (Drozdek, 2015). In other words, factors, such as separation from family and entering foreign territory with different belief systems, may intensify the psychological distress experienced from living in a conflict-affected area. Ecological systems theory helped guide this study by lending insight into how the mental health and well-being of Rwandan refugees are influenced by events that occurred prior to migration and during resettlement. Specifically, ecological systems theory underscores the effects of exposure to multiple events and changes (e.g., trauma, leaving one's place of origin, transitioning into new cultures) on refugees' mental health (Eriksson et al., 2018). Furthermore, interview questions were influenced by this theory to increase insight into the different systems that influence mental health experiences in Rwandan refugees. Finally, ecological systems theory informs the significance of the current study because it emphasizes the importance of using individual and contextual information to tailor mental health interventions for Rwandan refugees.

Conclusion

The review of the literature highlighted studies relating to the historical context and psychological impacts of the 1994 Rwandan genocide. Mental health barriers in the U.S. were discussed, along with refugees' experiences related to mental health. The results of the review

found that there is a plethora of literature regarding the psychological consequences of the Rwandan genocide and general refugee resettlement in the U.S.; however, limited research exists regarding the lived experiences of Rwandans resettled in the U.S. Furthermore, research encompassing effective mental health services for this population is limited. The review of literature also suggested that the majority of studies conducted post-genocide have been conducted using a *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition, which is a Western medical perspective (Hagengimana et al., 2003; Rieder & Elbert, 2013; Schaal & Elbert, 2006, Schaal et al., 2011; Schaal et al., 2012). Therefore, any resulting diagnosis of mental health symptoms is interpreted from a Western framework, which may help explain shortcomings in help-seeking and effective service delivery among diverse populations in the U.S. This suggests a need for more research grounded within the Rwandan context in order to develop culturally relevant interventions. Finally, refugees received healthcare benefits post-resettlement, multiple barriers inhibit refugees from obtaining the needed services quickly, affordably, and effectively. The evidence used for the review to address the information relating to the phenomenon under study included the complexities posed by the mental health challenges experienced by refugees; however, this group is not homogenous. Even though the information is pertinent for understanding the general experiences of refugees, it does not support a better understanding of the specific experiences faced by Rwandans resettled in the U.S. because all refugees have unique mental health challenges and socio-cultural encounters. To fill the gap in the existing literature, this dissertation study utilized a descriptive phenomenological approach, a method that provided a descriptive understanding of the participants' experiences.

Chapter Three:

Methodology

Introduction

The purpose of this qualitative descriptive phenomenology dissertation was to explore the lived experiences associated with (genocide, migration, resettlement) and sociocultural factors that influenced Rwandan refugees' mental health and well-being in the U.S. A qualitative methodology, a phenomenological approach, was chosen to explore these experiences. This section provides a discussion regarding the selected research design and approach, the population and sampling strategy, data collection, and data analysis techniques. The strategies used to maintain the trustworthiness of the study are provided in this section. To understand the lived experiences of trauma in Rwandan refugees resettled in the U.S., interview questions were shaped by the ecological systems theory to answer the following research questions:

RQ1. How do individuals from Rwanda describe their lived experiences of trauma associated with becoming a refugee and resettling in the U.S.?

RQ2. How do Rwandan refugees perceive the mental health services offered to refugees in the U.S.?

RQ3. What are the socio-cultural aspects of resettlement (i.e., culture, linguistic, economic, and social challenges) in the U.S. that influence Rwandan refugee well-being?

Instrumentation

In qualitative research, the researcher is the primary instrument, which requires the researcher to engage in reflexivity by acknowledging personal perspectives as a potential bias (Creswell, 2013). In this study, the learner was the primary researcher and the sole interviewer. Although the researcher is not Rwandan, the researcher is an African immigrant woman in the Ph.D. program at The University of Texas at Arlington with a research interest on immigrants'

and refugees' lived experiences. The researcher has a master's degree in social work. Even though the researcher is not from Rwanda and does not share the genocide experience, she brings a unique perspective to the study because she is an immigrant woman from African who believes her background was valuable when connecting with participants.

Additionally, the researcher can comprehend some Kinyarwanda words, speaks, and writes Swahili, which is some of the languages spoken by the Rwandan people. Furthermore, the researcher has two year of experience volunteering among Rwandan immigrants and refugees in the U.S. Participants were informed that the researcher had volunteered with Rwandan immigrants during their initial conversations, and the researcher believes it created some level of trust between her and the participants. The researcher acknowledges that her previous encounter with refugees from Rwandan could facilitate bias during data collection and analysis. To ensure bias was minimized, the researcher journaled her thoughts and feelings throughout, as discussed in the analysis section. The researcher spoke with experts as much as needed to debrief and discuss her own biases. The researcher adhered to the interview guide to ensure impartiality during the interview process. The researcher approached this study from an etic or outsider perspective (Morris et al., 1999).

Research Design

A qualitative research design was selected because it allows for an in-depth exploration of a phenomenon (Creswell, 2013; Merriam & Tisdell, 2016). Furthermore, a qualitative approach is appropriate for researchers interested in understanding how people describe their experiences, how they construct their realities, and what meanings they assign to their experiences (Merriam & Tisdell, 2016). The researcher approached this research study from a constructivist position with the underlying assumption that reality is socially constructed and context-driven and that multiple realities exist for the phenomena being studied (Kivunja &

Kuyini, 2017). Furthermore, this research was conducted to include the viewpoint that interaction between the researcher and participants that was essential to understanding their lived experiences (Kiyunja & Kuyini, 2017).

The review of the literature provided an understanding that little evidence regarding the mental health experiences of Rwandan refugees existed in the body of knowledge. In other words, little has been conceptualized or described, especially in understanding and uncovering the lived experiences associated with (genocide, migration, resettlement) and socio/cultural factors that influence their mental health and well-being of Rwandan refugees in the U.S. To capture these experiences, a descriptive phenomenological analytic (DPA) approach was chosen because it is used when little is known about a phenomenon. Additionally, DPA aims to describe, as opposed to interpret or explain, the lived experiences of trauma in Rwandan refugees who resettled in the U.S. (Giorgi, 2009).

Sampling and Recruitment Methods

Phenomenological research is less concerned about the number of participants interviewed and more interested in how often a phenomenon is described by participants. As such, a researcher can interview five or more participants (Giorgi, 2009). The University of Texas provided the approval to conduct this research at Arlington (UTA) Institutional Review Board (IRB) in mid-June 2019. Following the approval, thirteen participants (ten men and three women) were recruited, which aligns with DPA's sample size. This sample also enabled the researcher to understand the phenomenon of interest more in-depth. The researcher used snowball, purposive sampling techniques to recruit participants. It has been suggested that snowball sampling is a feasible sampling method, primarily when recruiting hard to reach populations such as refugees (Sulaiman-Hill & Thompson, 2011). Snowball sampling is a method where participants recruit others from within their social groups. The researcher

developed a volunteer relationship with Project Start Refugee in Dallas, an agency that serves individuals from all over the world, including those from Rwanda. However, the researcher did not belong to the Rwandan social network; therefore, using a snowball sampling technique was paramount. Since the researcher established a volunteering relationship with Project Start, the agency was supportive in partnering with the researcher in allowing the researcher to use the agency as a recruitment site. The agency leader Leo at Project Start provided a letter of support indicating that he was willing to distribute a researcher's recruitment script at the agency. On July 23rd of 2019, after IRB approval, the researcher met with Leo to explain his role and responsibility in the study. Leo's responsibility was to give out the IRB approved description of the study, which had the researcher's contact. This short description was distributed to refugees from day to day starting July 24th, 2019. Following this, refugees from Rwandan that developed an interest voluntarily called the researcher to learn more about the study.

Participants

Through the assistance of Leo in distributing the study script, the researcher received correspondence from a participant that called her with interest in learning about the study. The researcher explained the nature of the study more in-depth and screened to ensure they met the inclusion criteria as follows: 1) that the individual self-identified as Rwandan, 2) is resettled in the DFW, 3) is 18 years old or older, 4) can speak and read English, and 5) is associated with Project Start Refugees. The first participant that contacted the researcher with interest in learning more about the study knew the researcher through her volunteer relationship with Project Start. When the researcher spoke to the potential participant through a phone conversation, the participant exhibited an interest in participating in the study. The researcher scheduled a face-to-face interview with that individual who then connected the researcher to seven more participants through snowball sampling. In total, the researcher obtained eight participants recruited (six men

and two women) from DFW between July 2019 and September 2019. These interviews were conducted in English using a face-to-face format. The researcher noted that a majority of the participants willing to participate in the interviews were men. Women who were recruited in the study would want to learn more about the study; however, they would decline in the initial interview expressing that the topic was too sensitive for them or that they did not want to revisit any memories related to the 1994 Rwanda genocide. Additionally, there were several participants that were willing to be interviewed; however, most of them did not speak English; therefore, they were excluded from the study as they did not meet the study's inclusion criteria. The researcher noted that the use of snowball sampling included referrals that resided outside DFW; thus, the researcher decided to expand the data collection to the U.S. and include phone interviews to gather additional data because the researcher had not reached saturation with the participants interviewed in the DFW area. To ensure compliance with UTA's IRB as well as the researcher did not include telephone interviews as part of the data collection, the researcher modified the IRB protocol and resubmitted it to receive approval to interview participants via phone. The IRB modifications were approved, and the researcher received the approval letter in September 2019. The thirteen participants, the researcher, recruited an additional five participants (four men and one woman) who had resettled in the different midwestern and southeastern states. As earlier stated, some of the participants the researcher had interview face-to-face would often refer her to individuals who lived outside the DFW. Two participants specifically that the researcher interviewed in the DFW area were passionate about spreading the word regarding the research, and both wanted to reach as many people as possible. Therefore, through their social networks, the researcher was able to find more participants. It was common for the researcher to receive phone calls from participants stating that they were informed about the study she was conducting. Based on these initial calls, the researcher would explain the study in detail to ensure

potential participants understood the research from her perspective. Once the researcher had established a common understanding with the potential participants, she would request those participants to schedule a practical time for the researcher to call them for the initial interview. Using a similar sampling method, the researcher interviewed more participants and reached saturation with thirteen individuals. The researcher stopped recruitment by the end of October 2019. Saturation is a qualitative criterion for concluding recruitment when similar information continues to emerge in the data (Saunders et al., 2018).

Additionally, the researcher used an interview guide that served as a tool to ensure that the interview questions were all asked and delivered in the same structure and choice of words. Interview questions were informed by the ecological systems framework to gain insight into the different systems that influence the mental health experiences of Rwandan refugees (Eriksson et al., 2018). In phenomenological research, it is important to start by asking general questions (Giorgi, 2009). During the initial conversations, the researcher asked general questions pertaining to the study where she asked participants to tell her about their life, where they had lived prior to the U.S., and how they would describe their experiences if they were in Rwanda in 1994. Building on these conversations, the researcher moved on to the research questions following a pre-prepared interview guide, where participants explored and shared their experiences. The researcher utilized semi-structured interviews with open-ended questions because the design was adequately flexible to allow follow-up questions and probes to obtain more information from the participants (Schmied et al., 2011) and this technique was also consistent with DPA (Giorgi 2009), These semi-structured, open-ended questions were developed such that participants discussed experiences related to each ecological system.

Ethics

Before every interview, the participants signed informed consent or provided verbal consent if the interview was conducted via the phone. Participants also completed a demographic questionnaire. All interviews were audio-recorded and conducted in a private setting with no distractions. Those interviewed through the phone were recorded while on speakerphone. The researcher took detailed notes during the phone interview process to ensure all details were captured and not missed during the phone interview. Interviews lasted between 45 and 80 minutes.

