THE PATHOLOGY OF VICTIMHOOD: MENTAL HEALTH AND THE SOCIAL CONSTRUCTION OF "TRAUMA" AMONG IMMIGRANT SURVIVORS OF POLITICAL VIOLENCE IN NEW YORK CITY

by

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Abstract

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This dissertation explores ways in which the social construction of trauma among undocumented immigrant survivors of political violence transcends the etiology of mental health pathology (e.g., PTSD). Its main research question is: How does trauma move between time (past versus present) and place (there versus here) in the lived experiences of survivors of political violence? This research attempts insight into the multiple oppressions – in politics, immigration law, and racial, ethnic, and cultural identity – that impinge upon individuals whose experiences and narratives may not singularly conform to the paradigms of clinical, legal, or political epistemologies.

The theoretical framework of this dissertation encompasses an intersection of social thought: Medicalization and the social construction of illness, theories of refugee migration, and theories of contemporary U.S. immigration and ethnicity. The data for this work include a quantitative sample of 1,360 clients of a multidisciplinary torture

treatment clinic in New York City (NYC), a sub-sample of 25 qualitative interview and content analysis respondents, and participant observation at the clinic.

Findings reveal a multitude of post-migration hardships, including a profound convergence of these individuals' roles as asylum claimants (often facing deportation) and medical patients in their interaction with legal and medical institutions in the U.S. This convergence often leads to competing narrative demands in which the experiential truth of trauma must be presented variously, as testimony for tryors of fact and as objective symptomology for diagnosticians of pathology. Quantitative findings indicate the statistical significance of post-migration factors, most prominently immigration status, on ascribed clinical outcomes such as PTSD, depression and anxiety. Finally, looking at the immigration experiences of the two largest client groups, Africans and Tibetans, this research reveals high levels of material deprivation and problematic immigrant social networks that are a result of both current stresses and past exposure to political violence. Throughout their experiences, the racialization of participants' ethnic identities and contestations of nationhood, particularly within the unique political economy of NYC, often complicate their ability to negotiate emergent ethnic identities. These findings indicate that, for these individuals, conditions in the post-migration environment can be as detrimental, or traumatizing, as pre-migration experiences of violence.

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CHAPTER ONE: Introduction

Introduction

Civilian exposure to "political violence" predates modern conceptualizations of politics, military, and delineations of statehood. For as long as there have been violent conflicts over resources and power, individuals have been persecuted, exposed to mass violence, and driven from their homes, villages, and countries. Their responses to these experiences and their lives afterwards, specifically in the context of present-day U.S. society, are the focus of this dissertation.

Refugees (defined here as individuals who have fled their country in fear or persecution[1]) are a painful sight. From images of boatlifts, to tales of political repression by military regimes, to media accounts of widespread genocide, the "refugee experience" is intimately associated with experiences of hardship and trauma. In the 1990's, a myriad of social, economic, and political forces came together to bring the "mental health" of refugees to the forefront of health interventions. These interventions were built around treating and alleviating the trauma of violence, loss, and flight within the paradigm of Western psychiatry and medical pathology – the language of stress, anxiety, depression, and posttraumatic stress disorder (PTSD). In many respects, the refugee experience itself became subsumed by a medical etiology of trauma that is inherently individually-based,

[1] While not all survivors of political violence have formal refugee status (they may have entered the United States through other immigration procedures, or illegally), the bulk of these individuals left their country under refugee-like conditions. That is, they fled their country of origin because of fear of persecution and harm. Although I will look at the legal and socio-political mechanisms by which an individual is ascribed refugee status (and their ramifications) in depth in Chapter 2, unless specifically writing about this distinction in terms, I will use the term "refugees" interchangeably with "refugees and asylum-seekers" to refer to individuals who have fled their country because of fear of persecution.

static, de-racialized, and value-neutral – the relocation of a social role from "victim" to "patient."

Yet political violence is decidedly not value-neutral. It represents a violation that is fundamentally inscribed with elements of racialized global politics and differential international interventions and aid. Moreover, the traumatic journey of survivors of political violence is not over when they have reached the U.S.; their lives as immigrants unfold before an unsettling and complex backdrop of racial/ethnic tension, harsh immigration regulations, and socio-economic deprivation. This research considers how various social forces have converged to construct refugee "trauma" as pathology and the consequences of this medicalization in the lived experiences of immigrant survivors of political violence who now live in New York City (NYC). It also looks at the immigrant experience of these individuals within the racial and ethnic landscape and political economy of NYC.

Statement of the Problem and Research Questions

The goal of this research is to explore how constructions of trauma among immigrant survivors of political violence transcend the framework of individual-level mental health pathology. How does trauma move between time (past versus present) and place (there versus here)? How does it challenge categorization (medical diagnosis versus political victimhood)? This dissertation attempts an alternative to a medicalized interpretation of "trauma" among survivors of political violence, as well as a critique of its construction as pathology. It will offer insights into the multiple oppressions – in politics, immigration law, and racial, ethnic, and cultural identity – that impinge upon

individuals whose experiences and narratives may not singularly conform to the needs or paradigms of clinical, legal, or political systems of understanding.

Theoretical Framework

This project looks at the social production of trauma as psychopathology, specifically among a sample of non-Western[2] immigrant survivors of political violence. I describe the lived experiences of these individuals, including their articulations of trauma and their negotiation of ethnic and national identity within the racial/ethnic landscape of NYC. I also look at how contestations of nationhood and identity are embodied in the medical-legal processes in which they engage. The theoretical framework of this dissertation encompasses an intersection of social thought: Medical sociology, theories of refugee migration, and theories of contemporary U.S. immigration and ethnicity.

Medical sociology

Sociology in/of medicine. This dissertation represents an ongoing dialogue between two constructions of medical sociology that are at times posited as oppositional and at times complementary: sociology in medicine and sociology of medicine.

[2] Throughout this dissertation, I use the term "non-Western" to describe specific peoples, traditions, and social norms. My definition of non-Western is adopted from Donald Puchala who interprets non-Western, "as those states and societies culturally outside Europe and its cultural enclaves in North America, Australia, New Zealand and Israel. A more complex, and also a more accurate, definition of the non-Western world would include within the non-West the unassimilated immigrant enclaves of Africans, Asians, Middle Easterners, Caribbeans and Latins found within Europe, the United States, Canada, Australia, New Zealand, and Israel. In the same way, the West by this definition would include bourgeois strata and other 'westernized' or comprador groups within non-Western societies. Accordingly, interactions between the non-West and the West may take place between non-Western and Western states and societies as well as within both Western and non-Western states and societies. *The relevant frontiers across which interactions between the non-West and the West occur are cultural rather than geopolitical and they do not necessarily correspond to the world of states as depicted on political maps*" (Puchala 1997: 129) [emphasis mine].

Sociology *in* medicine employs sociological methods and analyses to look at the social causation, or production, of health and illness. It looks at macro-level determinants ("social determinants") of health such as poverty, environment, and inequality (rather than individual-level or clinical factors such as behaviors, genes, and family history) to understand the connection between social factors and the ways in which illness is distributed across populations. In addition to making this connection between individuals' health and their social environment (be it socio-economic status, food availability, cultural beliefs, social support, etc), sociology in medicine also looks at social pathways or processes that create ill health. Sociology in medicine is, for all intents and purposes, the insertion of sociology as a tool for expanding biomedical knowledge claims; it uses the same language and constructs of biomedical science (definitions of disease and illness, assessments of risk, etc), and guides biomedical science towards understanding where to look for disease, why the disease might be present, and how possibly to intervene.

In contrast to the sociology *in* medicine, sociology *of* medicine most often serves as a critique of the medical establishment and how it is situated in society. Sociology of medicine critiques the exclusivity and epistemological supremacy of biomedical knowledge (Armstrong 2000) by deconstructing the myriad of power-knowledge relationships established around health and illness, including the dominance of the medical profession (Freidson 1970), and the corporatization of medicine as a for-profit enterprise (Starr 1982). It examines the value systems embedded and perpetuated by the medical establishment and the consequences of diagnoses of illness and disease.

My own theoretical assumptions about health and illness are based largely in sociology of medicine. At the same time, I recognize that the concepts deployed by the sociology in medicine approach can represent meaningful states and situations of being and can be crucial in conferring forms of social currency (e.g., patienthood) that are only afforded meaning and material benefit when articulated in the language of biomedicine (e.g. clinical diagnoses). It is because of the importance of the diagnosis – in terms of material benefits conferred to individuals, as well as the development of a "science" of trauma – that I present a quantitative analysis in Chapter 3. In the tradition of sociology in medicine, this analysis employs psychometric constructs, however emphasizes the social, rather than individually-based, determinants of these outcomes.

The social construction of illness and medicalization. The social construction of illness employs many bodies of thought – such as the sociology of knowledge, deviance and labeling, and social roles – to apply a sociological lens to meanings of health and illness. Social constructionism argues that all knowledge, including scientific knowledge, is the product of conflict, negotiation, and struggles for power. The social construction of illness paradigm looks specifically at how medical knowledge is created and forwarded as an object of normalization and internalized social control. With this approach, medical power is seen as not only from the "top down," but also "deployed by every individual by way of socialization to accept certain values and norms of behavior" (Lupton 2003:13). Thus the concepts of health and illness (and the norms and values embedded therewith) are constructed and reinforced both at the macro-levels of societal power and at individual levels of interaction. In sum, "by studying how illness is socially

constructed, we examine how social forces shape our understanding of and actions toward health, illness, and healing" (Brown 1996: 34).

Medicalization looks at how lived experiences are increasingly recapitulated as pathology under the rubric of medicine (Illich 1976). Conrad and Schneider (1980) assert that medicalization occurs at multiple levels – the conceptual, the institutional, and at the level of doctor-patient interaction. On the conceptual level, a specialized segment of the medical profession introduces medical vocabulary (or models) to "order" or define the problem at hand. These medical definitions are often presented in the form of scientific discoveries and subsequently disseminated in medical and academic journals. At the institutional level, medical professionals serve to legitimate the medicalization of whatever issues their organizations specialize in. They function as gatekeepers of state benefits which are now legitimated by medical diagnoses. Although physicians are supervisors in organizations, most of the routine everyday work is accomplished by non-medical personnel. Finally, on a doctor-patient level, a physician diagnoses a phenomenon as medical, and the patient assumes or resists the sick role.

Conrad and Schneider (1992) further posit that defining and labeling deviance within individuals as a medical problem is concomitant with the use of the medical field as an agent of social control. Doctors typically present their defining and labeling as a medical intervention. Social control rests on the insertion of medical language into the field of what are in fact social problems, which serves to create scientifically knowable and value-neutral outcomes to characterize experiences that are intrinsically bound by socio-political factors and thereby depoliticizing them.

Medical language depoliticizes experiences by stripping them of context and temporality, while simultaneously imposing on them doctor-patient power relations. Rapp (1990: 29) writes, "The language of biomedical science is powerful. Its neutralizing vocabulary, explanatory syntax, and distancing pragmatics provide universal descriptions of human bodies and their life processes that appear to be pre-cultural or non-cultural." "Disease is perceived fundamentally in a space of projection without depth, of coincidence without development. There is only one plane and one moment" (Foucault 1975: 6). Moreover, the sick role, as articulated by Parsons (1951), asserts power relations; the patient necessarily yields to an authoritative force (i.e., the medical establishment) in exchange for social benefits. The patient-doctor relationship cloaks the doctor in scientific objectivity and, in fact, reinforces the standing of medical professionals as authoritative and, in the case of refugee health care, altruistic figures of legitimation.

The phenomenon of diagnosing refugees with clinical pathologies such as PTSD represents the medicalization of political violence. Recharacterizing experience with the language of biomedical science serves to rename victimization as a scientific event and obfuscates political accountability. The subject is put in a position of submission with language that is value-neutral. Being a survivor of political violence, however, is decidedly not a value-neutral state of being. It is a catastrophe, representing political and social disruption that lies outside the individual. Yet the "intervention" (i.e., ascribing a sick role) is enacted on the individual, in refugee camps, in hospitals, in health clinics. The medical gaze works to remove culpability and stigma from the patient but also

depoliticizes the doctor, the patient, and the traumatic event. In this way, the medical field is the arbiter of social control but also damage control.

