Chapter 6
Employing the Tools of Growth: The Example of Displaced Populations

Say this city has ten million souls,
Some are living in mansions, some are living in holes:
Yet there's no place for us, my dear, yet there's no place for us.
Once we had a country and we thought it fair,
Look in the atlas and you'll find it there:

We cannot go there now, my dear, we cannot go there now.
In the village churchyard there grows an old yew,
Every spring it blossoms anew;
Old passports can't do that, my dear, old passports can't do that.

The consul banged the table and said:
'If you've got no passport, you're officially dead";
But we are still alive, my dear, but we are still alive.
(W.H. Auden, "Refugee Blues").

It often appears as if [researchers] base their judgments on observations and ad hoc interviews instead of having profound and in-depth knowledge of the refugees' views on things. Authors frequently claim with great confidence that they know what refugees need, what problems they have, and that refugees have the same priorities. Often the impression is that refugees are not seen as subjects and actors, with their history, aspirations, resources, capacities, and views. Who has asked the refugees?
(Hoeing, 2004, p. 3).

Much of our work has focused on the experiences of the survivors of various forms of trauma and adversity. Specifically, we have conducted a number of research studies among survivors of the recently concluded civil war in Sri Lanka that lasted from 1983 to 2009 (Jayawickreme et al. 2010, 2012a, b) and the 1994 Genocide against the Tutsi in Rwanda (Blackie et al. 2014; Blackie et al., in press; Lacasse et al. 2014). In our fieldwork, we have had the opportunity to speak to the individuals directly affected by the long-term effects of ethnopolitical warfare and the counselors and aid workers supporting these individuals. These conversations

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revealed to us that many individuals, and counselors in particular, believe that posttraumatic growth is a relevant and observable phenomenon in these situations. Thus, our research and experiences leave us currently hopeful that a growth-minded approach to the welfare of these communities can provide useful tools in ensuring that they can recover and continue with their lives in their wake of their experiences. In this chapter, we will outline the potential of research into posttraumatic growth to contribute to meaningful interventions that aid the recovery of individuals exposed to repeated hardships of conflict and displacement.

How Has Refugee Mental Health Been Studied?

It should first be noted, however, that most research on mental health among refugee and internally displaced populations has focused on identifying patterns of psychiatric symptomatology and syndromes such as PTSD and depression (Jayawickreme et al. 2012). These studies have yielded important findings regarding refugees' experiences of distress (Somasundaraum 2014). The peak of interest in the psychological health of refugee populations was during the 1980s; a fact that can be partially attributed to the inclusion of PTSD in the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980. As a result of this, the study of refugee mental health was dominated by trauma researchers; a fact clearly marked by the increase in the number of articles in the psychology literature referencing refugees relative to articles in the medical literature (Ingleby 2005, 2005). However, critics of the concept of PTSD have argued that the increasing prominence of the trauma concept in the 1980s itself became a social phenomenon that arguably took precedence over the actual problems that individuals had (Jayawickreme et al. 2013; McNally 2003). The evaluation of the refugee condition in terms of their experience of trauma had the effect of both focusing attention on the mental health of refugee populations for the first time, and identifying individuals within those populations who were suffering from significant psychological distress. However, this focus meant that in many early studies, only data on mental illness (and in many cases, PTSD symptomatology) was collected, and alternative approaches of assessing refugee mental health were not considered.

Criticizing Prevailing Approaches to Refugee Mental Health

Early research on displaced populations focused predominantly on analyzing and describing negative and harmful aspects of refugee life and living conditions (Cernea and McDowell 2000; Strachan and Peters 1997). While it is undeniable that

