Refugees' Well-Being in Countries of Resettlement
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Introduction

Refugee movements have been a feature of human history since its beginning and they have been narrated in Greek mythologies and religious texts, the eviction of Adam and Eve from Paradise and the Biblical description of Moses' exodus been only few examples. In the 1990s the United National High Commissioner for Refugees (UNHCR) estimated that there were 18 million formally recognised refugees (a six-time increase since the 1970s) and an equal or greater number of internally displaced, with 90% of war refugees finding safety in Third World countries (Summerfield, 1999).

According to UNHCR (2001) there are currently 21.1 million individuals of 'concern' to the agency or one out of every 284 persons on earth. These numbers include 12.1 million refugees (57%), an increase of the global refugee population by 4%, 0.9 million asylum seekers (4%), 0.8 million returned refugees (4%), 5.3 million internally displaced (25%), 0.4 million returned internally displaced (2%) and 1.7 million others of concern (8%). These statistics do not include those persons that become internally displaced or flee their country of origin but do not register with the Agency.

The major refugee producing countries are Afghanistan (3,567,200), Burundi (567,000), Iraq (497,400), Sudan (485,500), Bosnia-Herzegovina (454,700), Somalia (441,600, Angola (421,200), Sierra Leone (401,800), Eritrea (377,100) and Vietnam (369,100). Most refugees find safety in neighbouring countries; for instance most Afghans are hosted by Pakistan and Iran, most Burundians are found in Tanzania, most Iraqis in Iran, and within Europe most refugees from Bosnia-Herzegovina are found in Yugoslavia and Croatia (UNHCR, 2001).

After Asia, which hosts 40.4% of the total registered refugee population, Europe is the second major receiving region in the world, with 26.7% of the total number, followed by Africa with 25.3%, North America with 4.9%, Latin American and the Caribbean with 2.7%, and Oceania with 0.4%. In 2000, compared to the size of the national population, the main refugee hosting countries were Armenia with 80 refugees per 1,000 inhabitants, Guinea with 59 refugees, Yugoslavia with 46 refugees, and Congo with 43 refugees.

Worldwide there are 896,000 individuals seeking asylum, that is the right to be recognized as *bona fide* refugees and the legal protection and material assistance that such status implies. In 2000, Germany received the highest number of applications (117, 650) from Former Yugoslavia, Turkey, Iraq, Afghanistan and Iran. The United States was second with 91,600 applications from China, Haiti, Mexico, El Salvador, and Somalia, and the United Kingdom was third with 75,680 applications mainly from Iraq, Former Yugoslavia, Sri Lanka, Afghanistan, and Iran.

Despite the high numbers of individuals forced to flee violence, only recently has forced migration gained recognition as a legitimate inter-disciplinary academic field of research and teaching (Harrell-Bond & Voutira, 1992). Assistance to refugees, the authors argue, relies on the premise that refugees are a transitory phenomenon of crisis and thus only temporarily relevant, and that human nature is best served in a sedentary setting, which means that "refugees have been re-defined as cases for more or less permanent international welfare" (p. 7). They find themselves unable to return to their country of origin, forced to spend years and at times decades in limbo in refugee camps or waiting to be granted asylum in countries of resettlement.

The aim of this paper is to examine the changed nature of refugee movements over time; to place the understanding of refugee well-being in a socio-cultural context; and to analyse the relationship between re-settlement programs and refugee well-being. The author suggests that the changed nature of conflicts worldwide has resulted in a modified profile of refugees seeking asylum in Europe, thus raising cultural, social and political challenges for understanding refugee well-being and integration. In this paper it is argued that since the 1950s social policies and programs for refugees have moved away from regarding refugees as healthy

productive individuals towards seeing them as dependent and traumatized (sick) persons, in this way promoting their marginalisation from host society and negatively impacting on their well-being.

Changes in the nature of refugee movements

Even though refugees have existed as a historical phenomenon for a long time, they have acquired a legal identity in 1951 with Governments' endorsement of the Convention on the Status of Refugees. The definition of refugee, according to Article 1 of the 1951 Convention, applies to any person who owing:

> "... to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country: or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable, or, owing to such fear, is unwilling to return to it."