Production of medical knowledge. Power creates illness. Much of the social construction of illness approach employs the work of Michel Foucault to understand the underlying power dynamics that shape conceptions of health and illness. Foucauldian concepts of power-knowledge and governmentality, as well as biopower and surveillance, are important in understanding the social construction of trauma among immigrant survivors of political violence.

Power-knowledge refers to the purposive and reciprocal nature of knowledge and power. Ultimately, the knowledge that is produced (i.e., the construction of trauma as individual psychopathology) is used to re-assert positions of power and subordination. Governmentality refers to an increased and centralized application of state power that creates knowledge, including scientific knowledge, and forwards a subjectivity that acts as a normalizing force. In this dissertation, I look at how strategies of power, employed variously by international governmental bodies such as the United Nations, U.S. foreign policy-makers, and the medical professions, serve to create scientific or medical knowledge under the guise of value neutrality.

Biopower is characterized by "an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations" (Foucault 1976: 140) and refers to the overt and subtle ways in which modern nation-states maintain social control over their constituents and, under premise of betterment, work to surveil and regulate populations to conform to the existing needs of power-holders. Biopower is employed through scientific categorizations of populations, including categories of health

and illness, as well as through disciplinary powers in which surveillance is internalized, including the acceptance of the sick role and its inherent subordination.

The immigrant body has historically been a site for claims of pathogenesis and imminent risk. These claims have been used to justify regulatory public health and immigration practices that reflect or further existing political agendas (Fairchild 2003; Kraut 1994). As such, I argue that the bodies of refugees and asylum seekers, as the foreign "Other" and bearing the traumas of foreign conflict, are conducive to government surveillance and the casting of patienthood, in this case mental health patienthood. Moreover, the importance of truth-telling or confession in the disciplinary pole of biopower (Foucault 1976) has added significance to the individuals I speak about in this dissertation. They must navigate the truth of testimony (confession to the state) and a truth of experience (confession to psychologists). The convergence of these narratives represents the larger convergence of politics, governmentality, and medicine, in that each narrative mutually supports the power of the other.

Situating survivors of political violence in migration/immigration theory

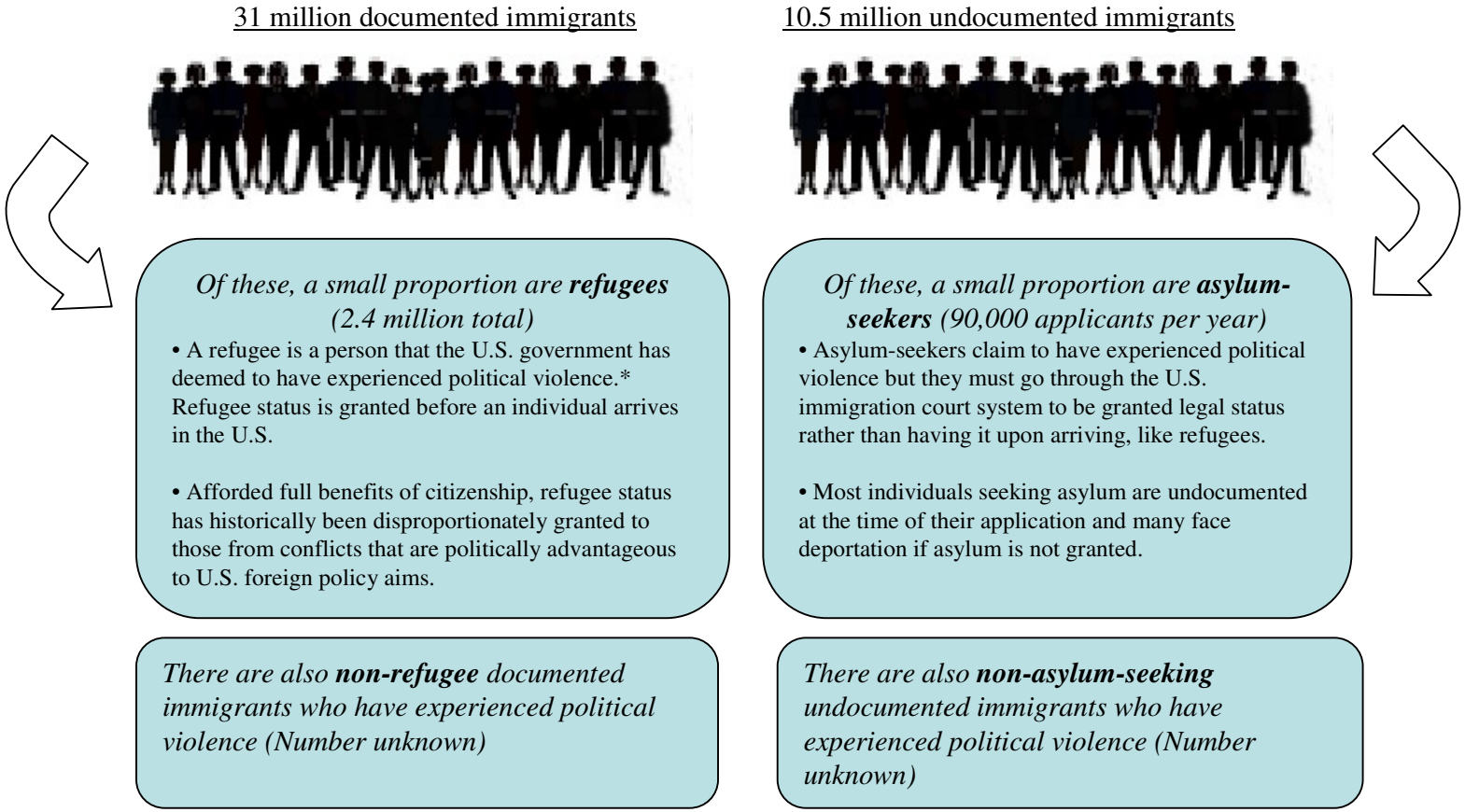
One recurrent theme in this dissertation is the importance of understanding the lives of immigrant survivors of political violence from a non-medical perspective, in particular the need to bridge medical sociology and immigration studies. The ascription of "torture survivor" may be meaningful in the context of obtaining services and seeking legal recourse. However, there is arguably no "torture survivor" or "political violence survivor" community in New York City; when these individuals exit institutional settings such as hospitals and courtrooms, they proceed about their lives as immigrants in a city

that is rich with various immigrant communities that they may engage in, react to, and become a part of. Moreover, they are often subject to the same immigration policies legislated by the U.S. legal system, and the same racial/ethnic scrutiny, including prejudice and discrimination, as their immigrant counterparts who have not survived political violence.

To be clear, the individuals in this research are immigrants who have survived political violence, an experience that does not fall neatly into any legal category or designation – e.g., refugee, asylum-seeker, undocumented immigrant, etc – that operate upon them (see Figure 1.1 below). Traditionally, sociological research in the U.S. concerning survivors of political violence has focused exclusively on those with refugee status. While it is problematic to apply these theoretical models to non-refugee survivors of political violence, at times I may focus on experiential truth rather than bureaucratic terminology and I may use the term "refugee" as shorthand to refer to immigrants who have experienced political violence.

Figure 1.1. Refugees, asylum-seekers, and other immigrant survivors of political violence in the U.S.

Regardless of their legal status, any of the over 40 million immigrants in the U.S. may have experienced political violence (including torture)



* In order to obtain refugee status, the U.S. government must deem an individual to be "outside his or her country of nationality who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution."

Above all the experiences of these individuals are not representative of the larger immigrant populations that they represent. As a contribution to immigration studies, this work is limited by its exclusion of members of immigrant groups who have NOT experienced political violence. It would be a folly to interpret these findings to mean that all or most individuals from, say, Sierra Leone or Tibet have been exposed to violence; it is not my intention to imply this. While I believe that understanding these individuals' migration experiences requires an exploration of the larger immigrant group even if they are not representative of that larger group (as explained above), I am also somewhat contradictorily motivated by the fact that, as they are such a "hidden population," it is unknown exactly how many of the larger Sierra Leonean or Tibetan community has actually experienced political violence. My baseline assumption is that these individuals represent only a small proportion of their immigrant group, but in reality I do not know (nor can I discover through this present undertaking) exactly *how* small of a small proportion that is.

Problematic legal terminology aside, what is the place of survivors of political violence in the study of immigration? How are their issues and experiences best studied? Portes and Bach (1985) propose an overarching four-category classification of immigration theories: (1) the origins of immigration, (2) the directionality and continuity of migrant flows, (3) the utilization of immigrant labor, and (4) the sociocultural adaptation of immigrants. Each theoretical topic can be approached "from a close-range level or a broad structural perspective" (Portes 1997: 811). For example, one can look at macro-level theories of state and state-systems, framing migration and refugee flows as a

reflection of the hierarchy of dominant and subordinate countries in the global political economy (Zolberg et al. 1986; Zolberg 1989).

Immigration theory may also address the characteristics and experiences of individual immigrant groups, often analytically "sorted" in the U.S. by ethnicity (for example, Min 1998; Waters 1999; Kibria 1995; Bozorgmehr 1997, Rumbaut 2005), or occasionally with the added dimension of refugee status (Gold 1992; Ong 2003) or generation (Kasinitz, Mollenkopf and Waters 2004; Portes and Rumbaut 2001). These studies, representing both qualitative and quantitative enterprises, focus largely on experiences internal to the U.S., that is, issues of immigrant origins, flows, labor, and sociocultural adaptation contextualized in the particular landscape – be it racial/ethnic, political economic, transnational, etc – of the U.S.

For the subject I am pursuing, I focus heavily on the "close-range" lived experiences of the individuals in this research, notably their negotiation of immigrant ethnic identity. Immigration, however, is a process located at the interface between internal (within country) and external (between country) theory construction, where politics is necessarily embodied by individual migrants' experiences. In a similar fashion, broad structural perspectives may serve to forward or recapitulate the particular political and cultural presence of migrants in a specific setting**.** It would be impossible to discuss the everyday experiences of an undocumented Guinean survivor of political violence without reflecting on the larger structural processes – e.g., immigration policy, human rights construction, differential foreign aid, international public health strategies, uneven development, etc. – that are working upon her, just as it would be impossible to discuss these structures without addressing their inherently racialized deployments.

In sum, while the experiences of survivors of political violence may not be representative of the majority of immigrants, understanding the lived experiences of these individuals requires going beyond their trauma history and requires consideration of theories of migration and immigration concerning both (1) their unique migration journey and, (2) the immigrant communities they inhabit in NYC. What follows is my theoretical framework for these considerations.

Theories of refugee migration

Theories of refugee migration offer insight into how and why refugees leave their country of origin, as well as whether their experiences are substantively different than non-refugee immigrants. In order to characterize the experiences of survivors of political violence across Portes and Bach's four categories and on multiple levels, I employ two typological frameworks concerning refugee migration: realism versus nominalism and categories/kinetics of refugee flight and resettlement.

Realism vs. nominalism. Over the course of 25 years, a body of international migration literature has looked specifically at the experiences of refugees and asylum-seekers, i.e., individuals who have migrated due to fear or persecution, as a discrete category of migrants (Mallki 1995). Central to these investigations is the debate over whether there is any meaningful difference – in terms of controlling political machinations, motivations, and resettlement outcomes – between refugees and "traditional" immigrants (Hein 1993). A realist perspective argues that the distinction is valid; refugees embark on a unique form of migration encompassing elements of forced displacement, violence, and geopolitical strife that is emblematic of unique political

processes. These processes are divergent from those that create “normal” migration flows and have ramifications for the prospects and psychological well-being of individual refugees.