displaced populations almost always live in conditions of significant material deprivation (e.g., Rawlence 2016), Hoeing (2004) has argued that a "deficit-focused" emphasis in research and in the general perception of refugees as weak and deficient can have serious negative consequences; it perpetuates the label of refugees as helpless and powerless victims (Eastmond 2000; Harrell-Bond 1999; Pupavac 2002; Wessels 1998); reinforces and justifies the humanitarian "aid regime" in assuming primacy in taking care of refugee populations (De Voe 1981; Dick 2002; Harrell-Bond 1986), and denies refugees the role of being active social and political actors and agents of their own recuperation (Bracken et al. 1995; Dick 2002; Jamal 2003; Punamäki 2000; Pupavac 2002; Rieff 2002; Summerfield 1995, 1999). A more extreme argument is offered by Summerfield (1995, 1999, 2002, 2005), who has claimed that for most people whose lives have been affected by ethnic conflict, the conception of posttraumatic stress is little more than an over-hyped label to the normative stress that individuals endure in times of conflict (see Jayawickreme et al. 2013, pp. 314–316 and Stagnaro et al., in press, for a more detailed discussion of these issues).

Moreover, it is worth noting that there is a significant difference between an individual who experiences a single traumatic event and the everyday challenges—including possible threat, lack of security, deprivation, and mental stress—that are part and parcel of a displaced individual's everyday life. The PTSD diagnosis posits (or at the very least encourages) a simplistic and singular reason for the psychological distress of refugees: a single traumatic event, or a finite sequence of traumatic events (Jayawickreme et al. 2013; Shing et al., in press). Not having meaningful roles or occupation, losing community and social support, economic concerns, relative powerlessness, social isolation, lack of environmental mastery, discrimination, and unwanted changes to their way of life can cause significant distress among refugee populations (Gorst-Unsworth and Goldenberg 1998; Silove et al. 1997; Sinnerbrink et al. 1997). The drawback of seeing refugees as unique "victims" is that such a perspective obfuscates the fact that they are also normal human beings with "normal" worries in exceptionally challenging situations (Miller and Rasco 2004).

Finally, the conception that refugees are simply victims hides the fact that many of them "are also survivors…. and even the most destitute still exercise active interpretations and choices" (Summerfield 1995, p. 353). Perhaps most famously associated with this view is the Holocaust survivor Viktor Frankl (1984) who claimed that when someone is no longer able to change the situation, they must instead change themselves (Stagnaro et al., in press). Thus, perhaps the biggest limitation of seeing refugees as "victims" of trauma is that it obscures the fact that people actively engage in finding meaning in what happens to them, and refugees frequently cite faith, religion, spirituality, and political convictions as resources that help them to derive meaning from and endure even in the worst atrocities (Jayawickreme et al. 2013; see also Hoeing 2004; Bracken et al. 1995; Cornish et al. 1999; Eastmond 2000; Harrell-Bond 1999). This tendency to search for meaning from our experiences is inherent to posttraumatic growth, and therefore the deficit approach to PTSD cannot accommodate this possibility.

From Victims to Survivors: Recognizing Individuals' Agency

Despite the fact that the PTSD concept has dominated the field of refugee mental health through the end of the twentieth century, other approaches have now begun to receive more attention (Somasundarum 2014). Watters (2001) outlined a series of "emerging paradigms" in the care of refugees. One such approach is the public health approach, which is closely connected to the psychosocial approach. Ahearn (2000) defines the term *psychosocial*, following the Oxford English Dictionary, as "pertaining to the influence of social factors on an individual's mind or behavior, and to the interrelation of behavioral and social factors." Agger (2000) cites Bergh and Jareg (1998) definition of "psychosocial" as attempting "to express the recognition that there is always a close, ongoing circular interaction between an individual's psychological state and his or her environment" (p. 13). The World Health Organization (1996) adopted the phrase "psychosocial well-being" and defined it as a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This definition goes beyond definitions of well-being in the psychology literature in its emphasis on physical and social well-being. In light of this, the aims of psychosocial assistance under war conditions have been defined as the promotion of human rights and mental health through strategies that support protective social and psychological factors that already exist and lessen the stress at multiple levels of intervention (Agger 2000; Agger et al. 1995).