To ensure confidentiality was maintained, each participant provided the researcher with a pseudonym to protect the participant's rights and avoid using personal identification such as their personal names. Pseudonyms were utilized during the interview conversation in addition to where the researcher reported the finding later in chapter four results. Additionally, the researcher was cautious in making sure that participants understood the confidentiality processes of the interviews prior to the interview process. The researcher went into detail about how their information would be protected. Reading the consent form to participants or having them read the form and ask questions before the interview achieved this part of the process. Participants were also informed about the voluntary nature of the study. Every participant was given a chance to ask questions before every interview. Clarification was provided to each participant that needed it. Participants were reminded that participation in the study was voluntary, and their information was anonymous outside of the interview. Participants were also reminded about the decision to withdraw from the interview with no consequences for them. After the interview, participants were provided with a list of free counseling services should any of them need to seek care. Participants received a $10 Walmart gift card after the interview. Once the data collection was completed, ten audio recordings were professionally transcribed using rev.com, a secure

transcription company. The researcher created an account with this company, where she uploaded the audio files to be transcribed verbatim. To access the completed transcribed data, she had to login to her personalized account. Within the site, there are options to listen to audio files while following along with each transcript. The researcher was able to utilize these features during her data analysis. Also, the researcher transcribed three interviews that could not be completed by rev.com, which allowed her to immerse herself in the data. Any identifiable information in the transcripts was deleted. All audio files were kept on an encrypted, password-protected computer.

Data Analysis

Once all transcripts were transcribed, they were uploaded to atlas.ti eight, a qualitative data analysis software package. The software was helpful in organizing, examining, and coding the data. As suggested by Colaizzi (1978), the researcher first read through the transcripts several times to familiarize herself with the data. She listened to the audio three times while reading through the transcript to make sure it was transcribed accurately. As the researcher listened and read, she took notes, which helped her gain a sense of the data. Once the researcher completed this step, she moved on to the second step, where she read and extracted relevant statements, phrases, and sentences that provided an understanding of the lived experiences of trauma associated with becoming a refugee and resettlement in the U.S. (Colaizzi, 1978).

The researcher was able to identify related patterns by rereading the information once more. This process enabled the researcher to develop codes/sentences within the data by lumping important statements together and to gain an understanding of the participant’s experience. Once the researcher had extracted phrases and codes, she began to engage in dialogues with individuals who are experts in the area, as well as those that are familiar with Rwandan culture. This process provided clarity in the researcher’s own understanding of the data and rigor of the

study. In the third step, Colaizzi (1978) suggests formulating meaning from the significant statements. This process was iterative. The researcher went back to the data as she kept formulating meaning, synthesized, and extracted codes. This resulted in the researcher's interpretation consistent with Colaizzi's fourth step (Colaizzi, 1978). Codes, phrases, and statements were grouped to form specific themes. In the fifth step, the researcher began to integrate all the ideas into an exhaustive description that best represented the participants' experiences.

Trustworthiness

According to Patton (1999), the integrity of qualitative research can be put to the question based on the researcher's assumptions (Patton,1999). Creswell (2013) suggested using two or more triangulation techniques can enhance the trustworthiness of the study. Thus, the researcher used several techniques to demonstrate rigor in this study.

Bracketing. Bracketing is part of qualitative phenomenology studies, a process where a researcher sets aside his/her assumptions, beliefs, or information known about the topic and population under study (Creswell, 2013). Giorgi (2012) suggested that bracketing these ideas allows a researcher to stay true to the participant's experiences. The researcher accomplished this task in the engagement in a reflective process where it was important to journalize reflections and thoughts to include assumptions during the data collection and analysis. This method helped lessen the bias inherent from prior knowledge/experience, as well as enabled the researcher to immerse in the data.

Expert review. This was accomplished when the researcher met with her dissertation chair for two hours to go over the data and finalized the themes. The researcher also met with a committee member whose research focuses on refugees' experiences to discuss codes and

emerging themes, and she offered another perspective. To ensure the accuracy of data extraction, engaging in these meetings was critical (Creswell, 2013).

Rich and thick description. Additionally, the researcher included thick descriptions of the participant’s experience of the phenomenon. Creswell (2013) suggested that thick descriptions are details of the participant's experiences that provide the reader with the context of the social problem studied. The researcher used rich, thick descriptions to illustrate participants' lived experiences, as expressed through in-depth interviews.

Summary

A qualitative research method was chosen because it allows for an in-depth exploration of a phenomenon (Merriam & Tisdell, 2016). Furthermore, a descriptive phenomenology analytical approach was chosen because the goal of the study was to describe, as opposed to interpret or explain, the lived experiences of trauma in Rwandan refugees who resettled in the U.S., and there was little known about this population’s experiences (Vagle, 2018). Data was collected from 13 Rwandan refugees using semi-structured interviews shaped by ecological systems theory. Data was analyzed using Colaizzi’s (1978) five steps of descriptive phenomenological analysis to identify themes regarding the lived experiences of Rwandan refugees in the U.S.

Chapter Four:

Results

Introduction

By using a qualitative descriptive phenomenological approach, the researcher was able to begin to understand the lived experiences of Rwandan refugees with the aim to explore the genocide, migration, resettlement, and sociocultural factors that influenced Rwandan refugees' mental health in the U.S. This chapter describes the findings that emerged from 13 in-depth interviews. Participants' demographic characteristics are provided in this chapter. Additionally, themes and sub-themes from participants' own experiences, as well as rich, first-person accounts of their experiences are detailed below.

Participants' Demographics

A total of 13 participants, including ten men and three women (seven in person and six telephone interviews) from five different states, consented to participate in the study. All participants ranged from 27 to 48 years old, with a mean age of 35.92 years old, which means some were born before and some after the 1994 Rwandan genocide. Experiences varied based on age. Eight reported that they lost family during the 1994 Rwandan genocide, and similarly, eight of them had been displaced as a result of the genocide. The sample was overrepresented by men, with 10 of the sample being male. Including English, participants also spoke a variety of languages such as Kinyarwanda, Swahili, and French, which were reported to be most commonly spoken at home. Almost all respondents stated that they had children, and 11 of them had young children. The participants' length of stay in the U.S. varied, ranging from 1.5 years to 21 years (See Table 1: Participant Demographics).

Additionally, the length of stay in the U.S. was a factor in participants' resettlement experiences. Half of the sample reported the amount of time that they had spent in the refugee

camps. Of those that reported, seven of them had lived in different refugee camps for more than ten years. This is important to note because experiences presented in this study represent experiences of individuals who had lived in other countries and different refugee camps for longer periods of time prior to coming to the U.S. Nine participants reported that they attended church weekly, while four of them stated they attended church at least twice a month. Church attendance played a significant role in participants' experiences, as described later in this chapter. The participants were highly educated. Four participants held master's degrees, five held bachelor's, two held associates, and the other two held at least a GED or a high school diploma. Those with minimum wage jobs reported more financial challenges during the interview. Eleven of the sample had a full-time job at the time of the interview. Participants' characteristics are illustrated in Table 1. Because participants' lived experiences varied tremendously, their unique experiences are presented to display the diversity and exposure to trauma. Additionally, it is important to note that it was uncommon for participants in this study to share their experiences and those of others in the community. This was noted to be a common pattern, especially with participants who are leaders and are engaged in their communities. It was also common for participants who are leaders in the community to answer questions giving specific mental health challenges and examples of cases in their community. All of these views and perspectives are presented in this chapter, as participants described them.

Table 1: Participant Demographics

AGE RANGE (YEARS)	**n =**
25-30	2
31-35	5
36-40	3
41-45	2
46-50	1
GENDER	
Female	3
Male	10
SPOKEN LANGUAGE	
Kinyarwanda	13
Swahili	10
French	10
English	13
# OF YEARS IN THE U.S.	
1-5	5
6-10	4
11-15	3
16-20	1
# OF CHILDREN	
0	2
1-5	10

6>	1
CHURCH ATTENDANCE	
Twice a month	4
Once a week or more	9
LEVEL OF EDUCATION	
High School or GED	2
Associates	2
Bachelors	5
Masters	4
EMPLOYMENT	
Full-time	11
Unemployment	2
LOSE FAMILY IN THE 1994 GENOCIDE	
Yes	8
No	5
DISPLACEMENT RELATED TO THE GENOCIDE	
Yes	8
No	5

In response to the research questions guiding this study, four major themes and one subtheme emerged from in-depth interviews. The identified themes and subtheme were as follows: 1) Traumatic Experiences of Rwandan refugees: 1a) Effects of Trauma 2) Resettlement Experiences of Rwandan refugees in the U.S. 3) Barriers to Mental Help-Seeking Among Rwandan Refugees in the U.S. and 4) Rwandan Refugee Coping and Help-Seeking Behaviors Differ in the U.S. Participants experiences are organized by the research questions. Also, the identified themes were based on the common experiences among participants; thus, each theme demonstrates the shared common experiences while each quote was selected as they represent those uniquely shared accounts.

Theme 1: Traumatic Experiences of Rwandan Refugees

The theme "Traumatic Experiences of Rwandan Refugees" emerged as participants were asked to describe their lived experiences of trauma and resettlement in the U.S. While four participants focused more on resettlement challenges discussed later in this chapter, experiences described in this theme were prevalent among a few respondents who survived the 1994 Rwandan genocide. These individuals reflected on exposure to trauma, which included witnessing dead bodies or living in difficult situations for an extended time. In particular, a participant with the pseudonym Ben expressed seeing dead bodies and watching people being slaughtered, undoubtedly a traumatic experience. Ben also shared what he witnessed and how it impacted his mind, stating, "Looking at the fresh body of people, you know, cut into pieces, you know. That really, uh, made my mind unstable." On the contrary, a participant with the pseudonym John disclosed his experiences about the torture inflicted on him, such as being abandoned to die alone in the ditches after having his life threatened. John described that despite such a humiliating experience, he survived the genocide, albeit with negative ramifications on his health. John stated,

> Because of the genocide, I was, uh, I was almost killed. I almost got killed. I was hacked with a machete, and I was left to die in ditch dead bodies. I lived in the swamps for three months, and, uh, by the time I was rescued, I was pretty much dying. I was a skeleton.

A participant with the pseudonym Joe, on the other hand, expressed that the genocide was traumatic for everyone, and witnessing killings are part of the memories that are imprinted on their minds and remain ongoing. Joe shared, “everyone was in a bad situation because to see someone killed or being killed is a bad situation. And for us still, we have that bad, um, picture in our, in our thinking.” Joe added due to the genocide; he was forced to witness his family killed. **“**Because you saw your brother, sister, parents, or your kid um, killed, or maybe you, you were attacked.” And for Joe, trauma is constantly present because the loss of family members cannot be reversed. In this passage below, Joe continued to describe what it is like not to see family again. He shared,

> But I cannot see them. I cannot see them. I cannot even say, ah, come and see me. I cannot go see them. That is another thing, which would give us, um, a trauma. Because you are, you know that you have your brother or your sister, your parents. Or you cannot see them. It is a big problem; it gives us very, yeah, yeah, it gives us trauma.

Amani, a non-genocide survivor, had spent seven years in refugee camp shared his understanding of causes trauma. Amani noted that a person with traumatic memories had to be present during the Rwandan genocide. He also added that life challenges could also provoke trauma. Amani said,

> Ah, in the camp, I was going to say; actually, there is no big trauma. Okay. There is no trauma, but the little bit of trauma is there about life. So, sometimes they face trauma. Yeah, and they, most of the trauma is caused by, ah, because of the genocide.