In contrast, a nominalist perspective argues that refugee status is a politically and bureaucratically constructed category that masks similarities between refugees and traditional immigrants. The legal designation of refugee or asylee status remains largely a bureaucratic function, and, as indicated by the statistical convergence of resettled refugees with their immigrant counterparts (Kunz 1973), these individuals face common immigrant experiences in terms of restrictive government immigration policies, post-migration participation in labor markets, and experiences of xenophobia and racism in host societies (Black 1991). On a purely legislative level, the nominalist argument is correct in positing refugee status as a near meaningless legal designation. As will be discussed in Chapter 2, policy responses to a large-scale crossing of national borders is guided by both immediate and overarching political demands and economic interests, both in Western countries of settlement and in the less-developed countries that are most likely to serve as the country of first migration (Jacobsen 1996). A nominalist interpretation of refugee flight emphasizes the legal status of refugees as a political tool and questions whether the larger forces within the world system that compel refugees into flight, and conditions within host countries that shape the process of resettlement and acculturation, are in fact the same forces and conditions that act upon traditional immigration flows (Hein 1993).

Meaningful comparisons between refugees and immigrants require the unification of realist and nominalist perspectives. While various facets of the refugee experience,

such as reliance on the foreign policy priorities of the host country, social network organization, and economic adaptation, may resemble those of immigrants, other aspects, such as family migration and social welfare access, may be distinct (Hein 1993). Moreover, the distinctions can vary for each individual throughout the migration experience (Koser 1997); whether any given psychological state, socioeconomic condition, or social configuration represents a refugee "predicament" or some larger immigrant experience often depends on the larger life-world and subjective interpretation of the individual.

Categories and kinetics of refugee flight and resettlement. Kunz's (1973; 1981) model of refugee kinetics and settlement details the variation in motivations, resources, and patterns of migration and settlement among various categories and types of refugee movements, while also drawing parallels to the patterns of traditional immigrants. Kunz argues against a push-and-pull model of migration, i.e., migrants are exposed to forces, most often economic, that "push" them from their country and are attracted to the "pull" of desirable conditions in the country they migrate to. For Kunz, refugee movements are characterized by kinetic models that vary widely depending on their flight-patterns (anticipatory versus acute refugee flights), as well as their individual and group relationships (vintages or fate-groups) with the government, event, or other entities from which they are fleeing.

Anticipatory refugees are those who leave their homes with a clear plan to flee the country and knowledge of their destinations. They tend to be well-educated and able to access the social and political resources necessary to arrange for their flight well ahead of time. "The anticipatory refugee arrives door-to-door to the country of immigration, leaves

his country before the deterioration of the military or political situation prevents his orderly departure. He arrives in the country of settlement prepared, he knows something of the language, usually has some finance and is informed about the ways by which he can re-enter his trade or professions" (Kunz 1973: 132). Examples of anticipatory refugee flows to the U.S. include waves of Cuban refugees who fled immediately after the Castro administration came to power in 1959, or soon thereafter when the nationalization of educational institutions, hospitals, private land, and industrial facilities severely affected the livelihood of landowners and professionals.

The level of coordination demonstrated by anticipatory refugees may seem similar to that of voluntary migrants acting in accordance with push-and-pull forces. Anticipatory refugees, however, are entirely distinct in that the displacement forces influencing their departure affects both where they migrate and why. While they are subject to the "push" out of their home country, the "pull" of foreign resettlement is largely absent. Moreover, while anticipatory refugees are often able to access chain-connections to facilitate their resettlement (for example, reaching out to a relative in the U.S. to sponsor their case), it is dissimilar to the chain migration of voluntary migrants where the 'pull' motivations are predominant; for anticipatory refugees, "the chain elements provide help or guidance when the 'push' factors have already determined flight" (Kunz, 1973: 135). Kunz agues that rather than a "push-and-pull" model, these refugees' flight patterns more closely resemble a "push-and-permit" dynamic, in which they are ultimately resigned to settle in whichever country will grant them asylum for "although he may have his preferences, the degree of the perceived 'push' and the availability of a landing permit, and not the desire

to live in a particular country determines [the anticipatory refugee's] choice" (Kunz 1973:132).

In contrast to anticipatory refugee movements, acute refugee movements are borne out of greater immediacy and danger. Acute refugees "flee either in mass or, if their flight is obstructed, in bursts of individual or group escapes, and their primary purpose is to reach safety in a neighboring or nearby country which will grant them asylum. The emphasis is on escape and at the time of passing through the border few refugees partaking in acute movements are aware that later further migration will become a necessity" (Kunz 1973:132). Acute refugees are more likely to move first to a refugee camp in an adjacent country, then, if possible, to a country of resettlement. Unlike anticipatory refugees, acute refugee movements often lack the resources of anticipatory movements and consist largely of women and children. A contemporary example of acute refugee movement is the flow of refugees who have fled from the Darfur region of western Sudan across the border into Chad.

Kunz characterizes the kinetics of acute refugee flight as a "push-pressure-plunge" pattern. After leaving their country (the initial "push"), individuals involved in acute refugee movements have little agency in deciding their next steps, often having their movements determined by the dictates of international agencies. "Subsequent administrative, economic, and psychological pressures may force him to make a further step and to become an immigrant in a country willing to receive him. This pressure following the original push, whether it eventuates in the form of freezing of charity funds, the forcing of refugees into uncongenial refugee camps, the offer of assisted passages or other actions intended to move him, appears to always be more decisive than the pull of

the country where the refugee eventually goes" (Kunz 1973:133). Acute refugees thus have forces of pressure acting upon them that necessitate further movement in some direct, any direction. They must take a "plunge," either traveling to and resettling in whichever country to which they can get access, or repatriating back to their home country.

Post-1965 theories of immigration and ethnicity in the U.S.

Every country has its own unique history of immigration policies, immigrant flows and settlement patterns, and immigrant identity construction. In the United States, the settlement patterns, experiences, and outcomes of the waves of "White" (e.g., Italian, Irish, Eastern European) immigrants of the late 19th and early 20th century provided a basis for enduring theories of immigrant assimilation (Gordon 1964; Gans 1979) and changing concepts of ethnic identity formation among "White" immigrants (Alba 1990; Waters 1990). However, the distinct patterns of assimilation and mobility of the racially diverse immigrant population in the next major wave of U.S. immigration (beginning in 1965) have challenged traditional "straight-line" Anglo-conformist models of immigrant settlement. Theories of how newer cohorts of immigrants adapt and adjust to their post-migration environment necessarily encompass their experiences as racial minorities in the U.S., in addition to the diversity of human capital and social resources they are privy to, and changing requirements of the labor market.

One of the goals of this dissertation is to locate the subjects of the research – survivors of political violence who are largely undocumented and non-Western – within the sociological literature that looks at the experiences of post-1965 immigrants in the

context of U.S. immigration studies. By exploring the experiences of the African and Tibetan immigrants in this study (Chapters 4 and 5, respectively) I examine how ethnic identity is a situational and emergent, rather than primordial, entity (Yancy, Erickson, and Juliani 1976). It is a function of the structural situations that ethnic groups in the U.S. find themselves in. These situations are mediated by racialized archetypes deployed from macro-levels of government foreign policy and immigration regulations, to informal "ethnic" labor market valuations of race, to interpersonal encounters and presentations of self.

Ethnic identity strategies. The negotiation of racial and ethnic identity is a subject at the forefront of contemporary sociological studies of the adaptation of recent immigrants to the U.S. Despite vast diversity in racial/ethnic make-up (in addition to nationality, immigration status, educational and occupational background, etc), the major distinguishing characteristic among post-1965 immigrants is their non-White racial ascription. Though immigrants in the classical period of U.S. immigration suffered deprecation and discrimination because of their ethnicity and religion, over successive generations they were allowed to "become white." Sorted into more phenotypically distinct racialized categories of Latino, Asian and Black, contemporary immigrants may face more challenging experiences. The racial/ethnic disadvantage model asserts that, despite linguistic and cultural familiarity, lingering discrimination and institutional barriers to employment and other opportunities block assimilation of immigrants perceived as non-White (Brown and Bean 2006). For these individuals, "enduring physical differences from whites and the equally persistent strong effects of

discrimination based on those differences … throw a barrier in the path of occupational mobility and social acceptance" (Portes, Fernandez-Kelly, and Haller 2005: 1006).

In response to these barriers, non-White immigrant groups may opt to retain their ethnic identity, as they find economic, social or interpersonal value in "staying ethnic." For example, Afro-Caribbean immigrants share a phenotypical resemblance with African Americans that, in a heavily bifurcated Black/White racial landscape, may lead to downward social mobility. As a result, retaining ethnic identity (e.g., emphasizing accents or national origin) has a protective quality (Kasinitz 1992; Vickerman 1999; Waters 1994). For many Asian American immigrant groups, acculturation and achievement (e.g., English language fluency, academic and professional achievement), which have traditionally been associated with social assimilation, can be achieved without the slackening of ethnic ties that facilitate small businesses, social activity, and voluntary organizations (Min 2002). For many Asian Americans, "acculturation, in the sense of replacing their ethnic culture with American culture, is not a precondition for social assimilation (Min and Kim 2002:176). These findings seem to support a pluralist model of immigrant identity in which high levels of ethnic attachment not only fail to hinder, but may indeed serve to protect and promote the success of the second generation.

Internal ethnicity conflicts. "Staying ethnic" as a response to threats of structural and interpersonal discrimination, however, can be a problematic strategy when individuals' conceptualizations of identity do not conform to dominant societal archetypes. Zhou (1999: 206-07) argues, "since members of racial or ethnic minorities can respond to the disadvantages imposed by the larger society by establishing group solidarity, it is important to consider the extent to which immigrants and their children

are able to use a common ethnicity as a basis for cooperation to overcome structural disadvantages." One key element in these considerations is the existence of a meaningful common ethnicity to begin with.

Internal ethnicity refers to the presence of ethnic groups within an immigrant group that outsiders may not recognize (Bozorgmehr 1997). Within broad racialized constructs of identity (e.g., Black, Asian, Latino), as well as regional or national classifications (e.g., African, Guinean, Southeast Asian, Cambodian), immigrant groups contain dimensions of heterogeneity that represent profound within-group segmentation.

Applied to refugees in the U.S., internal ethnicity represents a permutation of Kunz's "vintage groups," and is a significant construct in the formation of identity among refugees resettled in the U.S. Looking at Vietnamese and Soviet Jews in the U.S., Gold argues (1992) that because of segmentation within each refugee group – in religion, religiosity, ideology, ethnicity, immigration experience, and previous class background – there is no organized community that encompasses entire communities; ethnic identification and community formation tend to take place within subgroups that share commonalities. In accordance with Kunz's delineation of acute and anticipatory migrations, Portes and Rumbaut (1996) found that refugees who make the journey to the U.S. earlier in their country's political conflict had more economic resources, both before and after migration, than those who make the journey later. Those who leave a country first often are able to do so because can, i.e., they have more money and social capital at their disposal. Moreover, they may have pressing motivation to leave; it is often those who occupy high positions in the private sector or government who face open persecution because of their positions in the (now) overthrown or embattled power structure.

These observations, however, were based on select refugee groups (e.g., Cubans, Southeast Asians, Soviet Jews) who had legal refugee status. The observations may not have as much salience when applied to the undocumented immigrants who have been exposed to political violence. Further, for survivors of political violence, the profound nature of this segmentation can create especially troubling consequences when it occurs in the context of American scripts of broad racial, ethnic, and national identity. For example, a Tibetan immigrant who has experienced political persecution at the hands of the Chinese government must face the bureaucratic reality the U.S. government designates them Chinese citizens. Given the U.S.'s proclivity for undifferentiated pan-Asian ethnicity, most Americans would "lump" Tibetans with Chinese in a manner that would be unheard of in Tibet. Likewise, a Guinean immigrant persecuted for political activity may be cautious in engaging in pan-African, or even pan-Guinean, social institutions because they may encounter a member of the opposing political party.

Research Methods

The data for this research are derived from the client base at the Bellevue/NYU Program for Survivors of Torture (PSOT), an organization I have been collaborating with since 2004. Founded in 1995, PSOT has provided medical and psychological services, social services, and assistance with legal/asylum services for more than 1,500 individuals from over 70 countries. Of the 1,500 clients that PSOT has served, valid quantitative data were available for 1,360 cases – 1,305 of which were included in the GIS analysis, presented in Chapters 3, 4 and 5, and 875 of which were included in the multiple regression analysis presented in Chapter 3.