In keeping with this wellness-oriented approach, Cowen (1991) claims that psychological interventions should focus on building health rather than simply attempting to combat sickness. This approach has a historical lineage not dissimilar to that of positive psychology (Schueller and Seligman 2008), and owes much to both Maslow's (1954) discussion of basic human needs, and Jahoda's (1958) discussion of positive mental health. This psychosocial approach to refugee mental health has attempted to remedy the one-dimensional approach adopted by the PTSD model, primarily by stressing that the road to recovery for many people affected by conflict lies in alleviating their lives as a whole, and not simply focusing on treating symptoms of psychological distress in isolation (Almedom and Summerfield 2004). Moreover, the psychosocial approach adopts a substantially broader definition of what constitutes an appropriate intervention or treatment, given its focus on communal resources and negative social conditions, as opposed to solely focusing on the alleviation of individual pathological symptoms. Given that one of the goals of psychosocial interventions is to help refugees deal with stress through multiple levels of intervention, attempts have been made to disentangle the various domains that may be affected by trauma, and that may serve as efficient targets of intervention. Silove (1999) has proposed a model that defines the key adaptive systems threatened by disasters, arguing that identifying the systems that are mobilized or undermined by trauma may provide psychosocial researchers with a clearer perspective on the intervening processes linking the experience of trauma to mental health outcomes and whether these responses are restorative or dysfunctional.

The ADAPT (Adaptation and Development After Persecution and Trauma) model identifies five salient adaptive systems and their associated domains:

1. The safety system → Security and safety
2. The attachment system → Interpersonal bonds and networks (including the family, kinship, groups, community, society)
3. The justice system → Justice and protection from abuse
4. The existential-meaning system → Identities and roles (such as parents, worker, student, citizen, or social leader)
5. The identity/role system → Institutions that confer existential meaning and coherence, including traditions, religion, spiritual practices, political and social participation

(Silove et al. 2006)

Within this framework, the PTSD model is tied most closely to the safety system, with many traumatologists favoring the hypothesis that the perspective of threat is closely linked to increased risk of PTSD (Basoglu and Parker 1995). Expanding the scope of the systems affected by trauma allows psychosocial researchers to better understand how trauma weighs down each of these systems to the extent that they preclude successful *adaptation* to the traumatic experience. Such an approach would also allow researchers to better understand pathological responses to stress and trauma that are not captured by the PTSD model. For example, the disruption of the attachment system—through the loss of close family and friends—has been associated with nostalgia and homesickness (van Tilberg et al. 1996), as well as with traumatic grief (Horowitz et al. 1997). Other disorders associated with the disruption of the attachment system include separation anxiety in adults (Manicavasager et al. 1997) and cultural bereavement, described as an overwhelming feeling of nostalgia and homesickness for life back in the country of origin (Eisenbruch 1991).

Despite the increasing support of psychosocial programs by Western governments and other international humanitarian agencies, a number of serious limitations of the psychosocial approach have been noted. Given that a substantial amount of refugee mental health research has not utilized a well-being approach (Silove 1999), little is known about factors that promote resilience or serve as protective moderators among populations. This is where the research into posttraumatic growth and related concepts in the field of positive psychology can contribute to a fuller understanding of the refugee experience. In the absence of this information, the definition of psychosocial well-being will remain a source of contention (Jayawickreme et al. 2012) with most psychosocial researchers content to focus on the factors associated with psychosocial well-being including income level, household size, self-sufficiency, employment, schooling, and social networks (Ahearn 2000; McSpadden 1987). In contrast, the researchers who have attempted to define and measure psychosocial well-being have drawn too heavily upon the existing literature and therefore their analyses of refugees' psychosocial well-being draws substantially from concepts of loss, separation, stress, and trauma, emphasizing what is *lacking* for refugees to experience well-being (Ahearn 2000). The field of positive psychology (which posttraumatic growth is part of) therefore has much to offer in improving the definition and measurement of psychosocial

well-being. The primary aim of positive psychology is to identify the factors that promote optimum well-being in individuals in the form of positive experiences (e.g., happiness) and traits (i.e., optimism) and in societies in the form of positive values, institutions, and citizenship (Seligman and Csikszentmihalyi 2000).