Similarly, Paul provided his view on trauma, stating that trauma is often triggered and exacerbated during the Rwandan commemoration period in April. He said,

> So, during April is where in Rwanda, they remember the genocide. That is when people suffer. Mental health issues usually happen in April because that is when to remember the genocide. Trauma is usually bad then.

Even though a few participants were explicit in describing their experiences related to trauma, it is worth noting five respondents disclosed that they survived the genocide but not all disclose their traumatic experiences. Notably, participants understood the concept of trauma as a phenomenon related to the genocide. As such, this next sub-theme highlights the effects of trauma as described mostly by those who endured the genocide.

Sub-theme 1a: Effects of Trauma Among Rwandan Refugees

Respondents who endured the Rwandan genocide reflected more on this sub-theme "Effects of Trauma Among Rwandan Refugees," where they discussed the traumatic nature of the war and its consequence on their mental health. John is distinctly unique, unlike the other participants. After residing in the U.S. for more than 20 years, married to a spouse that understands the Western concept of mental health enabled him to learn more about his suffering. In fact, he shared that he had been actualized to the Western understanding of mental health care, which motivated him to learn more about his mental health challenges. Therefore, during the interview, he explicitly shared the effects of trauma, listing numerous disorders such as PTSD, depression, and anxiety. John said,

> So, uh, during... after the genocide, there were the refugee camps, group homes, uh, the boarding schools. I had PTSD, I, I had PTSD. I didn't know what it was, but right now, I know, you know, I had PTSD. I had a lot of anxiety, depression, uh, and, uh, I was, was, was, of course, you know, on the edge of a mental breakdown.

In sharing this, John also shared the general experiences of others in his community who endured trauma. He shared that it was common for those individuals to experience flashback memories, anxiety, and paranoia. John disclosed, “Some have flashback memories, and others do have what you could call anxiety. Um, because of what happened and the paranoia and panic…” He went on further to share that with his knowledge and understanding of mental health, he noted several individuals with depressive symptoms who stayed away from their social group due to the illness. He stated, “I know some of them who have been depressed, could not even stand where other people can be because of depression.” While sharing about trauma, the researcher noticed that Paul often focused more on the general effect of trauma. For example, Paul indicated that trauma is stored in one’s brain, and experiences stored in the brain can always come back. He shared,

> Any war, any...kind of violence, issue happens. Events happen. Some people will lose their family members. Some people will face, troubling images, and ahh, I think that those are flash-back memories. Will come back anytime, or those kinds of emotional stuff will not go anywhere. Because it’s in the brain, and the brain anytime can go back.

Similarly, a participant with the pseudonym Ezra disclosed mental health sequelae from trauma caused bad dreams, flashback memories, lack of sleep due to traumatic experiences that haunted them and kept them awake most of the night. Ezra described,

> Uh, because, when, er, emotion comes from inside, then go outside how. Because when you start thinking of having those bad dreams about those flash memories – you are not gonna sleep enough. All night you’re going to have insomnia. Or have a lack of sleep. So, when you sleep like two to three hours, what do you think is going to happen early in the morning? You wake up with no energy and fatigue all day. So physically, you’re not gonna do well as you used to do.

Alternatively, Ben indicated that life decisions could provoke traumatic memories for him. Therefore, when such instances occur, his natural response results in poor decisions. Ben said,

> Even now, it troubles me. Sometimes when I have to make decisions of particular simple issues in my life and, uh, that image, that situation comes back. There are some I make such an erratic decision based on that experience, and there is a certain time I make bad decisions because of that experience.

For John, however, traumatic memories made him suicidal and scared of the past. He disclosed, “That was something that would make me leave the classroom because I would try to commit suicide, you know, many times and, you know, that, you know, scare me.” And for others like Ben, trauma was viewed as a chronic illness. Ben described,

> I think, uh, you know, this is the thing. Once you have been there for a long time, it becomes part of your life sometimes. You feel like you are immune to them. It’s like you have an antibody and an antigen in your body, and you cannot lay awake ... like if you have HIV in your blood, you know you have it. You, you, you, you, you, you’re not gonna get better off it, so you have to live with it. So, this situation is like HIV in my body. I know I have witnessed this, have lived this situation, so I try to cope with it.

Using the same analogy, Paul shared that it was normal to be immune to trauma after experiencing it several times stating,

> But as I told you, sometimes you get exposed to bad things, and it keeps happening and happening, and eventually, you get used to it, and it doesn’t affect you anymore. So that is what’s happening to that is what is happening to us. It’s like a, you get sick, and you keep getting sick, and there’s no medication, and you keep getting sick and sick and then eventually your body does not know what to do with it and decides to quit any minute

> against the disease. And then... Yeah, but it is I mean, it is not a good analogy, but you just accept what happens to us.

Furthermore, John stated trauma was chronic because trauma symptoms were part of his lived experiences. He stated, “All that, anything goes with you, you know, uh, PTSD. Uh, it has, uh, you know, it has attached me in that way.” John continued to describe that trauma had a long-lasting effect. He disclosed,

> And that’s something I remember I used to just knock on my keys and my heart is like, turn down the water and I would just stand off and uh, uh, you know, deal like what’s going on, and it is just water and uh, until I realize, Oh, that’s a reminder.

Apart from trauma experiences, the researcher also sought to understand how Rwandan refugees described their experiences post-resettlement and how they influenced their wellbeing. All participants discussed their resettlement challenges that varied based on their length of stay in the U.S. In essence, this next theme focuses on resettlement experiences.

Theme 2: Resettlement Experiences of Rwandan Refugees in the U.S.

The theme “Resettlement Experiences of Rwandan Refugees in the U.S.” emerged as participants reflected on various aspects of their resettlement experience such as community, finances, worries concerning family members back home, and navigating the new system. All these are discussed individually in the sections below.

Importance of community. Having a supportive community was highlighted as important during resettlement. While this is true, only five participants touched on the importance of community, but five others shared they experienced isolation from their communities. Reflecting on the importance of community support in fostering positive wellbeing, a participant with the pseudonym Ade stated that having access to individuals from his country was crucial as they paved ways for the new incoming refugees. Ade said,

> Yeah, yeah. I met with some of them so they tried to give me the advice of how I can live in this new life. Okay. And that was helpful. That was helpful for me. Yeah, just the people who came from Rwanda before me.

Correspondingly, John shared community support was essential because it was ingrained in their culture. In John's community, people helped financially as well as emotionally. John stated,

> You know we are typical, if you lose somebody, uh, if you are having, or you have some kind of back away, we chip in, and if you have some troubles, we can help each... I mean we typical African community that is, we are looking out for each other, and that most of them, I would say the majority of, of Rwandans in the USA, like let's say in down wage. Uh, yeah. We encourage each other. You know, we all, you know...the good thing about us, we are a few of us, which is good, so we know each other and the week, you know, everyone looking out for each other.

Furthermore, a participant with the pseudonym Bimana, from a different state than John, shared his church community was instrumental in providing a wide range of support: social connections, fundraising for weddings and funerals, as well as a place to receive prayer and comfort. Biamana said,

> The church is the only place that you can get people together. Weddings also bring people together- people come to support each other for wedding functions. Family deaths- the church goes and helps families- they give them financial support and prayers and comfort them.

But, Jane shared that her support system aided encouragement, saying, "Helping each other, visiting each other and helping in listening to each other." In addition to social support, Jane found it essential to talk to friends about personal emotional struggles, especially about past trauma and what happened in Rwanda. Jane said talking created positive relationships and rebuilt

friendships saying, “People go to friends, can help, talk, we can talk to that friend, depend, the more you talk, the more reconciliation.” Ezra suggested that having people in the community provided bereavement support, which is a critical component of the Rwandan culture during difficult times. For Ezra, a sense of support and unity in the community allowed people to forget the past and the current challenges. Ezra said,

> If somebody passes away, everybody contributes, you know, because according to our culture, in the African culture, we have to, to contribute to whatever is going on, forget war or what is going too bad, to help as we can.

Even though community support was found essential for some, a participant with the pseudonym Yoseph, Ben, and Ezra had different perspectives to share regarding the availability of support. Yoseph stated due to the genocide, his trust in the community was lost, "No one to care for me. First, you do not trust anyone anymore after going through the genocide. No community lost my trust in people." Ben elaborated that people who have not endured genocide experiences may not believe what happened during the genocide; therefore, he avoided sharing his experiences with others. Ben disclosed,

> There’re still things that, you know, people who never lived in that situation, kind of, cannot understand. Unless you lived it. If I'm telling you now, you know, it's really hard to believe it, but one of the problems I have is to tell this story. Because I think, if I tell this story, this story to someone who never lived it, they would think I'm lying. They would think I'm crazy.

Due to a lack of support and loss of trust in people, many participants kept their painful experiences silent. Ezra stated living with the genocide experiences often meant withholding his personal story because it is something that cannot be shared with anyone. Ezra said,

> Here, the problem is you live. You have problems, but you think nobody can understand my problem. You don't have anybody to share your problem with. You decided to, to be, yourself, self ... how can I say? You start to you decide to keep everything in you, yourself. You know, so, the problem is that, uh, here, you, you are isolated alone. You have a piece, but you have a physical piece, but there is something in you that you cannot share with anyone.

Ben shared experience of the Rwandan genocide changed his perspective about people in the community. While reflecting on his experiences, he gave the researcher an example of his first encounter with a job here in the U.S. He stated that, to him, smiling at strangers during the genocide period meant that you were about to be killed. After resettling in the U.S., he took on a customer service job where he was expected to smile at people. Ben described this experience to be difficult because it triggered a genocide experience. He described,

> So, during the war, people who came in without us want to hide their... or their, their anger. They come smile, uh, smiling at you. You think they're coming to rescue you, but it's a way to attract you and kill. So, when I remember that and someone is telling me to smile to someone I don't know, I feel like, oh, if I find I smile to someone that I don't know, it's like, oh, it must be the person who was coming to kill me coming smiling at me. And you are telling me to apply the same strategy people use to kill others. So – there are still things that, you know, people who never lived in that situation, kind of, cannot understand.

Ben continued to share the experience of trust stating,

> Trust is another issue. It takes a long time to trust someone. Especially coming from Rwanda, people are fearful. The Rwandan genocide caused this. You trusted someone one minute the next they killed you. There is that trust; we do not have enough people in

> our culture that will understand your experiences. No one will ever understand the genocide, what you have been through or, how do you share with people.

Although Ben expressed trust issues, he was not hesitant to voice some of the concerns regarding the nature of the resettled placement. He stated placing refugees in communities with no social connections could lead to social isolation. He stated,

> The problem is sometimes people, they come here, and they do not have contact with anyone because they are here like two weeks, one month without knowing the surroundings. And, you are not going to know who is there and be able to help him if you do not know, you know, he or she. So, that is another challenge.

According to Ade, adapting to the U.S. lifestyle felt socially isolating. He shared issues may arise; however, nobody would know how to help because people in his community met less frequently compared to back home. Ade said,

> So now they associate where we live. You may have a problem, but you cannot see anyone come to see you and just say, "Sorry," or... sometimes it happens. Yeah, that is a difference. Is it because people do not know or what becomes, I mean, like being associated in the U.S. we do not meet people like we used to meet in Rwanda. Yeah, that is the difference. Because everybody stays with his life.

Bimana stated, due to a different way of life in the U.S., Rwandan refugees lost a sense of community cohesion, unlike back home. Bimana said without community, people “died alone” and lived in isolation. He disclosed,

> People are isolated, dying alone, and it is not ok. We need to help each other. It is the nature of the system that does not allow people to see each other. Very isolating and very sad and no community like we always had in Africa. We have lost the culture because we

> are not able to see each other, or people do not know where to go and help each other. We need a lot of help.