The drafting of the Convention took place soon after the genocide of Jews in World War II to prevent a potential re-occurrence of the Holocaust at a time when tensions between western and eastern blocs were augmenting and prior to the independence of States under colonial rule. Only 35 States were involved in drafting the Convention and they were the most powerful ones. The Convention was written with particular types of refugees in mind, Caucasian refugees moving to the west, individuals whose claim to refugee status could be ascertained through their specific history (e.g. Jews) and those who were politically opposed to State powers (e.g. fugitives from the communist bloc). The notion of the 'Other' in ethnic, racial or cultural terms was not a relevant issue and neither was the idea that individuals not actively opposed to State powers could move to the west as collectives.

However, over the last fifty years conflicts have dramatically changed in nature and consequently the profile of those seeking asylum and refugee status has altered. While in the 1950s there were nine active wars at any one time, their number has increased to 50 in the last few years, and 160 wars have occurred in post-colonial Third World since

World War II (Summerfield, 1999). The nature of conflicts has changed in ways that have dramatically altered the social fabric of entire nations, that have challenged the distinction between civilians and soldiers, and that have modified existing ways of lives of entire communities. Summerfield (1999) describes six major changes in the nature of conflict. First, over 90% of modern conflicts are internal ones, impacting on psycho-social relations amongst individuals belonging to the same nation-state. Second, the number of civilians becoming targets of violence has dramatically increased; in WWI civilians constituted 5% of all casualties, in WWII the percentage raised to 50%, in the Vietnam War to 80% and in modern conflicts civilians make up 90% of all casualties. In modern wars, individuals do not feel safe in their homes independently of political activism or social identity. Third, ways of life are purposefully targeted to damage collective self-esteem and identity. For instance, the Guatemalan army destroyed maize crops as a way of undermining the essence of Mayan identity fully aware of the symbolic identification that Mayans have with maize, which find expression in their self-designation of 'the people of the maize'.

Fourth, individuals holding symbolically significant jobs that represent collective values, such as trade union and religious leaders are targeted to demoralize the entire community. Fifth, sexual violence has become a weapon of war to ethnically cleanse or to attack the honour of the family resulting in loss of identity and stigmatisation. Sixth, infrastructures are destroyed to prevent information sharing and leading to social isolation. Therefore, Martin Baro points out (1988), in modern conflicts it is not just individuals and interpersonal relationships that are affected by violence but the total social fabric of society, a phenomenon that he calls social trauma and that is essentially different from individual trauma.

The changed nature of conflicts has resulted in new types of refugee movements. In the 1950s, individuals escaping from the Soviet block were welcomed as heroes and voters for western democracies while surviving Jews were assisted to appease western nations' guilt for having allowed the Holocaust to happen. Refugee movements were mainly taking place from and to industrialised countries. In the 1970s, as a result of the Southeast Asian war, Cambodian and Vietnamese refugees came to the west in groups from a socially and culturally different region of the world. In the

1980s, Latin Americans, escaping ruthless dictatorships, were welcomed in Europe as supporters of democracy and fighters against easily identifiable despotic regimes.

Currently, most refugee movements happen as collective displacements (rather than individual ones) due to persecution of ways of life of entire communities. Due to the internal nature of current conflicts, it is more difficult to distinguish the oppressed from the oppressors or to simply identify the reasons for new refugees' well-founded fear of persecution. They are the elderly, women-headed families and children that may not be well-versed in articulating the political reasons that justified their flight and are therefore more susceptible to mistrust on the part of Home Offices in European countries with regard to their genuine claim to seek asylum. Refugees coming to Europe nowadays are mostly non-Caucasians, they represent the 'Other' that is different and therefore potentially threatening with regard to culture, integration and identity.

In a changed socio-political world system, assisting refugees and asylum seekers that come to Europe is a challenge for policy makers and practitioners, who struggle to promote refugees' well-being and integration into host societies. In this context, psychological concepts and interventions have become more and more prominent both as ways of making sense of the refugee experience and as approaches for assistance to refugees, and it is the task of the next section to examine their role in promoting refugee well-being in countries of re-settlement.

Well-being in socio-cultural context

In Europe, refugee well-being is conceptualized according to dominant western models of individuals' place in the world, and refugees' well-being (of the mind) has become the domain of western psychology, with psychological concepts and interventions being the predominant ways of interpreting refugee adaptation to the west and shaping interventions, including social work, with refugees in resettlement countries. But western psychology is only one potential way of understanding the individual and her or his well-being.