The Value of Growth-Focused Models in Improving Refugee Mental Health

To summarize the literature reviewed thus far, much refugee research seems to have been almost completely dominated by the medical model, which has stressed the diagnosis of psychiatric disorders to the detriment of the notion that refugees are simply individuals with strengths and resources that have been caught in abnormal situations. The dominance of the PTSD concept in refugee research has resulted in an incomplete understanding of how individuals and communities react to and overcome the stressors associated with being a refugee. Much of the existing research obscures the fact that many refugees do not show evidence of any psychiatric disorder, and even those that do nevertheless function effectively (Summerfield 1995, 1999). There is little insight on how most refugees continue to function adaptively in the wake of extreme situations, and on which resources and strengths facilitate such functioning, mainly because of the focus on concepts of loss, separation, stress, and trauma, which emphasizes what is lacking for refugees to experience well-being. Additionally, most disorder-focused interventions designed to alleviate psychological distress neglect the many wellsprings that refugees may rely on to maintain an adequate level of well-being. While the psychosocial approach has the promise to provide an alternative perspective to the trauma-based perspective with its emphasis on "wellness," the lack of clarity in its definition of well-being and wellness, its implicit reliance on a deficit model in assessing and providing services for refugee populations, and the lack of significant empirical support to back up its programs constitute real weaknesses.

One of the main challenges thus far in addressing the needs of the victims of ethnopolitical violence has been that "a credible paradigm for the identification, treatment, and prevention of the mental health sequelae of refugee and civilian violence has not been forthcoming" (Mollica et al. p. 158; Jayawickreme et al. 2013). In addressing this challenge, the field of positive psychology has the potential to provide a paradigm within which many remaining questions in refugee mental health research can be explored. In this section, we outline how the existing work, including our own research into posttraumatic growth can help to inform psychosocial interventions among populations affected by ethnopolitical conflict.

Interventions that target the cognitive, behavioral, and social variables related to well-being are most effective (Lent 2004; Locke and Latham 1990), since these variables can be conceptualized as acquirable skill sets and environmental resources as opposed to innate and inflexible temperamental qualities (for a similar perspective on "skills", see Tough 2016). Of note, this was especially the case when

these resources were congruent with valuable personal goals (Diener and Fujita 1995). Of relevance to this discussion, we, along with our colleagues recently investigated the extent to which individual differences in one particular goal mechanism—*personal growth initiative* (Robitschek 1998)—were associated with lower levels of functional impairment among a population of genocide survivors in Rwanda (Blackie et al. 2014). The personal growth initiative scale measures a set of cognitive and behavioral skills that center on an individual's own conscious desire to develop as a person as well as confidence in their ability to set goals that enable such personal growth (Robitschek 1998; Weigold et al. 2013). One possible interpretation here is that personal growth initiative is a growth mindset necessary for posttraumatic growth. In support of our hypothesis, we found that individuals high in personal growth initiative reported lower levels of functional impairment in their daily lives, even when controlling for symptoms of depression, PTSD, age, gender, and location in our analysis; factors that had been identified by an earlier study to increase PTSD symptoms in Rwandan genocide survivors (Munyandamutsa et al. 2012). Our study suggests that personal growth initiative may constitute an important set of personal control beliefs for facilitating adaptive functioning in the aftermath of ethnopolitical war and as such might have practical applications for the development of intervention programs (at least for that specific population). Specifically, our results, although preliminary, suggest that individuals might be able to respond flexibly to the situation by changing their mindset and behavior to alleviate functional impairment in daily activities. Thus, interventions that can teach these skills to individuals might be an effective means through which they alleviate impairment and promote well-being (Fleeson 2001; Fleeson et al. 2002). However, while our results are promising, we should at this point remain cautiously optimistic. The results would need to be replicated in this population and other refugee samples before an intervention could be implemented. Additionally, our study was conducted 15 years post-genocide and even though many of the genocide survivors in our sample still exceeded the questionnaire cutoff criteria for clinically significant PTSD and depression, it is feasible that this type of intervention would be more effective when individuals' social, physical, and emotional needs have been first addressed with prior interventions.