While not prevalent among many participants, lack of role models was also discussed in the study.

Lack of role models. Similar to the importance of having good community support, some participants discussed the need for role models in refugee communities. Yoseph mentioned refugees were living in poverty because most of them had minimum wage jobs. Yoseph perceived role models as individuals who would assist in educating refugees on different job opportunities. According to Yoseph, without role models, refugees continued to experience challenges because a majority of them become complacent with the low income they earn. Yoseph continued to share that refugees transfer their earnings into their country's currencies which may appear to be more within that context; however, they fail to understand their income does not match their living standards in the U.S. Yoseph said,

> Poverty – people are living in poverty – no way to advance because they do not see anyone who has done it. Models would help to tell people they can do it. They can change their situation. No model keeps people in poverty. They all see each other, and making $10 is good because I have a lot of money in the African mind. If you have never made that people, you get super happy to have that and make that money. So, people do not think of something else.

Similarly, Ezra also emphasized the importance of community. Ezra said,

> We cannot even because of more Rwandans we start coming here in America maybe a few years ago. We do not have people from Rwanda who came before... who maybe... who finished the schools here who have maybe some organization or some of the businesses, some big jobs whatever. Those who can help us to say, um no, do this, do

> this, do this. So, other communities they came before, they came more years ago... so they have, they have a very big um, um, maybe associations.

In addition to community-related experiences, financial challenges were reported to influence participants' mental wellbeing during resettlement. More specifically, financial worries brought persistent anxiety among Rwandan refugees.

Financial worry. Some participants discussed their experiences related to financial issues or worry about income. For example, Jane, an unemployed woman with three children at the time of the interview, shared that she worried about how she would manage medical bills in the event that her children become ill. She stated,

> I worry about the health of my children. I do not have health insurance, so if my kids get sick, I worry about how I am going to pay for the hospital bills. I worry every day and pray for my kids every day.

Jane continued to say, "I worry about my kids' future, money to get to meet their needs." Likewise, Paul stated, "You know when you have a family, a wife and kids, you always worry about the future of your kids." Although employed, Ade shared with the researcher that he worried about money. Because he worked in a minimum wage job, Ade said, "Every day I worry about money problems. Okay. And I work every day; I don't see the money. Yeah. That's kind of a problem."

Joe informed the researcher that financial insecurity was something he worried about on a daily basis. Four young children and an unemployed wife meant relying on one low-income. Joe described this to be an overwhelming experience as he stated he had other financial responsibilities, such as repaying some loans. Joe shared,

> I have stress because each day I think about something which you are supposed to do, but financially I got to do that. Yeah. And whatever I have here... almost everything is a loan.

> So, I have that stress to say, now, how will I pay these loans? Because I'm doing this, the school for trucks is a loan. I have a car, that is a loan. I have a loan for building my credit, that is a loan.

Ezra, who is well engaged in this community, highlighted that financial strains caused depression and flashback memories of the trauma to some individuals. Ezra shared,

> You are gonna be kicked out of the house, and then you become homeless. It is the way in which even most of them become very depressed. They end up having those nightmares and those dark memories. Flashback memories because of what is going on with your financial situation.

Ezra and Amani associated financial stress to cause health concerns in the following ways. Ezra stated, "An African man will tell their woman, yeah, I am having anxiety because I did not pay the bill." Even though a number of participants did not discuss many issues related to accessing food in the U.S., Amani, however, suggested that stress-related financial challenges made people ill. He shared, "Because I know sometimes, you know, people may get, you know, they may even get sick, you know, thinking about all of, you know, 'I don't have enough food." Income and finances were not the only anxiety-driven experience reported by participants. Having left family members was concerning to them, respondents.

Worry about people at home (country). In addition to financial stressors during resettlement, there were a few participants who left family back home who shared that they worried about their safety. Yoseph shared, "You miss your family too; you worry about them. You left them behind. You do not know if they are ok. Being safe here is good, but what about your family in your home country?" Additionally, family separation fostered social isolation during resettlement. For example, Yoseph talked about how he felt lonely due to family separation and lack of friends in the community. He said, "You have no one to talk to; you have

no friends; you miss your friends, your community, and your people." Joe expressed similar feelings about isolation. He said,

> So, for us, we have that challenges because uh, we don't have those people who came before, who came a long time ago, who can teach us, who can show us... and you can even go somewhere to say, "Ah no, our fellow Rwandan, they have this problem, this problem." So, that's the only issue with, you know, with us here. Because you don't have anybody to talk to, to share, you know.

A participant with the pseudonym Moses, however, stated that losing his dad was an ongoing grieving experience that he and his family continued dealing with. Moses disclosed,

> Ahhh life over the camps is just it affects my dad was old, was having nothing like food, medicine, he is sick, then coz no one to take him to see the doctor, he passed away, just the only thing that affected us.

Difficulties navigating new the system. Stressors related to adjusting to the new system were also discussed. Despite the resettlement assistance that all participants receive upon arrival, some of them shared that it was difficult to transition into living independently and navigating unfamiliar systems. Ezra stated that he felt "dumped" after the three months of resettlement support. Ezra described,

> What's going to happen after three months when the refugees come here, we call it a honeymoon, they rent your house, they put everything inside, then the kids are going to school and then, after eight-month, all money they are going to cut out, and then they find you a job and then they will show you the bus, number one or number three- From here to go to your job, and then they dumped you.

Ben shared that transitioning to the U.S. life is difficult as integration took time. For him, he felt that he had to start all over again, which caused him tremendous stress. Ben admitted,

> You know, uh, from a refugee camp, you know, where life is totally different from life here. It was like, uh, you start from scratch. Everything has to start from scratch. Yeah. Which costs you much more energy than any other person.

Ezra, who assists in fostering transitioning experiences of African refugees in the community, shared some of his thoughts and daily experiences he encountered in the community. He mentioned that adjusting to the new systems had a pervasive impact on some individuals. Ezra shared these resettlement difficulties, including the inability to navigate the system, are often a cause of stress, depression, and suicidal behaviors. Ezra said,

> Somebody, you have never taught him or her how to navigate the system, what do you think is going to happen to him or her? What is going to happen? They are going to get depressed. Even they are going to, you know, some of them, they committed suicide. We have some cases where people end their lives because they cannot make it.

In discussing their experiences related to resettlement, Ben mentioned that they had to adjust to the different gender role expectations in the U.S. Ben shared gender roles differed in Rwanda. He stated husbands are often the main breadwinners while their wives assumed the caregiving role. In conversation, Ben told the researcher that reversed gender roles often created stress for both partners because they had to transition into the new responsibilities. Ben stated,

> So, I can say that in church-wise, it's not a problem. We tend to have the same belief, Christianity. It's not really a problem. But, money-wise, managing money, you know, paying bills, you know, like, back home, only the man, husband, is the one who knows how to pay bills. But here, the women, even the wife, have to learn how to pay bills because if a man is not there, you know, the wife should know how to do that. So, that's a different culture, too. The wife, the women, they feel like it's too much burden on me, you know? Man, man has to pay bills. Man has to know how to do everything. Do you

> know? And here, you both, because of equality... so, if you think we are equal, we need to know everything. We both need to know equally how to share everything.

As previous sections focused on trauma and resettlement experiences, this next theme demonstrates participants' perceptions of mental health, mental health experiences, and service use.

Theme 3: Barriers to Mental Help-Seeking Among Rwandan Refugees in the U.S.

The theme "Barriers to Mental Help-Seeking among Rwandan Refugees in the U.S." emerged while participants discussed their perceptions of mental health and the barriers that may hinder participants needing to seek care. For example, participants identified cultural factors such as stigma associated with seeking mental health care, lack of knowledge, economic factors, in this case, financial strain, and language barriers were discussed as some of the challenges and barriers that hindered Rwandan refugees from treatment.

Stigma of mental illness. Participants believed that stigma deterred people with mental health concerns from sharing their symptoms or admitting they needed care; thus, their preconceived ideas were aversive enough that individuals who needed care may have feared to ask for it to avoid the stigma. Ade stated that those who suffered from mental distress were perceived to act "crazy" or are seen, "foolish." For example, Ade shared,

> People think you are a crazy or foolish person if you have mental health issues. People do not seek mental health care. They do not want to be seen as crazy. Also, sharing about mental health is a risk. There is fear that the more you share, the more you are vulnerable. Many people prefer to keep to themselves, and others choose to drink. If you drink, you forget about your problems.

John also shared that mental health stigma generally made people keep their experiences silent. He described,

> They are going to call you crazy, and nobody who has those symptoms would not like to tell exactly what is going on because, because of that stigma, they are not going to let other people close to them to know what is going on.

Similarly, Ezra stated,

> Yes, I can say something about that. Because some people believe that PTSD, mental illness, is kind of like an abomination, it is a form of evil, kind of a voodoo-and this demon. They think that if somebody who is pure in spirit can pray for them, and then those things go away.

Because feelings of stigma were often patronizing, people avoided disclosing their mental health challenges to the public. Ben stated, “The only people, the neighbors or the family members, they know there is something wrong with this person.” And according to a participant with the pseudonym June, others concealed their experiences and engaged in behaviors. June shared,

> They don’t even; they don’t even think about it. It was just the same as typical; it was stigmatized. There is a stigma behind it, and people are scared to announce it. So, what they do, they do special meds. Meds, the one man, self-medicate, and stuff.

Paul also shared that if people have mental health issues, they are perceived as individuals who are needy and incapable of doing things on their own.

Paul said,

> But for the family members, I mean, they, they do what they can to make them, uh, comfortable the daily needs for like... But for other people from outside, uh, uh, I mean some people just, uh, uh try not to go around them and some people deep understanding and they just, uh, see them as people that, uh, need help.

Amani and Paul shared interesting perceptions about people with mental health issues that are important to note. Amani explained how mentally ill individuals are destructive and should be constrained and isolated. Amani disclosed,

> But sometimes, the equivalent is some crazy person; he can fight. He can break everything. They put him like this; he cannot say he cannot do that as an example. They put the buzzers on tradition, give it to him. Sometimes we cannot give, go out, or not.

Furthermore, Paul shared that those who had been exposed to trauma were individuals who are mentally disabled and stayed in isolation while family members provided care for them as Ben also shared earlier. Paul shared,

> Uh, I mean, they, uh, they still see that, and most of those people with a mental disability there is no go. They do not go around for the sights of everyone. They stay home all the time. And, uh, I mean it is because there is no, there is nothing that the, uh, it is, it is all about the family member. Whoever is to the person is the one who is responsible for everything. The patient himself or herself I do not know because he is mentally disabled anyway, so family members take care.

Similarly, Paul offered his thoughts about people with mental illness and described it below saying,

> So, has to, to extend to them cause it's really hard for them to understand what is, I mean, what is going on because depending on their cultural background, but when they see. I mean when they see. For them, they seem as if someone has a mental issue they think like, okay someone who has been running around and naked and just... Yes. That’s what they mostly think. That, that crazy person, yeah. So, if they see that person and they’re okay, yeah. So, this one is probably that of witchcraft or probably bad luck. But now they have, they have had the understanding that okay, maybe it's a drug addict or maybe it’s

> related to you know, the hardship of life. Now connect the hardships of life with their mental status, but few people, uh, see that connection. Not too many.

Furthermore, people did not consider exposure to trauma to cause mental health. A general understanding of mental health concerns is typically associated with bad luck or witchcraft. A participant with the pseudonym Judy said,

> Yeah. Okay, yeah. So, I mean, mental health I mean, some people take it differently. So, they may think that, uh, they may think that for someone to have some kind of mental issue... Maybe that is just for bad luck, you know. And maybe witchcraft. Bad luck or witchcraft, they don't really see mental health as a connection with the, uh, situation.