In the west, assumptions guiding life rely on the concept of the individual as a distinct and

independent person capable of self-transformation in relative isolation from particular social contexts (White & Marsella, 1982). Entire nations can be categorized as individualist and collectivist societies (Triandis, 1995) according to the degree to which they adhere to the concept of a distinct as opposed to an interdependent nature of the individual in society. Within the individual herself/himself, there is a further separation between body and mind, a concept that derives from western philosophical thought dating back to the 17th century when Descartes articulated the split between the tangible body, the domain of science, and the intangible mind, the field of theology (Swartz, 1998).

As a result, a separation between physical and mental well-being has occurred. Medicine has concerned itself with treating individuals whose physical well-being has been impaired while religion has been replaced by psychology in healing mental suffering. As a cultural product of western thought, psychology assumes the independent nature of the individual and it is interested in his/her intra-psychic nature. For instance, Maslow's hierarchy of needs (1943) describes a ladder of needs (biological, safety, attachment, esteem, aesthetic and self-actualisation) that must be met in order for the individual (rather than the group) to achieve intra-psychic (rather than social) self-fulfilment. Individuals engage in specific relations with others and with the natural environment in order to maximize well-being and self-actualisation. The survival of the fittest and control over nature are thriving forces behind the achievement of well-being, as the capitalist model of productivity and recent experiments on cloning and genetically modified foods testify.

The ways in which people express, experience, and give meaning to their well-being are shaped by specific social and cultural beliefs about the origin of afflictions and health. In western psychology, the cause of distress is located within the individual and responses rely on individual therapy (Boyden & Gibbs, 1997). Thus recovery is achieved through helping patients deal with their intra-psychic world and come to terms with traumatic experiences. Healing is mainly held in private sessions aimed at 'talking through', externalising feelings and afflictions, an approach culturally shaped by old religious traditions such as the institution of the confessional, that is now part of societal 'common sense' especially among the middle classes.

However, western psychology is only one of many

indigenous ways of understanding individuals' behaviours, emotions and thoughts, in other words it is one among many indigenous 'psychologies', each shaped by specific socio-cultural conditions and environments. In other non-western traditions, assumptions about the individual rely on different premises according to which the individual is part of the group, body and mind are one, and relations with nature, other living persons and the spirits of the dead are harmonious.

In Hindu tradition, an indivisibility of the 'true' self (*atman*) with the one-ness of God is assumed, and life is only one manifestation of the soul that is reborn again and again. While western psychodynamic therapies trace individual current problems back to childhood experiences, Indian Hindus philosophy explains current life events according to experiences that are traced back prior to childhood onto previous lives.

Among Latin Americans, specifically Guatemalan Mayans, a link between social and natural suffering is found and 'sadness' of violence is something experienced not just by humans but also by all other elements that have been violated. When Guatemalans touch the earth they can feel its sadness and they can taste it in the water (Smith, 1997). Guatemalan Mayans have drawn on Catholicism, animism and the politics of oppression to make sense of their suffering as war-victims and refugees. Mayans relied on concepts such as malignant fate, ancestral punishment and malicious envy to interpret violence and to cope with it (Zur, 1994).

In other traditions such as the Southeast Asian one, life and death are not sharply separated or isolated. The spirits of the death may come back and hunt survivors unless proper rituals are performed to ensure transition from this world to the one of the spirits. In Vietnam the 300,000 still missing nineteen years after the war with USA ended are considered wandering souls. Culturally bereaved Cambodians continue to feel guilty about abandoning their homeland and their unfulfilled obligations to the dead and, haunted by painful memories, are unable to concentrate on daily tasks. Cambodian adolescents in Australia that were able to practice traditional ceremonies adjusted better than those in the USA that felt pressured to conform to western values (Eisenbruch, 1991).