Demographically, PSOT clients in the overall quantitative sample[3] (N=1,360) are primarily from West and Central Africa (53%), Tibet (27%), and Eastern Europe (8%). Their average age is 34, and they often have families and children, either in the U.S. or their country of origin. PSOT provides services to clients regardless of their immigration status, and a majority of incoming clients are undocumented (only 13% have political asylum when they first come to PSOT) and require assistance in the legal process of seeking political asylum.

(1) Quantitative analysis of PSOT client intake records

For this research, PSOT made available to me their electronic Access database of approximately 1,360 client records. These client records include, at minimum, data collected during 2-hour intake interviews conducted by clinicians and interpreters. Data collected during these intakes include demographic information, trauma experiences, medical history, and psychological measures.[4] The purpose of this analysis is to identify quantitative factors that most affect mental health distress, as ascribed by the diagnostic criterion for depression, anxiety, and PTSD. In particular, I explore the quantitative relationship between pre-migration factors, (e.g., type of torture, loss, separation from family) and post-migration factors (e.g., uncertain legal status, current deprivation) in Chapter 3, employing multiple hierarchical regressions. I also use Geographic Information Systems (GIS) to map the residences of the clients in order to look at residential characteristics, such as the socioeconomic level and racial and ethnic makeup of their neighborhoods.

[3] Detailed demographic information about the sub-sample of 875 used in the statistical analysis is presented in Chapter 3.
[4] Hopkins Symptom Checklist -25 (HSC) and the Harvard Trauma Questionnaire (HTQ)

(2) In-depth interviews with survivors of political violence

By focusing on the role of post-migration factors, I hope that the quantitative analysis will shift the focus of "trauma" from the past to the present, from foreign to domestic soil. The analysis, however, is limited by the use of a heavily constructed and rigid variable, mental health status, as the outcome measure. It does not allow survivors of political violence to articulate their own experiences, needs, or problems. To compensate for this limitation, I and a research team at Bellevue conducted 25 in-depth interviews with current and former clients of the clinic during the period of September 2005 to May 2006. Individuals were recruited from the clinic's patient base, and they represented three major regions/countries of origin: West/Central Africa, Tibet, and Eastern Europe. It is important to note that we conducted these interviews, in part, for a pilot study specifically on clients with children; all clients had at least one child in the U.S. See Table 1.1 (below) for detailed demographic information of the 25 participants.

The 2-hour interviews asked subjects about their home life and relationships with family; how their lives have been affected by experiences of torture; experiences of migration to the U.S.; life in NYC, including social networks and relationships with co-ethnic/co-national counterparts and other racial and ethnic groups in NYC. In addition, I had access to the medical charts of the interviewed clients, giving me the advantage of comparing the "interview narrative" of the in-depth interview with the "medical narrative" of client charts and diagnoses.

Interviews were audio-taped and transcribed. With the assistance of Atlas.ti, a qualitative analysis software program, I analyzed interview texts first for emerging

themes, i.e., "open coding" and then performed a secondary "axial coding," in which themes identified during open coding were used to create discrete categories. I explored relationships between these categories. This part of the coding moved the analysis from a descriptive understanding of the phenomenon (i.e. looking at the themes present in the interview text) to a more inferential interpretation (i.e., looking at the relationships between these themes) (Strauss and Corbin 1990). Ultimately, the purpose of this coding process was to identify key concepts and themes to build a conceptual model and generate hypotheses of the experiences, problems, and needs of these participants.

Table 1.1. Demographic and research characteristics of interview and content analysis participants, by region of origin (Total N=25)

	All (N=25)	African[a] only (N=15)	Tibetan only (N=6)	Albanian only (N=4)
Gender				
Female	52%	40%	50%	100%
Male	48%	60%	50%	--
Average age	42.5 years	43.8 years	41.3 years	39.2 years
Religion				
Buddhist	24%	--	100%	--
Christian	40%	60%	--	25%
Muslim	36%	40%	--	75%
Average number of years in the U.S. (Ranges from <1 to 11 years)	4.7 years	4.5 years	5.2 years	5.2 years
Immigration status				
Asylum granted/Permanent Resident	75%	93%	100%	--
Asylum pending/No status	25%	7%	--	100%
Types of documents analyzed[b]				
Internal clinic intake documents	24	14	6	4
Legal documents	21	11	6	4
Among these, affidavits from client or health care provider	13	6	5	2
Medical/psychological	19	10	5	4
Social service	4	3	1	0
Other documents	6	5	1	0

[a] The 15 African participants were from: Angola (7%), Cameroon (13%), Congo/Zaire (20%), Guinea (20%), Sierra Leone (20%), Togo (20%)
[b] Refers to the number of clients for whom each type of document was available, rather than the raw count of documents. Any individual's file may contain multiple documents of each type, e.g. multiple legal documents, social service documents, etc.

(3) Content analysis of clinic records

In addition to the interviews, I also conducted a content analysis of the 25 research participants' records at PSOT which ranged in volume from 5 to 200 pages per file. These client records, or "charts," contain clinical information, such as the trauma narratives recorded during initial intake interviews, psychological assessments, treatment

notes, medical lab reports, and the like. Because PSOT is a multidisciplinary clinic, with two social service coordinators and an adult education coordinator on staff, these charts also contain a wealth of non-clinical documents, including clients' legal affidavits from asylum proceedings, letters of support written by clinic staff for social services and/or legal proceedings, photocopies of official documents, and letters to and from city agencies, etc. In addition, clients sometimes bring in personal documents to show the staff – one of the respondent's charts contained copies of his wedding pictures. Due to clients' housing instability and vulnerability to theft, the copies of these documents in the PSOT files often serve as a good back-up in case the originals are lost.

The "trauma narratives" recorded at their initial intake sessions, as well as the clients' legal affidavits for their asylum proceedings, give the clearest accounts of their background, history, and experiences in their home country. Taken together, these documents form a scrapbook of clients' pre-migration experiences, including their experiences of political violence, as well as their post-migration experiences in NYC, most notably their interactions with legal, educational, and social service agencies.

(4) The ethnography of a clinic

From February 2005 to July 2006, I worked as a volunteer researcher at PSOT, spending on average 10 hours a week cleaning and organizing the quantitative data, as well as coordinating the interview project, which ran from September 2005 to May 2006. Much of my insight into how the clinic runs is based on informal interactions with clinicians and staff. Moreover, I was able to observe two intake sessions in the fall of 2006, as well as a number of "Monday night clinics," which are the medical clinics in a

separate part of the hospital where PSOT clients are seen for medical or psychiatric care (tutoring, social service visits, and individual and group psychological sessions are held at PSOT).

On Writing about Torture

This dissertation is about people who have been tortured in their country of origin and who are now immigrants in the U.S. I purposely avoid graphic description of their torture experiences (which are presented in painful detail throughout their medical, psychological, and legal records) in part because this is not a dissertation about torture. The primary focus of this project is the experiences that occur when they get to the U.S., thus I only discuss a respondent's torture experience when it has direct bearing on the topic at hand.

I am also reluctant to talk about torture in an effort to not sensationalize an already sensational topic. I prefer the use of the broader descriptor "political violence," rather than "torture," to characterize these experiences in part because while using the word torture and describing torture always generates provocative conversation, it also often freezes the conversation on that topic. Reactions can range from hushed solemnity on one hand and an objectifying morbid curiosity on the other. It is important to acknowledge that these torture survivors are more than their torture experiences and that they live whole lives, as immigrants, workers, family members, etc, that are not necessarily entirely circumscribed by torture. Yet, this reluctance must be weighed against the fact that, on a very basic narrative level, it's difficult to talk about torture survivors without talking about torture (imagine discussing the experiences of Holocaust

survivors without mentioning the Holocaust). Moreover, whatever shock value the general topic of torture evokes, in their everyday lives and certainly in their dealings with the U.S. legal system, these individuals are not held out as exceptional for having survived these experiences. For me, it is the story of what they face when they are here in the U.S., rather than the torture story, that holds the greatest shock value.

When I first approached PSOT, my research interests concerned the social construction of trauma among refugees and forced migrants generally, not necessarily torture or torture survivors. The torture aspect of the work interested me the least. Torture, however, had suddenly become topical, and I found myself curious about the goings-on at PSOT, a largely government funded torture treatment center that exclusively served immigrant torture survivors. It was 2004; the U.S. was about one year into the war in Iraq, controversies about prisoner treatment in Guantanamo Bay were still fresh, and photos and news articles about the Abu Ghraib prison had just hit the headlines. Literally one of the first conversations with a PSOT clinician was about how some of her clients were extremely distressed at the images in newspapers and on television of tortured detainees – images that were disturbing to anyone but especially upsetting to individuals who had been tortured themselves.

What is torture?

Around that time, the U.S. Department of Defense (DOD) and the Department of Justice (DOJ) issued multiple memos regarding authorized interrogation techniques and their legality. Asserting that none of the allowable techniques used my U.S. military personnel constituted torture, the DOD (Rumsfeld 2003) authorized such acts as: the use

of stress positions for four hours, hooding during transport and interrogation, exposure to extreme temperatures deprivation of light and auditory stimuli, forced grooming (shaving of facial hair, etc.), using detainees' phobias (such as fear of dogs) to induce stress and subjecting prisoners to unpleasant smells (e.g., human excrement). Moreover, authorities seeking to use additional techniques were told that they may submit a request in writing directly to Defense Secretary Rumsfeld. A year later, the DOJ contended that for an act to be considered torture there must be proof that it inflicts "prolonged mental harm," thereby marrying torture and mental health status (Levin 2004). It excluded as torture mental pain and suffering created by acts that do not cause severe physical pain, which excluded all forms of psychological torture.

The DOD and DOJ assertions and decisions demonstrate how definitions of torture abound. These definitions, however, do not conform to international guidelines and standards. Prospective PSOT clients must meet one of the two prevailing definitions of torture – the UN Torture Convention or the Tokyo Declaration – to be enrolled in the program and obtain the medical, psychological, and social services that PSOT offers. The most widely accepted definition is contained in the 1984 UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Torture Convention") which characterized torture as:

> Any act by which severe pain or suffering, whether physical or mental, [that] is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

The UN definition specifies the motivation for the act and specifies that the perpetuator of the act must be a representative of public official or other person acting in an official capacity. Moreover, the Convention goes on the state that torture "does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions."

The World Medical Association (WMA) forwards a broader definition of torture in its 1975 Guidelines for Medical Doctors concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment ("Tokyo Declaration"). It does not specify that the perpetrator need be representative of official authority, nor does it specify any reason for the torture:

> Torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

Thus, the fundamental epistemology of torture is established by these two definitions, which do not name or characterize specific acts of violence but rather require that the circumstances of these acts have specific characteristics in order to be termed torture. A clearer, if distressing, indication of the scope of acts themselves can be found in the form of the "HURIDOCS" coding scheme. The Human Rights Information and Documentation Systems International (HURIDOCS), a global network of human rights organizations, offers a quantitative coding scheme for the documentation of human rights violations, including a section on acts commonly used in torture (defined in that document as treatment while in government detention). This is a non-exhaustive list and is not used at PSOT in any decision-making (i.e., as with the WMA and UN definitions of torture). Rather it is employed to input torture into the quantitative client database;

each client gets five “fields” in which the clinician characterizes the torture acts the client reported. In Chapter 3 of this dissertation I will employ these codes in the quantitative analysis of the PSOT client database. I am presenting, in Table 1.2, a selection of the “torture codes.” I often reference HURIDOCS codes as the more graphic response to the question, “What is torture?”