Additionally, John shared his stories regarding PTSD and how it was stigmatized within the Rwandan culture. This individual spoke about his experiences to educate the community regarding the importance of seeking mental health care. He shared his attempt to educate and explain the benefits of going to seek help. Here is how John expressed it.

> You know, once if we can get over that stigma that people get the help and people will live life. Cause, you know, a, a, anytime I tell people, especially my African people, I'll say, I, you know, I suffer from PTSD. They're like, "What? Are you crazy?" I'm like, "I'm not crazy. It's the same thing as diabetes. It is the same thing as, uh, you know, uh, other health issues." It's just like having a, you know, a, a, a, a, a torn ligament. You just have to deal with it and walk on it. Likewise, it is not a big deal. So, it's the biggest, biggest obstacles that I've faced, you know, to try to convince me, my people, to look for, to go to the...to seek help, because they feel like, you know.

Furthermore, stigma poses a particular challenge, as one participant noted that people might try to remain positive and resilient with the issue. Moses shared,

> But I said already, for someone who has a mental problem, he can't tell... he can't come from... scared to go from home to go to the hospital to say, "Ah doctor, um, I'm not feeling okay. I'm not feeling well." You know? Becausehe or she feels like, you know, he's okay. But what he acts, he acts. Whatever he does, he did; it's become long. So, for him, we can't know that he's in the wrong position.

In addition to stigma, lack of knowledge regarding mental health contributed to participants 'lack of mental health use.

Lack of knowledge. John expressed that he did not recognize he had mental health symptoms; however, after having received mental health care services, he was able to understand what he suffered from. He said,

> Oh yeah. I, I would say that here, I would spend the resources, the best thing I got here, is just, you know, being able to go to, to the hospital and, uh, meeting the, um, mental health, uh, worker or mental health specialist, who called that, who, who pointed out that I was suffering from PTSD. I didn't know what a post-traumatic disorder was. Sometimes, you know, like getting angry, then I was back to getting happy.

In the passage above, John is describing how, upon arrival to the U.S., he was linked to a mental health specialist who was able to explain mental health symptoms, and as a result, he was able to understand mental health. Without this type of interaction with a health care provider and openness to learning, he stated, "I, you know, I thought I was just crazy like everybody else." Similarly, Ezra stated,

> They do not know. The resources are there, but they need people to help them to get access to those resources. I think the services are enough, but the message is not really in the community about PTSD, what is it? About depression, anxiety, paranoia, about MDDD. And those kinds of sickness.

Furthermore, Ben shared that many individuals in the community are not aware that mental health services exist. He emphasized the importance of educating the community to foster help-seeking behaviors among Rwandan refugees. Ben shared,

> Also, uh, uh, many people that do not know that this service exists. You know. Go through the those community-based organizations and, uh, inform them, you know, educate them that there are these services. You know. So, people can use them. You might... I may; I may have the shop here say something. “But if I don’t let people know that I sell this service, nobody would come.”

In addition, another respondent reflected on the lack of knowledge, stating the importance of having resettlement agencies consider conducting assessments in creating awareness about mental health symptoms among Rwandan refugees who have endured trauma. Joe stated,

> Yeah. It’s why I said, if Catholic or IRC or another organization, or other health services can say, "Ah no. We have in this area – we have ten people from Rwanda. Let’s visit them. Let’s chat with them. Maybe those people because of the situation they pass through… They can have these problems. Let’s go and do that research we can know if they’re okay or not."

Comparably, Paul stated the lack of knowledge concerning mental illness is often due to the lack of understanding that exposure to trauma could impact one’s mental health. Paul said,

> Yeah. And then if you try to connect, let’s say to connect the, uh, mental health it is not congenital of course. It is not congenital. If you try to explain that depending on the condition of life, they were living in the impact that that has on their health. If you try to connect that to their mental status, mental status, people may not get it.

Paul stated further that disbelief of the illness made people refuse treatment. He described,

> You may not; you may not, you may not believe what they say. You may not; you may not accept that they are going to help because if your deep understanding will be denying on, on, on false facts. So yeah, I think if you have a, if you have a position of such understanding, and in disease. Somehow you are willing not to accept any kind of, uh, a Western type of healing.

Ben, on the other hand, voiced his concerns regarding mental health service availability. Through his engagement in the community, Ben suggested that his community needs education in creating awareness about the U.S. system and local services. While creating awareness is important, he proceeded to share that Rwandans have different cultural perceptions and beliefs of mental health. Lack of education about service availability and mental health understanding, in addition to language issues, were described to hinder the community from seeking care. Ben stated,

> You know? So many refugees, also, they have problems knowing which service. Where are these services located, how can they access these services? Uh, uh, it's our community of the Rwandese here in America who are not really aware enough of this system. So, they need... first of all they need, uh, education and the, they need transformation to believe how this system works. Yeah, after that, if being informed, they can make, you know, decisions. They can compare what they believe and, and what they are then informed about. So, the issue hasn't seen any such effort to inform the people about these services. Even if you see these leaflets, the posters are in English. People don't... the majority of them don't speak English. You know? So, I think, uh, it's going to be, uh, very tough to, you know, to know this, uh, system and get help from it. But, if the effort is, you know, is met to inform them, educate them, they can see the difference. And then decide which service to look for.

For some participants, seeking help for mental health concerns was their priority.

Help-seeking and financial strain. Given the opportunity to reflect on perceptions of mental health services, Ben discussed that it was impossible to seek mental health care prior to supporting the family and especially when resettlement medical insurance assistance was time-limited. Ben shared,

> But, it becomes very tough when it comes to health issues. Like, just of us, they have Medicaid, well, for six months. After that, no Medicaid. You have to work. You have to get your, uh, health issues and imagine, uh, someone... As you know, our African culture, we have so many kids, you know. So, you see the family comes with eight kids and the only... and those kids, all of them, they are under 18. Right. So, they, the working family, are mom and dad. Then, mom... excuse me. Mom and dad, they work for seven-point five dollars per hour. So, you expect that family to pay rent. Pay the basic needsof the kids and pay insurance for themselves. That will not be possible.

Similarly, due to family financial needs, mental health care was less prioritized to ensure basic needs were met first. Bimana shared,

> Mental health becomes less of a priority because people have to work to meet their needs. I cannot go see a counselor before I meet the needs of my kids, that is, making money so I can pay rent, pay loans for a car, and phones and all the bills I have. So, mental health is not something I think about. I think of surviving first. We don't even know what mental health is a lot of the time. We are just trying to make it here. We work 12-hour shifts. No way. Mental health – cost money – we are trying to pay other things that are due. Nobody would prioritize mental health.

Linguistic barriers and help-seeking. Linguistic barriers were shared to be another challenge and a reason why some Rwandan refugees experienced issues in seeking mental health treatment. For example, a participant discussed that due to language differences, most of them

often used translators when seeking care. This participant, who is also a leader in the community, expressed his concerns about using translators on the phone. He shared these concerns regarding the misunderstanding and miscommunication outcomes that can take place between the physician, interpreters, and the client. This participant was particularly unhappy with the lack of relationship when the health care provider used phone translation to care for individuals who had mental health concerns. He shared that doctors may not understand their culture, and to use phone translations to examine mental health patients meant poor service provision. Ben stated,

> First of all, you don't speak the same language as the doctor who is, uh, giving you the service. If they do it, they will call a translator, uh, on the phone. You, you cannot interpret a patient on the phone be... a mental patient on the phone. First of all, you need to observe his emotions. You need to observe the gestures she's, or he's making. And act as he is, so you are on the phone, you are telling the doctor, ay, the patient does this, this. First of all, the patient will not be treated accordingly… so that makes the service poor, the type of interpretation provided, and the way the doctors failed to understand the patient because of culture. Doctors don’t know the patient’s culture.

Judy shared that the language barrier made it difficult to express herself. Judy stated, "Language barrier, you don’t speak the language, so you struggle. You don't know how to express yourself." June reflected on the importance of language literacy in an employment setting and in learning the new system. June shared,

> Yeah, yeah, another challenge in language. Umm, mmm-hmm. Here is America, they use English, while in Rwanda, in my time, they use French. Kinyarwanda. So, to learn English...to be able to go to work, it is also another challenge. And to learn, as I said, the system. That learning, that English.

Despite the barriers and challenges to service use, participants identified a number of cultural coping strategies that are accepted and often utilized to help deal with trauma and resettlement stressors. This last theme illustrates those cultural strategies.

Theme 4: Rwandan Refugee Coping and Help-Seeking Behaviors Differ in the U.S.

This last theme, "Rwandan Refugee Coping and Help-Seeking Behaviors Differ in the U.S.," as briefly stated above, describes ways of dealing with mental health issues and different stressors. While sharing his thoughts on the mental health services in the U.S., Ben stated that many people from his culture do not understand mental health, and the lack of understanding could contribute to a lack of awareness about the illness. Ben shared that mental health is a phenomenon that is not well understood by Africans, especially refugees that are residing in the U.S. Ben shared,

> Those who are uneducated and, you know, majority of, uh, Africans and especially in Great Lakes, Rwanda, uh, do not have a good education, you know. So, they believe that, uh, they, they do not know such a thing as mental health as, you know, the way some world knows.

Ben continued to share some of the perceptions regarding mental health and healing approaches often used in this culture. He mentioned that when individuals in his culture observe certain behavioral issues arising, they often link such concerns to external factors such as witchcraft and spiritual causes. In such cases, Ben indicated that people would often seek help through church and church leaders to pray for those issues to go away, or others may seek help by turning to traditional doctors of witchcraft. Ben disclosed,

> So, they ... so, when things change, they believe, "Oh, this is witchcraft." You know? Yeah. This is witchcraft. Oh, this is demons. This is the devil. We need to take him to the church. The priest, here, the pastors, need to pray for him. They, this demon will be

> kicked out. You know? So, that's how they believe. And the other, they have to go find the witch doctor too, you know, to give them a little and say some citations but believe that, uh, the devils. And demons. That is how we believe. You know? So, like, like, every person, I think they believe, they believe that, uh, mental health is devils, uh, demons, you know, yeah.

In our discussion, Ben also shared information worth noting regarding the perceptions of mental health. He told the researcher that sometimes people link mental health issues to the relationship between a person and their ancestors. Ben stated,

> Our ancestors died, and they come back to this person and cause him to act in such a way he is acting. So, Nyabingi (a traditional healer in Rwanda) will come, and, you know, they will pretend Nyabingi will come and help calm down that person. So, those are different strategies. Different ways people use it. Christians will take the mental patient to the church. The educated people who know it are really mental issues, they will take him to the clinic for a psychologist or psychiatrist.

Despite the help-seeking options, it was interesting to hear Ben share his views. It is important to note that Ben is an advocate in his community for ensuring refugees have access to different resources, including mental health services. While he had knowledge about western mental health care, Ben preferred to seek care through his community. Praying and speaking to a pastor regarding emotional challenges was a norm for him. Ben said,

> So, um, the... Another way it is the the center ... where they go for, for, for different activities. Mostly by distracting myself, distracting myself into... or reading books most of the time. Uh, sometimes write in journals. Okay. And, um, all those... anything that interests me, uh, going to meet people, different people talk. I like to talk to people. Different story. Not like this story because it keeps me forgetting that story for a while.