Honwana (1999) writes that in Mozambique people perceive well-being as a natural state for all human beings, a life process that is based on the harmonious relationship between human beings and the environment, between human beings and the spiritual world, and between human beings within their environment. The social (the spirits and the living) and natural worlds are united within a larger cosmological universe. Thus rain should fall at its ordinary time, crops should grow, people should not fall sick, and children should not die. If this harmonious state fails to come about, it is perceived to be the result of the intervention of malevolent forces, or the sanction of ancestral spirits for incorrect behaviour, or a sanction of other spiritual forces. Ill-health is therefore a social phenomenon that results from an imbalance in these relationships. Similarly in Burkina Faso (Fainzang, 1986) ill-health is an event that marks an alteration in the normal course of life of individuals and groups.

The emphasis is not placed on the individual self as such but on the collective body that can interfere and affect the well-being of the person in ways that the individual cannot control. It is not only the well-being of the individual that is at risk but that of the community and a complex set of rules and practices are put in place to maintain a balanced state of affairs. In non-western settings, treatment is not focused on intra-psychic problems within the individual but it aims at addressing those entities, 'located' outside the person, that are believed to be the source of the problem.

Traditional healing adopts a holistic approach that combines divination, rituals and herbal remedies. Divination is a method employed to 'diagnose social life', that is the state of the individual's relationships in the community (living, dead and nature) that are believed to have been the social origin of the physical manifestation of the affliction. Herbal remedies are given to suppress bodily symptoms and rather than individual sessions, rituals are organised. Rituals specify what should happen and when and in this way they form a structural framework that fulfils a number of functions: they give meaning to the experience; they allow the expression of emotions; they spare those involved from having to make decisions during a disorganized moment of life; and they give the possibility to settle unresolved conflicts. They not only involve the individual but the family, neighbours, community, and the dead. During these rituals people do not talk but perform symbolic actions aimed at putting aside the traumatic experiences to allow a fresh start. Talking about

the past corresponds to allowing malignant entities to come back and disrupt the balance. For Mozambicans forgetting about past events is a means of coping with them and Ethiopians call it 'active forgetting' (Summerfield, 1999).

These examples highlight the importance that culture has in shaping meanings about the individual, his or her relationship with the natural, social and spiritual worlds, and well-being. Culture change and cultural contact are important aspects of the refugee experience and they are relevant both for an understanding of how refugees interpret events and for social interventions across cultures. The refugee experience is characterized by involuntary movements leading to exposure to different ways of life, a phenomenon accentuated by the fact that some refugees reach western countries, where culture distance is greater than that of neighbouring countries. The next section examines how re-settlement policies, cultural beliefs and well-being interrelate.

Re-settlement countries' policies and well-being

Re-settlement policies have an impact on how refugees adapt to host countries, how they are perceived by mainstream society and what opportunities they are given after their arrival in Europe. This section provides an overview of policies and programs for refugees from the 1950s onwards, focusing on the link between re-settlement programs and well-being.

In the 1950s refugees generally come to Europe on their own initiative and they integrated into their new societies mainly through their own personal resources or connections (Harrell-Bond, 1999). Cultural adaptation was not an issue as most of them were of European or western backgrounds, and linguistic and social assimilation was taken for granted as the desirable outcome of successful adjustment. When individuals manifested visible signs of distress and maladjustment they were treated within a biomedical framework in psychiatric wards (Ager, 1999). Mainstream social work programs did not address the specific needs of refugees because it was assumed that refugees would either successfully assimilate or being care for by the medical system.

In the mid-70s and early 80s refugees began to arrive to Europe from South-east Asia, Africa

(Uganda), and Latin America. With their distinctively different languages, beliefs and ways of life they challenged the assimilationist model of adaptation. In the United Kingdom, dispersal was adopted with the goal of integrating refugees into British society. Newcomers were helped to settle in, mainly through language training at reception, housing support and vocational training. It was assumed that communities of the countries of origin would look after the social and personal well-being of their members while social workers were beginning to be involved in re-settlement programs. Evaluations of these programs indicated that resources should not have been used only at the beginning of re-settlement, that housing availability should not have been the criteria for choice of locations, and that dispersal should have been more sensitive to economic planning (Bloch, 2001). When refugees manifested adjustment problems or mental distress, efforts were made to address them not only through individual medical care but also by setting up development programs and community mental health projects (Ager, 1999).