Table 1.2. Selected "Torture codes" used in human rights documentation

5.21	**BEATING**	**5.25**	**SEXUAL MOLESTATION/RAPE**
5.211	Slapping, kicking or punching	5.251	Physical assault and touching
5.212	Blows w/rifle butts, whips, sticks, etc.	5.252	Forced performance of particular sexual acts excl. rape
5.213	Attacks w/knives, sharp instrument	5.2521	Forced performance of rape
5.2131	Shot	5.253	Rape by opposite sex
5.214	Maiming or breaking bones	5.254	Rape by same sex
5.219	Particular beating techniques	5.255	Rape through introduction of inanimate objects into vagina/rectum
5.2191	"Telefono" Clapping on ears w/ mouth shut	5.256	Rape through introduction of animate objects (animals) into vagina/rectum
5.2192	"Falanga" Beating of soles of the feet	5.257	Electric shock of genital areas
5.2193	"Operating table" Victim forced to lie on a table with the upper half of body unsupported & the abdomen is beaten	5.2571	"Black slave" Electric apparatus inserts heated metal skewer into anus
		5.258	Female genital mutilation
5.27	**FORCED POSTURES**	**5.4**	**DEPRIVATION**
5.271	Suspension: Hanging the victim by thumbs, arms or legs	5.41	Deprived of food (> 48 hours)
5.2711	"Pau de arara" (Parrot's Perch) Hanging victim from a stick between knees and arms bound tightly together	5.42	Deprived of water (>48 hours)
5.272	"Planton" Forced standing often under the elements, for many hours	5.43	Deprived of sleep (< 4 hrs/ night for 5 days+, or 24 hrs+ continuously)
5.273	Stretching or "Potro" Stretching of limbs and trunk	5.44	Deprived of medical care (>48 hrs)
5.274	Forced sitting or kneeling	5.45	Deprived of medication (>48 hrs)
5.2741	"Saw horse" Victim forced to sit straddling a metal or wooden bar	5.46	Immobilized in darkness (>48hrs)
5.26	**ASPHYXIATION**	**5.7**	**PSYCHOLOGICAL TORTURE**
5.261	Strangulation	5.71	Verbal abuse
5.262	"Submarino seco" Head in plastic bag	5.72	Threats (not including death threats)
5.263	Submarine/"Submarino" Use of water	5.73	Death threats
5.2631	"Submarino mojado" Immersion in filthy fluid (water w/urine/excrement)	5.74	False accusations
5.6	**STRESS TO THE SENSES**	5.76	Degradation
5.61	Loud noises or music	5.761	Deprivation of personal hygiene
5.62	Screams and voices	5.762	Nakedness
5.63	Powerful lights	5.763	Abuse with excrement
5.64	Blindfolding	5.764	Being forced to act in a degrading way (bark like a dog, dance, etc.)
5.65	Bound or tied up	5.77	Torture as a witness
5.651	Immobilized completely	5.771	Victim forced to watch or listen to the torture of others
5.66	Exposure to extreme heat or cold	5.772	Family/friends present during torture
		5.78	Psychological games
		5.781	Change of repressor role to ally

Limitations

There are a number of limitations to this research. As discussed above, this sample of PSOT clients (both in the quantitative and qualitative components) is a non-representative sample that cannot be generalized to any particular immigrant group or category of experience (e.g., people who have experienced political violence). The limitations of the client database analysis include the fact that, as a working database reflecting changing clinic intake procedures over the course of 10 years, the dataset is often inconsistent and lacks certain variables. (These limitations are discussed in depth as part of the quantitative analysis in Chapter 3.) The convenience sample of 25 respondents in the qualitative research is small and was gathered based on clinicians' recommendations of clients they thought would be interested, as well as clients who happened to be coming in for clinic visits during the period of recruitment. Finally, this study is limited in its ability to make direct comparisons, both quantitative and qualitative, with immigrant counterparts.

Organization of Dissertation Chapters

Chapter 2: Converging Medical and Legal Status in the Social Construction of the "Traumatized Refugee"

This chapter examines the convergence of medical and legal identities among survivors of political violence. I describe the construction of the "traumatized refugee," presenting brief overviews of the origins of PTSD and its application to refugees and the international and domestic legal frameworks within which refugees are designated. I then look at the intersection of medical and legal status in the lives of these individuals as they

are manifested in issues such as\ mental health stressors, clinician testimony and affidavits, and the interplay of medical and legal narrative demands on clients.

Chapter 3: Trauma by the Numbers: The Role of Post-migration Factors in PTSD, Depression, and Anxiety Outcomes

The power of diagnosis plays a large role in the stories described in Chapter 2. However, the social determinants of these diagnostic "outcomes" are often overlooked and understudied. Clinicians and researchers primarily examine the most obvious origin of trauma among immigrant survivors of political violence – the actual experience of pre-migration violence. In Chapter 3, I work within the sociology in medicine paradigm in an analysis of the quantitative client database that looks at post-migration predictors of mental health outcomes (operationalized as diagnostic scales measuring PTSD, depression and anxiety). Specifically, I employ hierarchical regression analysis with 875 client records to determine pre- and post-migration predictor variables of mental health outcomes. Findings indicate that post-migration factors, especially immigration status, explain a significant amount of variance in all mental health outcomes. Having legal immigration status can be as powerful a predictor of PTSD and anxiety as pre-migration experiences such as rape and sexual assault while in detention in one's home country. Moreover, there is an interaction effect between gender and immigration status across all three measures.

Beyond their interactions with the medical and legal institutions described in Chapter 2, or their anonymous statistical contribution to the aggregated data presented in Chapter 3, PSOT clients have lived experiences that both complicate and transcend

ascriptions of patients, legal clients, or data-points. One particularly salient dimension of these individuals' resettlement is their immigrant experience. Chapters 4 and 5 are devoted to the immigration stories of PSOT's largest regional group, clients from Africa, and PSOT's largest national group, clients from Tibet.

Chapter 4: African Survivors of Political Violence

Clients from Africa are the largest regional group at PSOT; in the overall client database (N=1,360) over half of all clients (53%) come from an African country. In this chapter I present an overview of African immigration in NYC in order to contextualize the experiences of the survivors of political violence in this research. I then focus on the qualitative (i.e., interview and content analysis) data for the fifteen African participants. Themes that emerged from these data include hesitation engaging with co-nationals (or co-nationals of oppositional vintage groups); extreme levels of deprivation and reliance on social services; reactions to racism and discrimination; and articulations of immigrant identity based on migratory motivations.

Chapter 5: Tibetan Survivors of Political Violence

In this chapter I look at the experiences of PSOT clients from Tibet who constitute the largest single country of origin among clients; over one-quarter (27%) of clients represented in the client database are from Tibet. As with the survivors of political violence who are from African, in this chapter I first present an overview of Tibetan immigration in NYC in order to contextualize the experiences of the Tibetan clients in this research. Issues of note among these individuals were the encounters and

interactions with the Chinese immigrant community, including within ethnic labor niches; Western fetishization of Tibetan culture, including the construction of the "Tibetan Nanny," political economy of child care; and the role of intergenerational transmission of the Tibet cause.

Chapter 6: Conclusion

This concluding chapter examines the interplay of medical sociology and immigrant studies in the lived experiences of the survivors of political violence. Overall themes evidenced by the data are revisited, including the convergence of medical and legal jurisdictions, levels of medicalization, post-migration structural deficits, and immigrant ethnic networks. Policy implications and recommendations offered encompass reform of existing immigrant and health care legislation, better identification of survivors of political violence in immigrant populations, and the development of multi-faceted services and innovative psychological treatment for survivors of political violence.

CHAPTER TWO: Converging Medical and Legal Status in the Social Construction of the "Traumatized Refugee"

Introduction

Immigrant survivors of political violence represent the intersection of intertwined and often contradictory statuses: the medical ascription of "patient" and the political/legal ascription of "victim" or, in the case of an undocumented immigrant, "criminal." This chapter examines the convergence of medical and legal identities among the survivors of political violence in this research, nearly all of whom were undocumented when they entered the U.S. I describe the construction of the "traumatized refugee" by looking at: (1) a brief social history of the 20th century clinical conceptualization and continued medical "discovery" of trauma as PTSD, including the role of funding trends in humanitarian assistance and the role of professionalization of humanitarian aid in the selective production of medical knowledge and intervention for traumatized refugees, (2) the international human rights framework and U.S. immigration policies that guide the ascription of immigration status (e.g., as asylee, refugee, or undocumented, etc), and, finally, (3) I will reflect on the intersection of medical and legal jurisdictions in the lives of the survivors of political violence in this research.

The science of discontent: A social history of the psychological pursuit of trauma

The soldier as subject: Mental health and the military

Tales of wartime traumas predate the rise of the modern allopathic medical system by thousands of years; medical historians assert that symptoms that we now consider indicative of PTSD were widely present in literature, including the *Iliad*, the *Epic of Gilgamesh*, and works of Shakespeare (Dean 1997). The medical "discovery" and treatment of trauma as a pathology has progressed in a complex arch over the last 150 years. Founded on observations of how civilians reacted after railway accidents in the 1860s, and later elaborated on by Breuer and Freud as a psychoanalytic model of female hysterics (Leys 2000; Shepard 2001), PTSD, as we understand it today evolved in the aftermath of the horrific events that military combatants experienced in World War I, World War II, and the Vietnam War.

The modern incarnation of PTSD marked one of the most fruitful scientific partnerships that evolved from 20th century war – that of the developing science of psychology and the soldier who served as a subject of research and treatment. The virtual epidemic of "shell-shocked" soldiers after WWI created both motivation and opportunity for psychological researchers to apply the principles of their evolving discipline to large-scale practice. In the U.S., psychologists had already developed and tested the Intelligence Quotient (IQ) test on the ready sample of WWI soldiers. The results of this research, performed at the height of the early 20th century eugenics movement, went into almost immediate political effect with the 1924 National Origins Act, which restricted the immigration of "lesser" intellectual stock from Eastern and Southern Europe into the U.S.

The science of IQs was inherently politicized, and the guise of objectivity provided quantitative substantiation for the immigration policy being put forward. Although PTSD research developed primarily to assist soldiers returning from war rather than to serve any immediate political agenda, the precedent had been set for claims-makers to employ the new science of psychology in the legal arena.

After WWII, nearly 175,000 Holocaust survivors resettled in the United States, providing a sample of civilians who suffered horrific traumas. Preceding the formal conceptualization of trauma as PTSD by 30 years, the study of Holocaust survivors' reactions to trauma has nevertheless largely failed to create a "sociology of the survivor community" (Helmreich 2001: 15).[5] Of the vast literature on the psychosocial adjustment of Holocaust survivors, the greater bulk of studies with Holocaust survivors are centered on the breakdown of personality under such extreme stress (Shantall 1999) and focus on individual-level attributes and responses to trauma, including physiological correlates of PTSD such as cortisol levels and hypocampal volume (see Golier et al. 2005; Yehuda et al. 2007).

Yet a great many Holocaust survivors prospered in the U.S., despite the severe handicaps that they faced in the U.S. – including anti-Semitism, high unemployment rate immediately following the WWII, a lack of language skills, and interrupted education or vocational training (Helmreich 2000). The analysis of *how* they achieved prosperity came to be is most often considered by examining individual coping skills and personality

[5] However there is a great deal of psychosocial literature on survivor communities in concentration camps, rather than in postmigration settings. For example, Luchterhand, Elmer. 1970. "Early and late effects of imprisonment in Nazi concentration camps. Conflicting interpretations in survivor research." *Social Psychiatry* 5:102-09 and Luchterhand, Elmer. 1980. "Social Behavior of Concentration Camp Prisoners: Continuities and Discontinuities with Pre- and Post-camp Life." Pp. 259-283 in *Survivors, Victims, and Perpetrators: Essays on the Nazi Holocaust*, edited by J. E. Dimsdale. New York: Taylor & Francis.

strengths exhibited by Holocaust survivors, such as flexibility, assertiveness, tenacity, distancing ability, and group consciousness (Helmreich 1992), and forgiveness and resilience (Greene 2002).[6] In sum, the trauma responses of Holocaust survivors, whether seen as pathological or resilient in nature, are presented as products of individual-level components or factors, and contextualized in relation to pre-migration traumatic events rather than post-migration environment.

The Vietnam War, and the experiences of Vietnam veterans especially, represented a watershed moment in the history of contemporary trauma. By 1975 2.5 million veterans had returned home to the United States. The incidence of psychological dysfunction and trauma among these individuals was staggering and prompted the 1980 inclusion of PTSD in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorder – Third Edition (DSM-III).[7] The term "Post-traumatic Stress Disorder" was introduced, and with the validation of medical authority, it replaced the parlance of the "shell shock" of WWI, the "battle fatigue" of WWII, and the "operational exhaustion" of the Korean War. The medicalization of war trauma was now fully operationalized at the conceptual level.