> (he meant genocide) But sometimes when I'm alone, it comes back again, you know. They can go there to chat with people. With people who have that experience. We can go there to pray, to do what. We can go to churches. I mean, the people from church, like pastors or fathers, we can go to that area to try to chat with those people, pray with them. You know, uh, I can't say that it is traditional, but... it's not a hospital or clinic as such... but it's just a way to distract someone you know... because sometimes you can because... because, sometimes it's because someone is thinking too much... so he needs someone to distract him, to take him from those thinking to put him in another, another, another, another field.

Similarly, Yoseph stated to cope with trauma, people pray and give back to their community while others do advocacy work. Yoseph said,

> Some people also pray. In Rwanda, that is how people deal with it. You find others wanting to give back to their society a way of healing. They advocate for others. This is another way of rebuilding community and healing.

Religious coping practices, such as trusting God and working hard, were present as part of the coping strategies. Ezra stated, "To do things here truthfully people trust in God, but real people believe in hard work. And, er, some people cannot even afford their insurance." However, Bimana had a different perspective regarding help-seeking. He stated, "Rwanda culture is Patriarchic – especially men are supposed to be strong. You do not go share your challenges with anyone. You keep strong. You should be a man."

Not many participants in this study shared that they sought help through professionals. However, it is important to note the perceptions of the few that discussed professional help-seeking behaviors. Even though Yoseph was not utilizing this service, he stated that he did not

understand why mental health services were separated from the rest of the health care services. Yoseph said,

> I think mental health services should be considered part of regular health care services. Why do we need to separate it from other health needs? People do not get access to it because those with good insurance only are limited to them. If it was part of a health checkup, maybe people could use it more. It is limited to people with good health care coverage.

John, however, had sought treatment during the resettlement period in the U.S. While he does not utilize psychiatric services anymore, John expressed,

> I would say that here, I would spend the resources, the best thing I got here, is just, you know, being able to go to the hospital and, uh, meeting the, um, mental health, uh, worker or mental health specialist, who called who, who pointed out that I was suffering from PTSD. I didn't know what post-traumatic disorder was

Meanwhile, Ezra shared his hesitation to use pills for mental health disorders. He shared with the researcher that he felt counseling and therapy were better for healing. Ezra stated, “Medication is helping, but therapy and counseling can be better than medication.” Ezra was sharing about his experiences with the use of these services.

In addition to positive coping mechanisms, other participants discussed general maladaptive coping strategies common in their community. None of the participants in this study admitted to having utilized these strategies. Amani shared that some people may choose to engage in self-medication, i.e., alcohol consumption. Amani suggested that, due to resettlement stressors and prior life struggles, the easier way to cope with these challenges is to engage in “drinking or smoking.” Similarly, John said, youth is engaged in drug abuse, “That means the alcohol and um, you know, you know, young people now started using drugs. Drugs I’ll say are

now a huge thing; it's now a huge problem in our society." John was revealing some of the concerns that have caused issues among the youth in his community.

Furthermore, Bimana, another community leader, stated that he had noticed similar patterns that caused issues in the community. In his perspective, young people engage in these activities because their parents engaged in such. Bimana disclosed,

> Drinking and driving is another issue that I have noticed within our community. As a leader of the community, I see our people suffering from these issues. We come from Africa, we do not know the law, and people learn to drive. They drink and drive. It is not good. People get in trouble. It is a huge problem that we need to address. We need to teach about the law. We need to make this a priority. People need to understand this. You see, if parents are doing this, children are going to do that same. Children are going to repeat the same patterns because they do not have good role models. Children start drinking and get into drugs.

Another aspect that was shared was that people waited until it was too late to reach out, and as a result, people committed suicide. Ezra shared,

> But alcohol, alcohol, it is, it is very, especially those who live here, you know, I've, you know, they, I, and um, then we even lost a kid, uh, this, um, this summer, uh, he committed suicide. So, and they wouldn't know what it was, not until, you know, the the the mom called the nurse told us that he suffered from depression and anxiety. So that and nobody could talk about it because it's very, very taboo. So, it's not spoken in our lang... you know, in our culture. It's something very, very, I would say. It's; still, it's still a taboo in our culture.

Meanwhile, Joe discussed how mental health issues were difficult for people to openly share because individuals were afraid they would need to seek professional help. Therefore, living in

silence and pretending to be well was a common way to avoid sharing personal struggles with others. Joe said,

> But I said already, for someone who has a mental problem, he cannot tell... he cannot come from... scared to go from home to go to the hospital to say, "Ah doctor, um, I'm not feeling okay. I'm not feeling good." You know. Because he or she feels like, you know, he is okay. But what he acts, he acts... whatever he does, he did, it becomes long. So, for him, we cannot know that he's in the wrong position.

And Ben shared a similar perspective saying. "You know, someone who has that issue, first of all, he doesn't believe that he has that issue."

Summary

The purpose of this study's qualitative descriptive phenomenological study was to explore the lived experiences of trauma in adult Rwandan refugees who settled in the U.S. and the sociocultural factors that influenced Rwandan refugee's wellbeing. Findings from this study suggested that Rwandan refugees had diverse experiences, such as exposure to the Rwandan genocide trauma, resettlement stressors, and challenges in seeking mental health to include cultural barriers: adjusting to a new system, linguistic barriers, stigma, financial strains, lack of knowledge about mental health symptoms, lack of mental health services, and lack of trust. Such challenges were noted to hinder refugees from successfully integrating and utilizing the host culture mental health services. Despite the challenges, participants shared different coping strategies that were often preferred based on personal preference and understanding of mental health, including social support (i.e., friends, church members, and personal hobbies), religion, (or spiritual practices), and professional help.

Chapter Five:

Discussion

Introduction

The purpose of this descriptive phenomenological analytic (DPA) study was to explore the lived experiences (associated with genocide, migration, and resettlement) and socio/cultural factors that are associated with Rwandan refugees' mental health and well-being – unexplored phenomenon among this population in the U.S. The sample consisted of thirteen participants (seven in person and six telephone interviews) who self-identified as Rwandan refugees. The ecological theory guided the research questions, and data were analyzed using Colaizzi's (1978) five steps for DPA. Findings presented in chapter four provided insight into traumatic experiences and the effects of trauma, resettlement experiences, barriers to mental help-seeking among Rwandan refugees, besides, to help-seeking behaviors that differed from their U.S. counterparts.

These findings extend the literature on how untreated traumas may be exacerbated by socio-cultural aspects or migration to produce lasting negative effects on survivors. For instance, in the current study, survivors reported continued experiences of trauma-related challenges two and a half decades after the genocide. This study highlights the urgent need for relocation programs to consider mental health screening and support as refugees resettle in new environments. Similarly, the findings of this study extend the current literature on post-resettlement stressors to spotlight the pervasive influence of resettlement stressors on refugees' well-being. Collectively, the challenges that Rwandan refugees face cannot be resolved by one-size-fits-all or a silver bullet, but rather calls for development and implementation of multi-level and multi-component culturally attuned interventions that include participants cultural assumptions. The findings from the study also demonstrated that refugees 'experiences are

interconnected, requiring both formal and informal settings to collaborate to target their needs holistically. This chapter is organized such that findings are further discussed in relation to the previous literature, implications for practice, policy, and social work education. The limitations and strengths of the study and recommendations for further research close to the chapter.

Research Consistent with Previous Literature

Trauma Experiences

When participants were allowed to describe their lived experiences of trauma, the experiences of three Rwandan genocide survivors were prevalent on the theme of *Traumatic Experiences of Rwandan Refugees*. In this theme, respondents described atrocities of the 1994 genocide similar to those that have been documented by previous scholars. These findings were congruent with recent findings of Banyanga et al. (2017), who investigated the trauma caused by the 1994 Rwandan genocide among Rwandans residing in Finland. The current study found that witnessing or being forced to witness killings, being exposed to dead bodies, and experiencing torture were some of the traumatic experiences reported in the current study and consistent with the testimonies of other survivors (Human Rights Watch, 2003; Pham et al., 2004; Schaal & Elbert, 2006). Although a majority of the sample did not report having utilized any mental health services in the U.S., one participant that had used psychiatric services post-resettlement shared his mental health diagnosis during the interview.

During the interview process, these respondents identified symptoms that were much in line with other symptoms reported from existing studies conducted in Rwanda using quantitative methodology. The reported symptoms in the present study included on-going PTSD and anxiety (Fodor et al., 2015; Hagengimana et al., 2003; Munyandamutsa et al., 2012; Neugebauer et al., 2014; Pham et al., 2004; Schaal et al., 2014) as well as depression (Bolton et al., 2002; Brouneus, 2010; Eytan et al.,2015). Furthermore, genocide-related effects disclosed by participants

constituted flashback memories and panic attacks (Hagengimana et al., 2003), and the long-lasting effects of trauma (Schaal et al., 2012).

Suicidal behaviors, sleep problems, and feeling tired due to insomnia and chronic symptoms of trauma were also expressed in the current study. These findings suggested that Rwandan refugees, specifically genocide survivors, may continue to struggle with war-related traumatic effects post-resettlement. This knowledge is important and helpful, especially in informing resettlement agencies and health care professionals to prioritize screenings for refugees who have endured trauma and continued assessments during resettlement to develop trauma-related interventions specifically for this group.

Resettlement Experiences

Participants disclosed different stressors that contributed to their mental health distress of which were highlighted in the theme *Resettlement Experiences of Rwandan Refugees in the U.S.* Among the stressors discussed, financial worries were commonly reported and acknowledged to have caused mental distress among Rwandan refugees. These findings corroborate that of Sangalang (2019) documented that low-paying jobs caused depression and other poor mental health outcomes among refugees. In the current study, some participants revealed financial worries regarding their inability to meet family health care needs, and low-wage employment was associated with stress. These considerations are echoed in Kim's (2016) study among Latino and Asian refugees who experienced depression due to a lack of employment opportunities. Kim and Kim (2014) and Kim (2016) reported that financial distress negatively perpetuated the mental health experiences of Southeast Asian refugees during resettlement. These findings were consistent with the experiences of Rwandan refugees, who also shared that money problems triggered depression.

Participants expressed concerns about family separation one of the salient determinants of anxiety among resettled refugees across studies (Miller et al., 2018; Nsonwu et al., 2013; Tinghög et al., 2017) was reported to cause higher PTSD and depressive symptoms among Iraqi refugees (Nickerson et al., 2010) while the death of loved ones has been associated with social isolation (Tinghög et al., 2017). With Rwandan refugees, family separation triggered persistent fear about family safety and the death of loved ones generated insistent grief.

Additionally, existing findings indicated that refugees experienced depression due to reversed gender roles (Kim & Kim, 2004). Although depression was not explicitly reported in the current study, participants shared reverse gender responsibilities changed family dynamics, and those changes initiated stress within the family because individuals had to adjust to different family obligations. Further, difficulty navigating health care systems has also been reported to be one of the factors to poor mental health outcomes from previous studies (Cengiz et al., 2019; Ibrahim & Hassan, 2017; King et al., 2017). In this study, participants reported that they felt stressed and depressed while maneuvering the new system, and these experiences were coupled with the stress of having to start over and feeling abandoned when refugees' resettlement assistance ended after three months.

Interestingly, a community leader described that resettlement caused suicidal thoughts among some individuals and that integrating into a new environment was perceived as an overwhelming experience, especially for refugees coming from refugee camps. Participants in this study shared their experiences of social isolation, and this experience is directly linked to poor mental health (Li et al., 2016). Social isolation was correlated with family separation among refugees in previous studies (Nickerson et al., 2010; Tingog et al., 2017). However, Rwandan respondents shared that social isolation was a result of the busy lifestyles in the U.S. For instance, some felt isolated and lost touch with the community because of working long hours to

meet family needs. And for others, lack of community cohesion compared to that back home and have no access to other African refugees in the resettled community created isolation. Furthermore, while not true for all genocide survivors, lack of trust among people was one of the consequences of the 1994 Rwandan genocide and its aftermath. As a result of this, individuals felt vulnerable to openly share the massacre experiences, which resulted in isolation for some.