The 1980s were an interesting decade in terms of re-settlement programs, policies and debates. In the 1980s different countries adopted different approaches to address the needs of refugees. Steen (1992) conducted research on the impact of policy on Tamil refugees in the United Kingdom and Denmark. At that time the Danish government funded an elaborate program for refugees that consisted in 18 months of training in language and 'culture' to help refugees become acculturated and integrated into the Danish labour force. Provisions for such training could last for up to five years. Nevertheless, she found that unemployment among the Tamils remained very high and that Tamils became socialized to behave, as their social workers describe them, 'like children'.

In Britain, Tamil asylum seekers were generally accorded the status of 'exceptional leave to remain' rather than full refugee status, and that meant that they were only eligible for minimum social welfare benefits. Her study showed that Tamils in Britain behave very differently, with some of them holding three jobs at the same time and being described as 'Thatcher boys'.

In European countries, debates on the meaning of multiculturalism, cultural pluralism, and integration were ongoing while cultural awareness about refugees' needs increased among social workers, resulting in the development of cultural awareness

training and in the use of cultural interpreters for the implementation of social programs.

In the 1980s, the term Post-traumatic Stress Disorder (PTSD) was being used in the United States to describe the problems that American Vietnam war veterans were experiencing after returning home. The war was seen as the traumatic event and the term post referred to the experience of returning to 'normality' after having experienced trauma (war). The term was subsequently used to make sense of refugees' experiences in re-settlement countries to distinguish the traumatic experience of war that had occurred prior to their arrival in re-settlement countries from 'normal' life in host societies. Refugees' psychological difficulties in adjusting to life in European countries were attributed to the intensity of the trauma of war, to past experiences undergone outside the country of re-settlement, ignoring the role that host countries' policies, the adjustment process itself, or the way refugees were treated after resettlement could have had on their well-being.

Reactions to the widespread use of PTSD emerged but were framed as cultural rather than political discourses. The term 'cultural bereavement' was proposed (Eisenbruch, 1991) to acknowledge the importance of cultural meanings in interpreting and dealing with psychological and social difficulties. This had an impact on programs for refugees that were then supported to maintain their culture and to perform rituals as ways of dealing with their past and of overcoming cultural differences.

The PTSD versus cultural bereavement debate took place within an international climate of discussions on health in general that resulted in a major conceptual shift in the definition of health by the World Health Organization. Health was re-defined not simply as absence of physical ailments but as a state of physical, mental and social well-being, away from purely medical models towards holistic and social approaches. Increased awareness of the importance of social health meant that assistance programs, including social work, had a role to play in promoting well-being by implementing programs that recognized refugees' needs as cultural, social and collective ones.

Since the 1990s, refugees' quality of life in re-settlement countries has deteriorated, and consequently their well-being has diminished. European countries re-settlement policies are

becoming more and more exclusionary and they tend to marginalise those in need of asylum. In efforts to unify a diverse Europe and to strengthen a European identify exclusionary policies tend to represent migrants, refugees and asylum seekers as the outsider, the other, the un-European.

Deterrence policies such as border patrols and airlines fines for passengers without visas make it almost impossible for those fleeing persecution to reach Europe legally. It has also become more and more difficult for those escaping violence to obtain refugee status, forcing them to months and years in limbo while waiting for their asylum claim to be assessed. During this time they are placed in separate accommodations or in detention centres and in some countries such as the UK, most of their subsistence support is given through vouchers instead of money. They have to rely on the welfare system for their subsistence, which in the United Kingdom is approximately two thirds of that allocated to a national on welfare benefits. They are confined to lead their life in separate and visibly different physical and social worlds from those of other residents, making it virtually impossible to integrate.

In February 2002, the UK government drafted a policy document on Asylum and Immigration in the UK entitled *Secure border, safe haven: Integration with diversity in modern Britain* (draft, 2002), whose title itself emphasizes the government agenda of deterrence and secure borders, while the term integration is not clearly reflected in the text of the document where either assimilation or separation are promoted. The document contains a section on citizenship that deals with the rules that refugees and migrants must fulfil to obtain citizenship such as language proficiency, oath of allegiance to the Queen and knowledge of rights and responsibilities associated with being British. This section represents a policy change away from more pragmatic approaches to citizenship found in previous policy documents towards a symbolically charged meaning of identity (JCWI, 2002).