It should be clear by this point that posttraumatic growth research has great relevance for refugee mental health, given that this work focuses on how individuals deal with past, present, or upcoming stressors, compensate for or accept the harm caused by the stressors, derive meaning from those experiences and, in some instances, achieve personal growth (Schwarzer and Knoll 2003). In support of this claim, Powell et al. (2003) found that posttraumatic growth was reported by former displaced people and refugees living in the former Yugoslavia who had been exposed to severe trauma during the war of 1991–1995, but the mean levels of posttraumatic growth were much lower compared to previous studies with Western nonrefugee samples. Furthermore, the factor structure of the Posttraumatic Growth Inventory (Tedeschi and Calhoun 1996) was substantially different from that of the original instrument, with only three instead of five factors being identified: *change in philosophy of life*, *relating to others*, and *changes in self/positive life attitude.* Thus,

although the concept of posttraumatic growth might be relevant to non-Western samples that have suffered severe and repeated episodes of trauma related to ethnopolitical warfare, it is possible that the expression of posttraumatic growth may differ across cultures. With regard to developing an empirically grounded typology and gaining an appropriately accurate cultural understanding of posttraumatic growth, psychologists should be open to using qualitative methods, especially in the initial assessment of refugee populations. Given how little we know about refugee well-being (let alone posttraumatic growth), adopting a "bottom-up" approach and listening to the refugees first before making any claims about their mental health seem to be the most prudent first step. As King (2004) notes, qualitative data offers psychologists the opportunity to answer many questions at once, gain a vivid understanding of human experience, and lends itself to multiple analyses.

In a recent publication, we, along with some of our other colleagues drew upon testimonial data from survivors of the 1994 genocide in Rwanda to analyze how posttraumatic growth was experienced in this context (Blackie et al., in press). Our analysis was based on a corpus of 32 oral testimonies retrieved through our research collaboration with the Genocide Archive Rwanda based in Kigali, Rwanda. Archive staff members collected the interviews during 2004–2011 and survivors gave their full written consent for their testimonies to be stored in the archive and accessed by staff, educators, and researchers. The interviews were divided into three sections: before, during, and after the 1994 genocide. Our analysis employed an open-coding method as recommended in similar research by Jayawickreme et al. (2012) in which the testimonies were first examined individually line-by-line to identify tentative themes of posttraumatic growth. Afterward, we undertook a thematic analysis based on the responses recorded from all the testimonies to identify the master themes of posttraumatic growth in this context. Our analysis identified three themes that were not previously contained in any existing published questionnaires, such as the posttraumatic growth inventory (see Tedeschi and Calhoun 1996). The themes were as follows: empathy, wisdom, and forgiveness. Specifically, survivors reported feeling more connected and supported by fellow survivors (empathy), they recognized the need to ensure that their grievances and distrust were not transferred to the younger generation to prevent further conflict between the two groups (wisdom), and some survivors demonstrated a remarkable willingness to forgive the perpetrators who had harmed them (forgiveness). These manifestations of posttraumatic growth are therefore culturally specific and represent adaptive responses to the unique experience of survivors of the genocide in Rwanda.

Toward an Integrative Approach to Refugee Mental Health

Research into posttraumatic growth and related concepts in positive psychology therefore can address some of the problems created through the deficit approach to refugee mental health. However, the psychosocial approaches discussed earlier go beyond psychological well-being to state that an individual's well-being and

physical health is tied to their unique social and political environment. Indeed, research by Mollica et al. (2002) found that among Cambodian refugees, positive work status was a protective factor against major depression, and religious practices were a strong protective factor against PTSD. The link between religious practices and reduced emotional distress has also been noted among Bhutanese refugee in Nepal (Shrestha et al. 1998). Thus, a fully comprehensive approach to refugee mental health would therefore result from the integration of psychosocial approaches and positive psychology.

The challenge is developing (or finding) integrative models that can account for all these different factors and issues. However, we believe a model put forward by Lent (2004) shows promise in this domain. Lent (2004) has presented an active-agent coping model of restorative well-being through which well-being is restored, and the likelihood of positive adaptation and growth maximized, following the experience of extreme stress (Jayawickreme et al. 2013). Key variables here would include personality (such as trait affectivity, extraversion, and neuroticism), cognitive and behavioral coping strategies involving mastery and meaning, coping self-efficacy, and social support and resources. Such a model represents a good starting point for a more specific conception of refugee mental health. That said, we also note important alternative models by Miller and Rasmussen (2010), and Hinton and Good (2009).