Coupled with resettlement experiences, individuals avoided sharing their genocide experiences. Silencing one's lived experiences is common, especially among African refugees from Burundi who have resettled in other western countries. In a study conducted five years ago, the authors noted that minimizing or choosing not to disclose their own traumatic experiences was seen as a form of protection (Puvimanasinghe et al., 2015). Additionally, minimizing such experiences was a way to make sense of own experiences of trauma and post resettlement adaptations (Puvimanasinghe et al., 2015). Previous qualitative findings also argued that fear to uncover mental health challenges might stem from the fear of not trusting one's information can be kept confidential, a factor that influences mental health disclosure among refugees (Shannon et al., 2015).

These findings provided evidence that resettlement surely is a stressful experience but varied among Rwandan refugees. Such evidence supported prior work suggesting that pre-migration challenges and emerging resettlement stressors directly impacted the well-being of refugees (Hynie, 2017. Li et al., 2016). Since participants in this study expressed different challenges that impacted their mental well-being during resettlement, suggest the need to explore strategies to examine how these stressors can be reduced.

Barriers to Mental Help-Seeking

Also, resettlement challenges and Rwandan refugees' perceptions of mental health care undoubtedly influenced their help-seeking behaviors. These experiences were delved into in the

theme *Barriers to Mental Help-Seeking Among Rwandan Refugees in the U.S.* During the interview, it was evident that participants associated numerous factors to their lack of health utilization. Those factors, as previously discussed, consisted of personal experiences such as financial issues, trust concerns, and inability to navigate the health care system, meaning some did not understand where to seek services. Other resettlement barriers discussed below included language issues, the stigma of mental illness, and lack of knowledge about mental health symptoms collectively influenced Rwandan refugees' mental health use.

The stigma of mental health, lack of knowledge and trust were interwoven in participants' narratives, and these factors were emphasized as key barriers to help-seeking among Rwandan refugees in the U.S. In fact, participants believed that individuals with mental illness were immobile, "crazy" "foolish," or useless and destructive individuals. Due to such labels, participants mentioned Rwandan refugees feared to disclose their mental health challenges to avoid being classified into these categories. Such descriptions implied that Rwandan refugees with mental health concerns experienced greater stigmatization consistent with the findings by Boise et al. (2013), who suggested that mental health stigma can have a negative influence on African refugees' perceptions, attitudes, and behaviors towards treatment. In this same study, Boise and colleagues (2013) also indicated mental health stigma was one of the stumbling blocks in mental health service use among African immigrants and refugees.

In addition to stigma, Rwandan refugees disclosed personal and structural barriers such as a lack of knowledge in recognizing their mental health symptoms and the lack of knowledge regarding mental health resources. Similar findings across refugee populations have reported refugees' lack of service utilization due to their lack of understanding of their symptoms as well as the lack of awareness of service treatment options (Yun et al., 2012).

Findings from the current study suggest the need for mental health support, specifically in educating refugees about mental health symptoms and creating awareness after resettlement. To support this population, it is important to foster community educational opportunities that can provide information on mental health symptoms. Increased knowledge and understanding may potentially increase Rwandan refugees' service utilization as needed.

Rwandan refugees endured financial distress, and linguistic barriers caused challenges in seeking assistance. Concerning finances, Rwandan refugees prioritized their basic human needs, such as feeding the family. Although two participants discussed having utilized mental health services and reported no language concerns while seeking help, a community leader explained in detail how the language issues impacted the experiences of others in the community. Despite the availability of interpreters, the community leader raised concerns regarding misdiagnosis and misunderstanding when assessing and providing services to a mentally ill client through telephone interpreters. Concerns voiced in the study were associated with the client's cultural perceptions, and taboos of mental health were shared to exacerbate confusion between the health care providers and the recipient. A study by Yako and Biswas (2013) indicated that language barriers lead to poor health quality. It is imperative to consider and come up with applicable solutions to improve the quality of care for refugees. One of the strategies that should be put in place should include training both interpreters and health care professionals about cultural aspects that may impede clients from accessing the care they need. Additionally, focusing on using locally trained interpreters that understand participants' cultural concepts of health may minimize miscommunication and misunderstanding. Collaborative efforts would foster effective care provision (Kirmayer et al., 2003).

Help-Seeking Behaviors

While collaboration may create opportunities to foster more exceptional health experiences for Rwandan refugees, holistic approaches in considering their help-seeking approaches may also improve these experiences. As noted in the interviews, it was evident that participants' ways of healing from trauma, mental health challenges, and resettlement stressors were different from that of the U.S as reflected in the theme *Rwandan Refugee Coping and Help-Seeking Behaviors Differ in the U.S.* Participants indicated that they often sought help through various avenues. Even though none of the participants stated to have utilized traditional healers and witchcraft doctors in the U.S., some community leaders alluded that seeking help through these individuals was common in their country. Additionally, it was disclosed participants' help-seeking behaviors were determined by the cause of mental health and their understanding of the illness. For example, participants stressed the importance of seeking care through their community, including a church, religious support, and talking to trusted friends. Religious practice, such as prayer, was stated to mitigate stress and diminish negative thoughts and emotions from trauma. Similarly, existing literature has identified similar coping strategies for psychological distress in studies with African immigrants residing in the U.S. (Isakson & Jurkovic, 2013; Simmelink et al., 2013). Some participants also indicated that having a support system such as attending church, being in a community with others of similar values and beliefs, or consulting with their religious leader was a great source of support that alleviated stressors for some. In line with previous research, support was found to be an important factor for psychological distress among Congolese youth as reported by Joyce and Liamputtong (2017) and among Sudanese refugees in the findings by Schweitzer et al., (2006). Specifically, social support for the Rwandan refugees meant having family, friends, as well as a community member, to talk to for emotional support. For some, support systems, such as having a community of other refugees from African during arrival to the U.S., was critical because they

contributed positively to their integration experiences. Besides, participants mentioned how those individuals helped in navigating the system to obtain different resources, which enhanced their resettlement experiences and fostered their wellbeing. Some participants also identified that social support came through the community where support contributed to their needs through assisting one another with child care needs and raising funds for memorial events or weddings. Having such a sense of community was a way to get through different challenges, especially during resettlement, and, as a result, reduced their stress levels. Keeping this in mind, it is beneficial to incorporate some of these coping strategies in practice.

Implications for Social Work Practice

Findings from this study demonstrate that Rwandan refugees' experiences and understanding of mental health are not only complex but also interconnected and interactive--informing social work practice with refugees (Eriksson et al., 2018). This study's use of the ecological framework to provide an in-depth understanding of refugee mental health and resettlement experiences lends relevant to advancing the development of targeted and culturally-attuned interventions for marginalized populations. Findings of this study contribute knowledge that will contribute to achieving four social work grand challenges of (1) closing the health gap; (2) eradicate social isolation; (3) create social responses to a changing environment; (4) achieve equal opportunity and justice (Uehara et al., 2013).

Microsystem. The microsystem consists of individual influences within a person's immediate environment. This system may include the individual's beliefs and persona (Bronfenbrenner,1979). Participants attributed different factors, such as exposure to trauma, to their ability to trust others on a day-to-day basis, which varied across participants based on age. For individuals who survived the 1994 Rwandan genocide meant they suppressed their own lived experiences to avoid being vulnerable or because they believed their stories would not be

believed. Trust, while identified on a microsystem level, can also influence how refugees seek mental health care services on a larger system (macrosystem). For example, distrust among people as well as other interrelated factors on this system (macrosystem) may be perceived as a barrier that is pronounced a refugee individual with such experiences while seeking help, Therefore, from an intervention perspective, it is important to build trust and understand the root of their trust concerns. A good place to start building trusted relationships with Rwandan refugees may include allowing clients to tell their stories when they are ready, allowing more time during therapeutic relationships, staying consistent but more importantly showing interest in wanting to learn client's culture would eventually lead into opportunities where Rwandan refugees may not feel vulnerable. By applying the principles of cultural humility as suggested earlier, where a client is perceived as an expert, could also foster positive experiences for them (Ortega & Coulborn Faller, 2011). Fear is associated with being a Rwandan, and a refugee was identified as barriers to care. Therefore, it is important to note that this may be a unique maladaptive coping behavior and may hinder this population from seeking needed care. Explaining the importance of consent and emphasizing the importance of consent may also promote trustable collaborations (Shannon et al., 2015). Others discussed stressors, such as gender roles concerns. Women often assumed caregiving roles in Rwandan; therefore, having to change these roles was part of the on-going adjustment for families. Perhaps integration opportunities specifically on labor-force participation for women during resettlement might be important.

Mesosystem. Mesosystem factors comprised of how microsystem factors interact with other factors, including those of the community, church, and social support (Bronfenbrenner,1979). Nine participants stated they attended a church weekly while four attended at least twice a month. Support from church, friends, and family was perceived to be

paramount for many individuals. Similarly, other studies have found that having access to support is critical for emotional well-being (Leaman & Gee, 2012) and social support such as the presence of family and friends has been reported as a protective factor for distress and resettlement stressors for refugees (Dako-Gyeke & Adu, 2015; Mitschke et al., 2016). Noteworthy, refugees from collective cultures such as those from Rwandan may benefit from group interventions. Previous interventions have focused on individualized time-limited interventions, such as narrative exposure therapy (NET; Gwozdziewycz & Mehl-Madrona, 2013; McPherson, 2012; Neuner et al., 2004), interpersonal therapy (IPT; Meffert et al., 2014), and eye movement desensitization and reprocessing (Acarturk et al., 2015; Ament-Lemke, 2018; Ter Hiede et al., 2011). The reliance of participants on support from their church, friends, and family could be an indication of the importance of collective cultures among the Rwandan refugees. Collective cultures are common within African cultures. Such cultures place emphasis on cumulative experiences such as those of others and less emphasis on individual experiences (Schlaudt et al., 2020). In line with collective culture values, some Rwandan refugees might find group counseling services more valuable than individual services. Hence, practitioners could expand service provision to refugee communities such as church settings where Rwandan refugees indicated to have received more of their emotional support. Not to mention, practitioners could adapt to Kaffa Intervention when conducting group counseling. Kaffa is a therapeutic intervention that is specific to East African refugees, which incorporates psychological and spiritual healing practices similar to modern group counseling in the west (Loewy et al., 2002). Kaffa intervention uses coffee in a group counseling setting where clients are given the opportunity to serve each other coffee, allowing space for others to be vulnerable without judgment and creating a supportive environment for those in the group. This intervention has been found effective among East African refugees and could be adapted to fit the mental

health needs of Rwandans (Loewy et al., 2002). While this may be favorable for some, it is important to conduct an assessment to understand the importance of these interventions among Rwandan refugees. Additionally, ensuring that Rwandan refugees have access to social connections might create a sense of connectedness in their communities and a decreased sense of social isolation for some.

Exosystem. Exosystem factors consist of those systems from the outside that influenced the micro and meso systems of a person. For example, displacement experiences and media (Bronfenbrenner,1979). Exosystem factors were less frequently discussed by participants in this study. However, a few participants shared their worry and fear for family safety, missing family members, and the death of a loved one. Practitioners should be aware of these factors and examine refugees' experiences from a holistic perspective. It is essential to be mindful that stressors of the family in the original home country or death of loved ones are part of refugees' on-going experiences in addition to resettlement factors in their immediate environments. Therefore, focusing on the ecological factors and the interactions within each system may be an effective way to target their diverse challenges (Miller et al., 2018; Worabo et al., 2016).