There are a few commonly accepted explanations for why the Vietnam War was so especially "traumatic." Unlike previous world wars, guerrilla warfare tactics were the norm in Vietnam; anti-insurgency combat often involved injuring and killing women and

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[6] For a more in-depth discussion of Holocaust "survivor studies" see: Shantall, Teria. 1999. "The experience of meaning in suffering among Holocaust survivors." *Journal of Humanistic Psychology* 39:96-124.

[7] Using this new diagnosis, government studies at the time reported that over 30 percent of Vietnam veterans suffered from PTSD (NVVRS 1988), over twice what was estimated to have been the lifetime prevalence rate of PTSD among veterans in general (US CDC 1988). These numbers were subsequently refuted, in part because only 15 percent of all Vietnam veterans had been involved in active combat which is not a requirement of being diagnosed with PTSD but is highly correlated. Current figures estimate that just under 20 percent of Vietnam veterans suffered from PTSD symptoms (Dohrenwend et al. 2006).

children as enemy combatants. Moreover, the negative political and social reception upon homecoming further exacerbated veterans' psychological distress and impeded readjustment to civilian life. The specter of the downtrodden and damaged Vietnam veteran became so entrenched in how we understood the war experience that PTSD became an expected military and societal diagnosis of anyone who had ever gone to war (Dean 1997).

The Vietnam War produced other traumas. Over 500,000 refugees from Southeast Asia were settled in the U.S. after 1975. It was at this time that refugee mental health became a "niche" in psychiatric literature, and the applicability of the veteran-centered PTSD diagnosis on non-Western civilians was tested, albeit on a much smaller scale than the government-sponsored epidemiological studies on veterans. While the symptomology of trauma among Vietnam veterans and Southeast Asian refugees was similar in many ways (though refugees had often endured graver hardships and losses, both during the war and during resettlement), knowledge and research findings among these two populations remained largely "sequestered" (August and Gianola 1987). Further, studies looking at the trauma responses of Vietnamese refugees in comparison to the other another immigrant group massively traumatized by violence, Holocaust survivors in the U.S., are virtually non-existent. By this time, despite continued anti-Semitism in the U.S., the horror of the Holocaust was roundly denounced as evil and Holocaust survivors were generally considered sympathetic victims (we did, after all, successfully defeat their oppressors). In the case of the Vietnam War, Vietnamese refugees represented military defeat and characters of greater moral ambiguity.

Bringing trauma home, exporting it abroad.

Throughout the 20th century, the pursuit of a medical model of trauma seemed like a logical convergence of a long-standing intuition of war trauma, an expanding empirical model of psychology, and an overwhelming population of traumatized soldiers. By the late 20th century, the conceptualization of PTSD as primarily a trauma of soldiers started to change. In the 1980's a model of trauma in civilian life, which had been superseded by the exigencies of 20th war, re-emerged. Civilians, specifically advocates for those who suffered sexual abuse, were asserting the right to a PTSD diagnosis as a social movement strategy. Domestically, the feminist movement actively asserted that traumatic symptoms stemming from sexual abuse and domestic violence were as psychologically deleterious to women as war events were to soldiers (Bloom 2000; Herman 1992). As discussed above, medicalization represented legitimation, and almost 100 years after Freud's "hysterical" woman, trauma became an important tool in the feminist politicization of violence and crime.

Simultaneously, post-Cold War conflicts created millions of civilian experiences of war in largely non-Western settings. This was especially prevalent in the 1990's, during which time global humanitarian assistance doubled and war-exposed individuals were increasingly coming under the purview of Western medical intervention. The Wars of Yugoslav Succession in the 1990's inspired an onslaught of humanitarian aid, including psychological aid that was deemed to be important to European refugees.

By the late 20th century, PTSD diagnoses had become associated with the widespread treatment of civilian refugees exposed to war, and medical health research struggled to produce the necessary conditions that would address the needs of civilians

who were largely non-Westerners (Summerfield 1997). In keeping with the rising authority of medical psychiatry, medical personnel both domestically and at refugee sites "exert[ed] a tremendous amount of control over large populations well before the production of any significant or legitimate evidence that they could accurately diagnose, treat or even care for the mentally ill patient" (Holt 2008: 80). Unlike sexual abuse survivors, these patients were not active agents in the medicalization of their experiences. Both of these groups of civilians shared one thing, however; they were in some way victims of crimes. While the sexual abuse survivors actively advocated for the medicalization of their experiences in an effort towards legitimation, refugees had the sick role ascribed to them as an act of political disempowerment. What refugees "needed" was medical attention rather than legal or political intervention.

Patenting and pitching a cure: The rise of psychopharmaceutical therapy

The pharmaceutical treatment of affective disorders such as depression, anxiety, and PTSD also became widespread during the 1990's, specifically with the development of selective serotonin reuptake inhibitors (SSRI's) such as Prozac, Paxil, and Zoloft. Developed in the mid-1980's, SSRIs did not actually produce better results than their predecessors, the tricyclic antidepressants, but they had fewer side effects, were safe in overdose, and faster in therapeutic dose. Since its FDA approval in 1988, Prozac, in particular, has become a cultural icon representing, alternatively, the miracles of modern medicine and the postmodern consumption of indulgent "lifestyle" medications.

Direct-to-consumer advertising of pharmaceuticals, primarily psychopharmaceuticals, in mass media became commonplace in the 1990's, particularly

after the Food and Drug Administration (FDA) loosened restrictions on direct-to-consumer television advertising in 1997. Antidepressants, which are now indicated in the treatment of other affective disorders such as anxiety and phobias, are a $12 billion dollar industry and are currently the second-largest class of prescription drugs, exceeded only by heart medications. In 2001, 7.1 million Americans took antidepressants, an increase of 700,000 from the previous year (Goode 2002).

It is against the backdrop of increasing corporatization of disease and patient consumerism that PTSD and its associated affective comorbidities (i.e., depression and anxiety) became more easily treatable. The first medications to have received FDA approval as indicated treatments for PTSD were, in fact, the SSRIs Sertraline (Zoloft) and paroxetine (Paxil). By the early 1990s, mental health advocates had successfully lobbied state legislatures, including New York, to include psychophamaceuticals on the list of drugs eligible for Medicaid reimbursement. Not only did new (corporately-produced) knowledge create a market, it created the diagnostic and treatment structures in which refugees were repositioned.

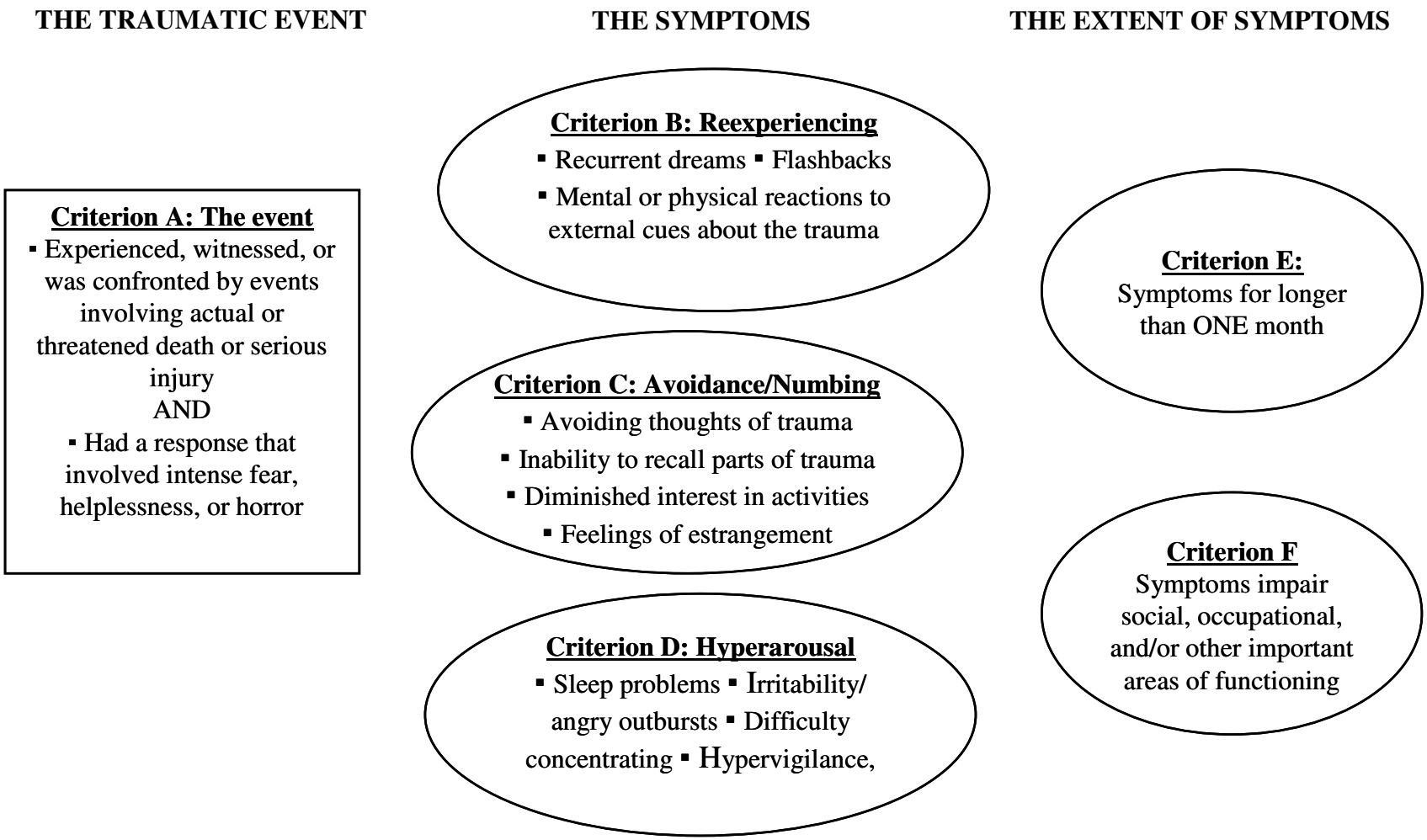
What is PTSD? Language and changes in the DSM definition of a trauma event

When experiences are re-characterized as disease, their names and how they are referred to in common parlance shift to reflect the changing paradigm. Often this recharacterization reflects the move from non-medical to medical jurisdiction, such as when crib deaths became SIDS. Similarly, the language of war trauma evolved in common parlance from “shell shock” to “battle fatigue” to “operational exhaustion” during the Korean War, and finally to “PTSD.” However, even once a condition is firmly

entrenched in the medical model, the diagnostic language "inside" the disease continues to shift constantly. The rewording of diagnostic criteria, especially in the absence of any "new" discovery that might substantiate the change, provides some insight into the direction of the social and political ideas about that disease.

The current diagnostic criteria put forward by the Diagnostic and Statistical Manual-Fourth Edition (DSM-IV) define PTSD along 6 dimensions, commonly referred to as Criterion A through F (See Figure 2.1 below). Criterion A is the event itself, defined as a situation where a person experienced, witnessed, or was confronted by events involving actual or threatened death or serious injury and responded with intense fear, helplessness, or horror. The actual psychological symptoms associated with PTSD are contained in Criterion B ("reexperiencing"), Criterion C ("avoidance and numbing"), and Criterion D ("hyperarousal"). Criterion E and F involve the duration and intrusiveness of these symptoms in everyday life. Criterion E is met if the duration of symptoms is longer than one month), and Criterion F encompasses the degree of day-to-day dysfunction associated with these symptoms (American Psychiatric Association, DSM-IV 1994).

Figure 2.1. Diagnostic criteria for PTSD presented in the DSM-IV (1994)



The psychological indications of PTSD (Criterion B through F) have not been greatly altered from the first 1980 DSM-III definition. Criterion A, the definition and conditions of the traumatic event, however, has been progressively rewritten in a more specific, and arguably, exclusionary way from DSM-III in 1980 to the 1987 DSM-III-R, and the 1994 DSM-IV. The original 1980 DSM-III only required a *"... recognizable stressor that would evoke significant symptoms of distress in almost anyone."* The 1987 DSM-III-R specified that the stressful event fall *"... outside the range of normal experience and that would be markedly distressing to almost anyone ..."* The current DSM-IV, however, defines a stressful or "traumatic event" as one in which both of the following were present: "(1) the person experienced, witnessed, or was confronted with an event or events that involved actual threat or threatened death or serious injury, or a threat to the physical integrity of self or others, (2) the person's response involved intense fear, helplessness, or horror." The vocabulary of "almost anyone," and "outside the range of normal experience," has been removed from the current definition of a traumatic event.