At the same time, separate accommodation, support to detention centres, and long-term reliance on the welfare system separate asylum seekers from the rest of the population and prevent them from becoming the productive citizens that the 1950s refugees were. These policies are implemented by local authorities, non-governmental organizations, and social workers, which have

become instruments of the State's policy that promotes dependency and marginalisation.

The role of refugee communities in taking care of the social needs of their members has also come under scrutiny. Walbech (1998) writes that Kurdish community associations in London are divided according to political affiliations and countries of origin. While these associations give language classes and legal advise to those refugees and asylum seekers that share the same political views, they marginalise those who do not hold strong political positions and women, who are socially invisible. Similarly, Eastmond (1998a) writes that Bosnian associations in Sweden are associations for Muslim Bosnians to the exclusion of Bosnian Serbs and Croats.

The war in Former Yugoslavia has raised public consciousness about the psychological needs of refugees, which have been formalized within the 'trauma' paradigm leading to what Eastmond (1998b) calls the medicalisation of refugees. This tendency is visible in the UK when refugees are forced to adopt the label 'in need of psychiatric help' to be exempted from dispersal on the grounds that the only services available are located in London.

The medicalisation of asylum seekers and refugees reflects a return to a biomedical model of well-being according to which the problem is individual rather than socio-cultural, that it lies within the person and not with the system, in past traumatic experiences of war and not in current re-settlement programs that undermine asylum seekers' sense of dignity and the fulfilment of their potential as productive human beings. Nowadays asylum seekers in Europe are not assisted to find jobs but they are given counselling, promoting and perpetuating a 'sick' label (traumatized) as a way to capture the essence of their experience of refugees and asylum seekers.

The paradox is that when individuals fleeing similar circumstances are assisted in their countries of origin as displaced populations or in neighbouring countries, different paradigms are adopted. For instance, assistance to Bosnian refugees within Bosnia or in other Republics of the Former Yugoslavia is implemented within a psycho-social framework. Ager, Buss, and Jacobs (1995) describe assistance to Bosnian war-victims by using the picture of a pyramid at the bottom of which there are political interventions, followed by physical/survival interventions, and then psycho-social interventions, which include emotional/social survival interventions, task-oriented interventions, psychologically oriented group interventions, counselling interventions, and intensive psychotherapy interventions. It would seem that political and socio-cultural analyses of assistance programs to displaced individuals can only take place outside the European context of re-settlement, with Europeans feeling that they have a right to point out the role of political interventions on well-being in contexts of violence, a right that we seem to find more difficult to exercise within our national borders.

Conclusion

This paper has examined refugees' well-being in a socio-cultural context, which is affected by the changed nature of refugee movements and by re-settlement policies and programs. It has been suggested that features of conflicts worldwide have altered resulting in a new profile of refugees seeking asylum in Europe. Cultural, social and political challenges for understanding refugees' well-being and integration have ensued. Interactions among asylum seekers, refugees and helpers in Europe are often instances of cross-cultural interactions during which different assumptions about the world, the individual, 'assistance' and well-being cohabit and at times clash.

People move across the boundaries of medical and social systems to maximize their well-being. People make use of western medicine, traditional healers, and prophets of religious denominations. In some cases people start with one and then move to another, or use them simultaneously. Therefore a pluralistic approach to well-being, combining several therapeutic strategies (western, non-western, pagan, religious, and the like) should be considered. Western therapies should neither be considered superior nor discarded (Honwana, 1999) and non-western therapies should be recognized as valid and integrated into mainstream programs for refugees. Similarly, social programs for refugees should be flexible enough to ensure refugees' achievement of social, physical and mental well-being through support for self-reliance and integration while offering specific help to those in need.

However, resettlement policies and programs for refugees have moved away from viewing refugees as healthy productive individuals towards treating them as dependent and traumatized (sick) persons leading to their marginalisation in countries of re-settlement and negatively affecting their well-being. The impact that the socio-cultural context, which includes re-settlement policies, has on well-being should be acknowledged and different paradigms for identity and integration should be considered. This means that social work with refugees and asylum seekers in Europe should promote wider inclusion of members of refugees' communities into planning and implementation of assistance programs; greater awareness of cultural assumptions about the individual, the world and well-being in social work curriculum; broader critical analyses of resettlement policies; and deeper analytical reflections on the role of social work programs as instruments of State policies.

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