Macrosystems. The macrosystem represents the cultural and societal structures which also interact among the previous methods (Bronfenbrenner, 1979). However, different experiences discussed often overlapped. In this case, how the culture of a Rwandan refugee is influenced by other systems and, in return, impacted by societal perceptions. In this study, perception of mental health, beliefs of mental illness, the stigma of mental illness, language barrier, and lack of cultural interpreters and reverse gender roles were evident as part of interactive factors within Rwandan refugees' experiences. Mental health stigma is one of the most commonly recorded barriers among refugees. Shannon et al. (2015) argued that culture-related beliefs and perceptions of health shape individuals' understanding of health, which may

influence their willingness to seek care. Kleinman (1997) suggested the importance of exploring clients' understanding of health and illness in order to understand some of the cultural aspects that align individuals' views with regard to treatment and illness. As noted in this study, several factors cumulatively influenced Rwandan refugees' perceptions of mental health and help-seeking. For example, shame and stigma associated with individuals who had mental health concerns may have delayed their disclosure of these issues or resulted in them denying the existents of the problem. In addition, those with mental health issues, as earlier mentioned, were not regarded as relevant in the community. Therefore, to avoid such consequences, Rwandan refugees were common for them to suppress or deny emotional issues. Furthermore, since seeking professional health was not customary in Rwandan systematically contributed to the seeking behaviors of this population. Developing informative strategies targeted to dismantle negative perceptions of mental health such as stigma is needed among Rwandan refugees.

Chronosystem. Chronosystem examines transitions taking place over time and on each system discussed above (Bronfenbrenner & Ceci,1994). Life transitions for refugees are diverse, complex, and interrelated. For example, refugees are forced to leave their country of origin, which may result in family separation, their social system, and part of their culture. Additionally, refugee experiences in refugee camps can be detrimental. Evidence suggested that prolonged stays in refugee camps can be a daunting experience for refugees, and longer waiting periods at refugee camps can worsen their mental health (Li et al., 2016). Participants in the study shared that refugee camps were crowded with a scarcity of resources such as food, in the health care system, and insecurity. Upon resettlement, refugees were faced with challenges related to family separation and loneliness for some of the participants in the study. Post-migration, as discussed earlier, consists of challenges in adjusting to a new foreign social environment, difficulty finding employment, and new cultural norms. These challenges can be personal but influence the

refugees' larger system. For example, Rwandan refugees encountered social and systemic challenges. These consisted of linguistic barriers, economic challenges, lack of knowledge and awareness, challenges in expressing health concerns, in addition to cultural barriers such as stigma associated with mental health, all of which limited them in receiving care. Noteworthy, Rwandan refugees experiences varied based on one's age, length of time in the refugee camp, length of stay in the U.S., social-economic status but findings from this study suggest the importance of understanding their experiences holistically because of pre-migration experiences along with post-resettlement challenges may put refugees at risk of mental health issues. The adoption of Bronfenbrenner's ecological framework provides insight that individuals' factors all intersect and influence Rwandan refugees in different ways and on each ecological system. Using this framework calls for collaborative partnerships that create a holistic examination of refugees' risk and protective factors and targeted interventions for positive well-being for this population.

Policy Implications

As already suggested, a multi-modal approach is also critical in policy settings. This means that healthcare providers, resettlement agencies as well as community agencies have a role in fostering the well-being and resettlement experiences for the Rwandan community in the U.S. Participants in the study highlighted the limited time with refugee resettlement funds and the insufficient time given to learn about the U.S. culture. This process for participants created not only stressors but stirred previous traumatic memories for some. To ensure a smoother transition, it is important to consider putting programs in place where participants receive follow-up assessments about their progress during resettlement. This may include re-education about available services, employment options, and checking to ensure they are connected to their community or are integrating well and with no issues. Resettlement agencies could distribute

these tasks by reaching out to other communities such as churches or local organizations who can volunteer to host community events to educate these communities in their language. Having these in place would enhance community cohesion and foster positive experiences of refugees. Hynie (2018) suggested that to improve the mental health state of refugees during resettlement, receiving communities and arriving refugees both have to changes. This process requires collaborations, initiating social connections activities, and hosting learning opportunities to deconstruct stereotypes, attitudes, and beliefs about refugees, which in turn can shape the daily interactions and experiences of the newly arrived and those in the local communities.

Implication for Social Work Education

Educating social work students to understand heterogeneous among refugee experiences is important because these future practitioners have an important role in providing culturally relevant services to refugees. For example, educators should provide first-hand knowledge by inviting refugees as guest speakers. Guest speakers would expose social work students to learn real-life experiences of refugees who have endured trauma, migrations, and resettlement. Also, using different refugee case scenarios in classrooms would engage students to implement solutions as it relates specifically to refugees. In addition, the National Association of Social Workers [NASW] (2016) outlined a number of assessments that are critical when assessing at-risk populations, including refugees. In such cases, educators could invite social workers working with refugees to share and inform students on how these assessments play out in the field. Furthermore, including refugee policy analysis assignments, assigning research papers on refugees to work, placing students in resettlement agencies, and having students present on their work or internship experiences increases learning opportunities for students from various perspectives.

Limitations and Strengths of the Study

There are limitations worth noting in this study. There were more men than women in the study. Although, the snowball sampling method is recommended for the hard to reach populations such as refugees (Sulaiman-Hill & Thompson, 2011) this method of recruitment may have influenced access to more men in the study because the respondent's social networks were drawn from participants' groups. There are other factors related to the over-representation of men that may explain this as well. For example, exposure to violence may differ by gender. Even though every intention was made to ensure diversity in recruitment, the researcher noted that women often declined the interviews stating that the genocide occurred 26 years go, and they wanted to forget it while some shared they were afraid to share their stories because they felt that someone might be spying on them. This was common among women who were recruited to participate in the study, suggesting that their unwillingness to shared personal experiences may be related to fear or that trauma memories would come back. It is noteworthy that in previous studies that have examined the difference between men and women in response to trauma have indicated that refugee women who have experienced sexual violence are more likely to avoid trauma-related discussions due to guilt and shame (Ainamani et al., 2020; Alpak et al.,2015; Neuner et al., 2004). Even though the women recruited did not cite sexual violence as a reason for their hesitation, it could be a factor that may have played a role as well.

Furthermore, it might be worth pointing out that hegemony is prevalent in many African countries. That is the notion that men have the authority to make the final decisions for the family. While gender equality may not be dismissed within the African context, it is imperative to note that culturally, a man from a patriarchal society such as Africa considers a man to have authority over his wife (Connell & Messerschmidt, 2005; Stern et al., 2018). The researcher noted that even though she recruited families (i.e., husbands and wives), husbands who were

interviewed did not refer their wives to be interviewed in this study, suggesting that perhaps gender hegemony may have been a factor as well. In other words, since males had spoken in the interview, gender hegemony would suggest that male voices may have represented the entire family's stories as such explains why male participants never referred their wives to be interviewed.

Also, interviews were recorded and conducted in English, which was limited only to those who could articulate their stories in English. Even though participants understood English and confidentiality of the study, it is possible that recording interviews and language may have resulted in participants withhold information when sharing their stories. In addition to this, four participants self-identified as leaders in their community. These leaders often shared their experiences and of those in the community. While the information was pertinent and valuable, their perspectives of others may have different implications.

Additionally, the sample was highly educated. While this may not be a limitation, it is worth noting because certain demographics were underrepresented; thus, these findings cannot be generalized to the entire population of Rwandan refugees. The sample was also overly represented by participants who mainly stated they are Christian; therefore, experiences of those that have different religious values may vary. During data collection, the researcher intentionally excluded asylum seekers, many of whom were readily available in Texas. Their experiences would have enhanced the scope of this study.

Given that this was an exploratory study, the sample was drawn from Rwandans with various demographics, as shown in Table 1. Stressors and experiences were different based on these variables, and future studies should consider these factors when conducting research. For instance, some participants who experienced genocide discussed their experiences regarding this event while those born after the genocide shared their accounts as well. Therefore, it is important

to keep in mind that Rwandan refugees have a range of experiences, including genocide exposure, as well as resettlement, which shaped their lived experiences. Exposure to trauma differs across refugees, but evidence suggests that those exposed to trauma prior to resettlement often report increased PTSD symptoms five years after resettlement (Bogic et al., 2015). Thus, studies should consider these experiences separately. Also, the length of stay in the U.S., and availability of social support (other Africans in the community, access to African churches, and close friends) contributed to refugee mental health experience. As such, it not possible to rely on the finding of this study or generalize these experiences to others but rather acknowledge and consider these variations while examining similar topics. Additionally, two participants had sought mental health treatment, but the continuity of care was different for these two individuals. For example, one participant suggested the use of medication to alleviate mental health concerns was not their preferred method of healing; however, having knowledge of the mental health symptoms was important because it enabled them to identify personal ways of coping with trauma through non-medical strategies. This participant had a great social support system. On the other hand, the participant that utilized medication found it beneficial, however, this individual had spent less than two years in the U.S. and did not have social support (community member from own country to talk to) in their community. Hence, while informal coping strategies for distress was important, findings from this cannot be generalized as participants' help-seeking experiences were also diverse. Given that African immigrants and refugees commonly lean on their support system (i.e., family and church) for distress (Piwowarczyk et al., 2014), it would be beneficial to examine the correlation between social support and participants formal service utilization.

Despite the limitations, this study was the first to explore the experiences of genocide, migration, and resettlement and socio-cultural experiences that influenced Rwandan refugee

mental health and well-being in the U.S. The advantage of conducting qualitative research is its ability to capture in-depth narratives of participants' stories and the healing process that occurs as participants narrate their stories (Creswell, 2013). The study findings would inform individuals working with Rwandan refugees about the diversity of their experiences. From an ecological perspective, findings from the study suggest the importance of seeking to understand multifaceted experiences when working with Rwandan refugees.

Implications for Future Research

To address these limitations, future studies should consider sampling the experiences of women. Their voices would be critical in understanding their experiences and broaden the scope of research. Additionally, this study had a mixture of survivors and non-survivors, and future studies would likely benefit from separating and exploring these experiences separately. Such experiences could suggest implications in working with survivors, non-survivors, and as well as understanding their on-going preferred mental health treatment options. Future studies should also examine the lack of knowledge and understanding of mental health symptoms as well as the cultural barriers that may hinder individuals from seeking help a much-needed knowledge that would call for attention in developing strategies to increase participants' awareness of these symptoms and thus increase their help-seeking behaviors.

Given that the length in the U.S. was related to refugees' ability to connect with their community as well as connect to resources. It also seems that participants' access to similar cultural support systems fosters resettlement experiences. Examining these experiences on a continuum basis, for example, the use of longitudinal studies to explore the nature of resettlement stressors on genocide survivors and non-survivors, would be beneficial in tracking the mental health experiences of Rwandan refugees from different stages.

Conclusion

This study explored the experiences of resettled Rwandan refugees, which provided an understanding of the multifaceted experiences of trauma and resettlement among this population. Findings from in-depth interviews suggested that exposure to trauma and the effects of trauma differed for every Rwandan refugee. Additionally, Rwandan refugees faced different stressors during resettlement and their willingness to seek mental health services was influenced by their knowledge of mental health, varying trust level, the cultural association of mental health symptoms, stigma, language fluency, their awareness of mental health care. Addressing Rwandan refugees' mental and resettlement concerns can be examined from an ecological framework that emphasizes a multi-dimensional approach in targeting refugees' diverse concerns. This includes creating partnerships with refugees' existing support systems while assessing the immediate needs so enhance their mental health experiences as well as their services use.

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