Why did the definition of a traumatic event change in the 1994 DSM? Until that point, when returning soldiers were the primary subjects of analysis, PTSD was an "instance where the cause of the disorder was shifted from the particularities of an individual's background to the nature of war itself; it is 'normal' to be traumatized by the horrors of war" (Conrad 1992:224). The 1980/1987 definitions tacitly acknowledged that the soldier's trauma was indeed outside the range of normal experience and that anyone would be traumatized by the experience.

The 1994 incarnation of a traumatic event seemed to reflect the continued push

for value neutrality in diagnostic renderings of pathology. Rather than evaluate the "traumatic-ness" of the event itself (i.e., the event is inherently traumatic if it would have been traumatic to almost anyone), the criterion now brought to the foreground the patient's subjective reaction of "intense fear, helplessness, or horror" as a defining element of what makes an event traumatic. In the new definition, the actual event could more or less be anything, (i.e., any instance in which you are or think you are in danger of being seriously injured or killed), as long as the subject reacted in a certain manner. In many ways, this change was indicative of the political advocacy around PTSD by civilian survivors of sexual abuse for the inclusion of their experiences as traumatic events, as well as the growing niche literature on Southeast Asian refugee trauma. The new definition had to encompass new traumatic experiences that were perhaps considered less relatable or universal that those of Western male soldiers; if it was normal for a soldier to be traumatized by war, was it also normal to be traumatized by sexual violence or by forced migration? By laying much of the weight of the definition on the subjective response of the subject, the new definition sidestepped the need for the medical establishment to engage in the valuation of these more non-masculine, non-war related traumas, e.g., refugee flight, sexual abuse.

The issues of "under-endorsing" or "over-endorsing" symptoms now became important in the epistemology of the traumatic event. At PSOT, staff considered it common knowledge, for example, that Tibetan clients were prone to under-endorse items on psychiatric diagnostic scales. This led to a number of troubling comparisons (Asian clients under-endorsed, African clients over-endorsed), but also called into question the significance of the event itself. If an individual did not exhibit symptoms of

psychological distress (whether delineated by clinical assessment or a 16-item Likert scale questionnaire) as a result of an event, did it mean that the event was not traumatic?

Creating medical knowledge on the coattails of humanitarian assistance

As with all medical knowledge, what we know about trauma as a psychopathology we have learned through the patients that were treated and studied. In the development of trauma as a medical and academic enterprise, these patients were soldiers returning home from war. In the late 20th century, these populations were often refugees, specifically refugees who had been recipients of humanitarian assistance. It is under the auspices of this assistance that medical and public health practitioners, who up until now had been occupied with the work of treating injuries, bacterial and viral infections, and establishing nutrition and sanitation, began to treat this new disorder, PTSD, among refugees. They conducted epidemiological research, measuring the incidence and prevalence of trauma just as they would have cholera or tuberculosis, which served to further and refine their diagnoses in the medical canon.

Humanitarian assistance, then, not only brings material relief but also provides a stable and productive research site – an "office space" for doctors and researchers alike – where the science of PTSD is constructed. Because researchers cannot generally travel and work in unstable conflict areas, and because psychologists and psychiatrists work only in refugee settings where basic structural, sanitation and health needs are met, differential humanitarian assistance necessarily yields differential science.

By the end of the 1990s, global humanitarian assistance[8] had more than doubled, from $2.1 billion in 1990 to $5.8 billion in 2000 (Buchanan-Smith and Randol 2002). These funds were channeled variously, through multilateral UN organizations and NGOs, as well as in the form of bilateral assistance (i.e., aid given directly from one country to another). Humanitarian assistance is disproportionately allotted, however, to high-profile emergencies in countries or regions that may be considered politically or strategically important.[9] Thus, refugee groups may receive vastly different amounts of international aid, creating a class system of refugee settlements where some groups get no aid whatsoever and remain in a semi-permanent state of depravity, lacking basic sanitation, food, and human security. Others are housed in refugee settlements that are provided with services, activities, and (importantly) a plan for these refugees to be eventually resettled elsewhere. In 1999, during the conflict in Guinea, the security of refugees was severely compromised due to a chronic lack of funding and assistance. That year, the UNHCR was unable to raise any funds towards a $4 million appeal to move the refugee camps away from the border with Sierra Leone where they were at serious risk of cross-border attacks and incursions. At the same time, the agency had a weekly budget of $10 million for Kosovar refugees and was even able to airlift refugees actively out of refugee

[8] Humanitarian assistance is defined as "emergency and distress relief" by the Development Assistant Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD), which collects and reports the humanitarian budget of its 30 member nations. This is a very broadly interpreted definition. Member nations often interpret "emergency" relief to include rehabilitation and developmental assistance and may even write conflict reduction and management costs into their humanitarian budgets. Moreover, DAC nations may also include aid to refugees within their own countries for the first year of residence, though these figures are presented as line items on their budget and more easily teased out of the total calculation. (HPG 2002)

[9] Over the last decade, these countries have included nations in the Balkans, Iraq, Afghanistan, Israel, and Rwanda. In 2000, five countries received less than $10 per affected person (North Korea, Somalia, Tajikstan, Uganda, and Guinea-Bissau); five received between $20 and $36 per person (Sudan, Angola, Burundi, Sierra Leone, and Tanzania); and one received $87 per person (The Democratic Republic of Congo). Southeastern Europe received $185 per person.

camps in Macedonia. That year, the international community reportedly spent $120 for each person under the mandate of the UNHCR in the former Yugoslavia, as opposed to about $35 per person in West Africa (UNHCR 2000). "These substantial differences cannot be explained by the varying costs of providing humanitarian assistance in different countries….They imply that different standards are being applied, that that resources are not being allocated on any equitable basis. In other words, the allocation of official humanitarian aid is not impartial" (Buchanan-Smith and Randol 2002: 4).

If the allocation of humanitarian aid is not impartial, neither is the research that follows, not only because of *where* the aid is provided, but also because of *who* is providing it. There has been an increasing trend through the 1990s to channel humanitarian assistance through NGOs. By 2000, NGOs such as Medecins Sans Frontiers (MSF), Red Cross/Red Crescent, and Oxfam funded 64 percent of humanitarian assistance. For the United States, strained relations with multilateral UN organizations, which the government criticizes for being wasteful and misdirecting funds, account for increases in aid given through NGOs (as well as the increased aid given bilaterally[10]).

The reason NGOs, particularly U.S.-based NGOs, are often preferred is because they are seen as more accountable and are mandated to consistently submit evaluation research of their aid work. If their work is to provide psychosocial support or interventions to refugees, then their evaluation research specifically reflects the efficacy of the psychological paradigm being presented on their client population. Consequently, intervention sites are fast becoming venues for data collection. Moreover, the continued professionalization of humanitarian assistance (e.g., the prevalence of research personnel

[10] Humanitarian funding from the U.S. is increasing provided in the form of bilateral support, which in 2000 totaled 1.3 billion, over double the amount channeled through multilateral organization such as such the High Commission of Refugees (UNHCR) and the World Food Program (WFP).

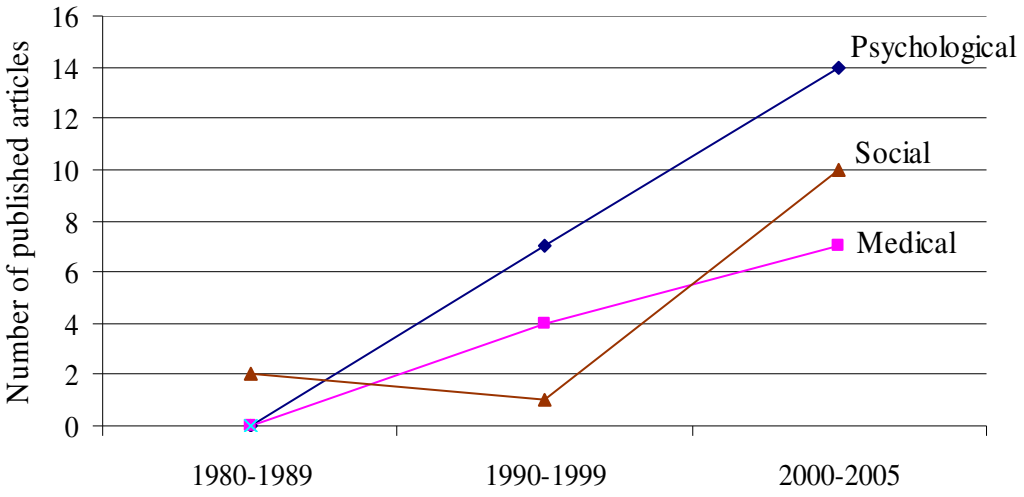
with academic affiliations) assures that a good amount of this research will be published in academic and medical journals and potentially accepted as canon.

Health interventionists and scholars at work

If the academic literature is any indication, psychological interventions are on the upswing (see Figure 2.2 below). This review of published literature on health interventions for refugees[11] indicates that, over the past 26 years, a growing number of interventions that academicians write and publish about are psychological ones. Moreover, not only are health interventions increasingly psychological in nature but that these psychological interventions are primarily focused on Western refugee populations, e.g., Eastern European refugees (see Table 2.1 below). During the height of the humanitarian response in Bosnia, over 180 organizations were known to be providing psychosocial support and counseling to at-risk clients (Black & Tosic 1999). The bias in these types of humanitarian responses has no doubt yielded a body of literature on refugee trauma that is similarly preferential in its research population (Eastern Europeans) and epistemological paradigm (trauma as psychopathology).

[11] In EBSCO Academic Search Premier, a database which includes public health and other health related journals such as the *American Journal of Public Health*, *Journal of Community Health*, *Journal of Epidemiology and Community Health*, *JAMA*, *Social Science and Medicine*, etc, I entered the search terms "refugee," "health" and "intervention" with the limiters being that results come from peer-reviewed journals, published from 1980 to 2005. This yielded 69 articles. Of these, I looked at only those articles that were about interventions directed at refugee populations. This reduced the total number of articles to 41.

Figure 2.2. Types of health interventions for refugees presented in peer-reviewed academic journals: 1980-2005



Psychological: Interventions most often involving individual focused or family focused therapy. **Medical:** Interventions such as vaccinations, obstetric procedures, nutritional supplementation, etc. **Social:** Social/community intervention such as efforts to strengthen social networks, building community capacity, etc.

Table 2.1. Peer-reviewed articles on refugee health interventions: 1980-2005

	All interventions (N=41)		**Psychological Interventions only (N=21)**		**Non-psychological Interventions only (N=20)**	
	Number	*Percent*	Number	*Percent*	Number	*Percent*
Number of articles						
1980-1989	2	*5*	0	*0*	2	*10*
1990-1999	15	*37*	7	*33*	8	*40*
2000-2005	**24**	***58***	**14**	***67***	**10**	***50***
Type of interventions						
Psychological	**21**	***51***	--	--	--	--
Medical	11	*27*	--	--	8	*40*
Social	13	*32*	--	--	9	*45*
Structural	3	*7*	--	--	1	*5*
Origin of target pop. (if applicable)						
African	**9**	***22***	3	*14*	6	*30*
Southeast Asian	**9**	***22***	4	*19*	5	*25*
Middle Eastern	4	*10*	4	*19*	0	*0*
Eastern European	**9**	***22***	**6**	***29***	3	*15*
Latin America	2	*5*	1	*5*	2	*10*
Site of intervention (if applicable)						
North America	**15**	***37***	**6**	***29***	**9**	***45***
South America	1	*2*	--	--	1	*5*
Northern Europe	4	*10*	2	*10*	2	*10*
Eastern Europe	2	*5*	1	*5*	1	*5*
Africa	6	*15*	2	*10*	4	*20*
Australia	1	*2*	1	*5*	0	*0*
Asia	5	*12*	4	*19*	1	*5*
Intervention for children/adolescents?	6	*15*	1	*5*		
Intervention for women?	7	*17*	3	*14*		

In EBSCO Academic Search Premier, a database which includes public health and other health related journals as the *American Journal of Public Health*, *Journal of Community Health*, *Journal of Epidemiology and Community Health*, *JAMA*, *Social Science and Medicine*, etc, I entered the search terms "refugee," "health" and "intervention" with the limiters being that results come from peer-reviewed journals, published during 1980 to 2005. This yielded 69 articles. Of these, we looked at only those articles that were about interventions directed at refugee populations. This reduced the total number of articles to 41.