To summarize this model, individuals react to a negative event by appraising its severity and their own coping efficacy. This reaction is mediated by personality variables such as extraversion or dispositional optimism (Carver and Scheier 2002), as well as by environmental and social support, such as interventions, therapy, or other activities associated with coping (e.g., praying). These factors in turn mobilize a wide range of coping strategies, such as positive reappraisal of the event (a form of benefit finding or secondary control; Stagnaro et al., in press; Helzer and Jayawickreme 2015). Such coping strategies can have a positive impact on an individual's coping efficacy as well as the problem resolution process. In addition, the perceived capability to manage domain-specific stressors or obstacles—coping efficacy—is also impacted by environmental and social resources. This, in turn, can facilitate use of more active coping and support-seeking methods (e.g., persisting at coping efforts despite setbacks—a form of primary control; Rothbaum et al. 1982). Both forms of coping have the potential to lead to well-being (Helzer and Jayawickreme 2015).

We note that one factor that should be considered when developing models to account for refugee mental health is cultural differences. Given that much of the positive psychology research on the constructs discussed in earlier sections is founded upon research by Western psychologists (on a mostly affluent undergraduate population), it is likely that this model may have limited value to other (more collectivist) cultures. However, Lent (2004) notes that some of the processes described in the model above may be universal to a degree, although the nature or utility of particular variables within each model may be somewhat culture-specific. For example, although goal setting and pursuit have been identified as basic human processes, the content of people's goals (seeking self-expression vs. relational

harmony), the degree to which goals are self versus collectively set, and the resources available for goal pursuit are all affected by culture. Similarly, the relevance of particular personality factors such as internal versus external locus of control (Roesch et al. 2006) and coping methods (mastery vs. meaning) to well-being would all be affected by cultural differences. Despite the fact that psychological resources such as optimism, personal control, and a sense of meaning have been shown to correlate with happiness (Seligman 1998; Taylor 1989), and autonomy, competence, relatedness, and self-esteem have been identified as psychological needs fundamental to a satisfying life (Sheldon et al. 2001), another consistent finding in the well-being literature is that the characteristics and resources valued by societies also correlate with happiness (Lyubomirsky et al. 2005). This means that conceptions of wellness can vary by culture, as culture is potentially a major force constructing individuals' understanding of happiness and consequently their subjective experience of happiness (Lu and Gilmour 2004).

This question of cultural variation is especially important with regard to refugee well-being, given the wide cultural origins of different refugee populations around the world. Understanding how different refugee populations conceptualize happiness and well-being, and which resources they associate with well-being, is important for understanding the coping mechanisms individuals use in times of war and conflict. When considering assessments of mental health and interventions designed to improve well-being, it becomes clear that a number of factors need to be taken into account:

1. Understanding the values that different refugee populations espouse, and how individuals' goals are culturally determined;
2. Identifying what constitutes "well-being" and "growth" in their perspective—a task that relatively few organizations working with refugees undertake (Hoeing 2004);
3. Assessing existing instruments of mental health for their suitability in assessing the needs of the target population.

Paying careful attention to the refugee community can have another positive, if unrelated result. Many refugees are wary and suspicious of government agencies for their lack of interest in the actualities on the ground, as Hoeing (2004) has pointed out, and paying attention to the specifics of the situation may have the effect of improving the *effectiveness* of the psychosocial interventions provided, given that the refugees would feel that the intervention is not a "foreign" import, but instead has been developed with their specific needs in mind. In a sense, the efficacy versus effectiveness distinction plays out here: even if an intervention has been shown to be effective empirically, insufficient attention to the specifics of the context may serve to blunt its effectiveness.

In summary, a growth-focused approach to understanding how individuals endure, survive, and potentially grow from different forms of adversity can lead to new research questions and better care for people who are coming to terms with their new lives. The model proposed by Lent (2004) in particular affords a number

of exciting research questions that can lead to important interventions that can be of great benefit to counselors in the field. However, having made the case that a growth-focused approach does have great potential value (at least from the vantage point of our own prior work), we still need greater clarity about the nature of posttraumatic growth.

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