Interventions are meant to improve health and well-being. The research above represents canonized academic knowledge that informs the social construction of the traumatized refugee archetype, but it also represents attempts by doctors, psychologists, and other health personnel to address at least one aspect of the myriad of needs that refugees have. Given the history of public health atrocities – from forced sterilizations to the Tuskegee syphilis experiments – the possibility of providing individuals, particularly individuals who have gone through horrible ordeals, with extraneous psychological care does not seem like a hideous transgression, regardless of what it represents. Even if the traumatized refugee paradigm was borne out of a racialized Eurocentric humanitarian response to traumatized Yugoslav refugees, and the translation of Western psychopathology is at times imperfect, does having an intervention where people are simply given the opportunity to talk to someone (i.e., a therapist) really hurt anyone?

At minimum there is little evidence that it always helps. Common objections to models of psychotrauma programs in refugee camps include the argument that refugees do not see their mental health as a priority issue to be addressed separately, that there is no empirical basis for the claim that a large percentage of refugees have mental disorders, that there is no such thing as universal trauma response, and that there is limited evaluation research available to prove the value of trauma counseling (Van Ommeren 1997). Moreover, the "sick role" precludes a myriad of other roles. Derek Summerfield, who offers one of the most often cited critiques of the promotion of PTSD as a public health issue, argues, "Trauma programmes have not been asked for by survivor populations. The objectification of the understandable misery of war as a pathological entity apart ('trauma') – a technical problem to which short term technical solutions like

counseling apply is a serious distortion, and for the vast majority, posttraumatic stress is a pseudocondition" (Summerfield 1999: 1461). Mental health models fail to acknowledge the role of social engagement (including work) as an antidote to mental ill-health, even among the "White" refugees who would presumably get the most out of mental health interventions. Eastmond (1998) compared how cohorts of Bosnian refugee families in Sweden from the same rural town and refugee camp in Bosnia fared. He found that the groups resettled in a location that offered temporary jobs had fared better. In the group that had been offered psychological services but no work, most of the adults were on indefinite sick leave a year after arrival.

When the refugee experience is subsumed by a medical etiology of trauma, the inherent political and social justice implications of being a refugee fade as a consequence into the periphery. The psychological services and interventions provided to these individuals may not always "harm" them in the short run (though they have severe ramifications at the conceptual and institutional level – discussed in later in this chapter), and interventions are not necessarily a zero-sum game (e.g., a choice between vaccinations for smallpox and group therapy for trauma). However, framing trauma as "biopsychomedical" not only depoliticizes it but dulls the urgency of securing structural factors that would affect the health of this population, such as employment and housing, i.e., the *other* things refugees may need.

Researching trauma: On a scale of 1 to 10, how pleasurable was your torture?

The next chapter of this dissertation is a presentation of quantitative analysis using psychological measures as outcome variables. From a sociology *of* medicine

perspective, I am critical of the use of these measures to represent emotional distress for anyone, far less for individuals for whom such quantification is foreign to their cultural understanding of affective expression. Ultimately I decided that it was important that I undertake this research because of the translation of such constructs into immediate material gain for clients (i.e., the benefits conferred with medical diagnosis – discussed later in this chapter). Moreover, I felt that I would be contributing something important to the field, bringing a sociological perspective to the medical sciences by utilizing the tools and language of psychometrics to question the medical construction of trauma from within. As the resident "skeptical researcher" at PSOT, I often encountered not only varying interpretations of psychological measures, but also conflicting attitudes towards research and knowledge creation.

"Clinical impression always supersedes diagnostic scales or surveys." This was one of the first things the research director at PSOT explained to me as I was familiarizing myself with diagnostic instruments such as Harvard Trauma Questionnaire, (a 16-item Likert scale measurement for PTSD) and the Hopkins Symptom Checklist (a 25-item Likert scale measuring symptoms of anxiety and depression). These survey instruments are meant to be tools for a clinician to reach his/her diagnosis with some consistency, but if a clinician feels that a patient is depressed, despite the failure of his/her score on the Hopkins Symptom Checklist to reach the 2.5 cut-off score, the instrument can always be overridden. Though they conduct these surveys with their clients as a matter of protocol, most clinicians at PSOT acknowledge that perhaps these instruments measure *something*, but it is not always clear what. For someone who interacts with people in a care-taking role, a score of, say, 2.3 versus 2.5 is negligible.

Where a score of 2.3 versus 2.5 *does* have profound significance (both conceptually and statistically), however, is among the researchers who are working to produce and refine these diagnoses as a matter of science.

The pursuit of medical knowledge often manifests surreal encounters between the patient-subject and clinician-scientist. Kevin[12] is a clinical psychology student who was conducting his dissertation research at PSOT in 2006. He was a very serious, slightly nervous, graduate student who looked to be in his mid-20's, with a sly but quiet sense of humor. At that time there were only the two of us who were actively collecting research data at the clinic. We were under the supervision of the research director and there were two additional graduate students acting as research assistants.

Kevin's dissertation project had to do with resilience and coping style among torture survivors. I never learned much about the actual topic, all I knew was that it was a quantitative project that involved validating a number of psychological scales that had never been used with this population and that he had a goal of conducting about 60 interviews (the sample size he needed to attain adequate statistical power) by the end of summer/early fall.[13] I knew about the "magic number" he needed because it was a constant source of stress for him. Whenever I saw him it was a big topic of conversation – how many interviews he got that month, what was the average for the last week, and if

[12] All names used are pseudonyms, and identifying information has been altered for survivors of political violence.

[13] I was sympathetic to Kevin's plight because I was finishing up my 25 interviews and knew how complicated the logistics were. He was reliant on clients volunteering for these unpaid interviews, and needed to coordinate with the stable of volunteer interpreters (who were often the ones you had to call first so that they could call the client and make the appointments for you), as well as research assistants to solicit and conduct the interviews in his absence. The process often involves multiple rounds of "phone-tag," and even after a client has consented to an interview and an interpreter has been arranged, simply finding an empty room can be problem.

this trend continued would he get enough respondents by the end of the period he had allotted for data collection.

The particulars of Kevin's project came to my attention one day because, either browsing through his questionnaire or talking to the research team, I learned that one of the scales administered was a 7-point "semantic differential" Likert scale in which respondents were asked to respond to items on a scale of -3 (strongly disagree) to +3 (strongly agree). Likert scales are a Western-derived phenomenon, created in the 1930's by Rensis Likert, a psychologist and the founder of the University of Michigan's Institute for Social Research. These scales are popular in consumer research, public opinion polling, and social science research in a variety of cultural settings; Likert's later work became particularly popular in Japanese management theory in the 1960's and 70's. However, groups that are not routinely the subjects of such inquiry – including many non-Western populations – may be unfamiliar with the concept representing or ranking feelings with numbers.[14,15] This is a common issue at the clinic; clinicians have on hand large laminated cards with numbers along a linear continuum that are used as visual aids when administrating diagnostic scales. I didn't know much about psychometrics, it struck me that the -/+ scale could only make the enterprise all the more confusing and nonsensical.

The scale that Kevin was administering became more disturbing when I saw that the "semantic differential" part of the scale referred to bipolar, or opposing, pairs of

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[14] See: Carr, S. C., D. Munro, and G. D. Bishop. 1995. "Attitude assessment in non-western countries: Critical modifications to Likert scaling." *Psychologia* 39:55-59; Flaskerud, J. H. 1988. "Is the Likert scale format culturally biased?" *Nursing Research* 37:185-186; and Lee, Jerry W., Patricia S. Jones, Yoshimitsu Mineyama, and Xinwei Esther Zhang. 2002. "Cultural differences in responses to a Likert scale." *Research in Nursing & Health* 25:295-306.

[15] Moreover, scale development is commonly conducted with convenience samples of college students (Hodge and Gillespie 2007)

adjectives (e.g., pleasant/unpleasant, enjoyable/unenjoyable) which respondents were asked to relate to an experience (e.g., "Did you find the event pleasant?" Did you find the event unpleasant?") Again, this scale was designed to measure psychological reactions to a range of experiences and stimuli. The problem was that the event Kevin was inquiring about was respondents' torture experiences, and the scale he was validating did in fact actually include "pleasant/unpleasant" and "enjoyable/unenjoyable" among various pairs of opposing adjectives. In his research endeavor to apply this psychological scale to these situations he hoped to validate it with a population for which it had never been adapted, he wound up asking torture victims to rate how enjoyable or how pleasant they found their torture experience.

Kevin knew how absurd those particular items were, and he was uncomfortable when he got to that part of the survey. He told me he tried to explain to the respondents that this was a set of questions that was obviously designed for other situations…but that he still asked them. At least one research assistant, a first year clinical psychology student named Anya, eventually refused to ask those items. It was ridiculous, she said, and she was embarrassed to even ask them, apologizing profusely before, during, and afterwards. Aside from the callousness of doing this to torture victims (though apparently they were more confused than indignant or offended), I did not understand how those particular items were going to yield meaningful statistical data. "I'll probably have to boot them in the final analysis," Kevin admitted. "Then why not just exclude them now and save everyone from a potentially upsetting encounter?" I thought.

The answer was that, as a graduate student and a research scientist in training, Kevin was being prudent. I had enough experience with survey research and quantitative

data collection to understand the basic premise that, methodologically, it's always better to have more data and justify collapsing categories or excluding items later, than not to have collected it at all. In his pursuit of a viable, scientifically-sound dissertation, Kevin was straddling the uneasy line between eliciting meaningful aggregate data from individual experiences and treating individuals as data points.

U. S. refugee policy and the politics of human rights victimhood

In November 2007, a Canadian federal court declared that the U.S. had breached the human rights of asylum-seekers as they were articulated in the Refugee Convention and the Convention against Torture. The breach was of a degree that Canada was obligated to suspend the three-year-old "Safe Third Country Agreement." This agreement had allowed Canadian officials to turn back asylum-seekers who arrived in the U.S. but preferred to seek asylum in Canada. With its 2007 decision, the Canadian courts declared the U.S. an unsafe place of refuge for these individuals, and Canada would no longer return any asylum-seeker who wanted to leave the U.S. While domestic and international NGO's, such as Amnesty International, the American Civil Liberties Union, and the Lawyers Committee for Human Rights (now, Human Rights First), have long argued that U.S. violates international human rights principles by forcibly repatriating asylum-seekers to countries where they would be at risk of serious human rights violations (Salehyan 2001), this was the first instance where a country openly declared these claims and used them as a basis to alter its own policy.

Despite its claim of, "a historic policy…to admit to this country refugees of special humanitarian concern, reflecting our core values and our tradition of being a safe

haven for the oppressed" (U.S. Department of Health and Human Services 2007), U.S. refugee/asylum policy has long been openly biased in its assignation of refugee status. Formal refugee status is a privileged and selective designation, and asylum-seekers, even if they reach the U.S., continue to face harsh detention conditions and adversarial asylum hearings. What follows is a brief overview of U.S. refugee/asylum policy, including the historical roots of "refugee" designation as a Cold War-era political tool, as well as the increasingly chaotic asylum policies of detention and repatriation that led Canada to its severe court ruling.

What is a refugee?

In 2005, the *New York Times* published a photo of three African women casually sitting around the cluttered but festively decorated office of *Nah Weh Yone*, a community-based African support group in NYC. It was initially started for the many Sierra Leoneans who migrated to NYC during that country's civil war in the 1980s and 1990s by a senior clinical psychologist at PSOT who is from Sierra Leone. In the photo, the women were having an animated conversation. One woman was holding a baby in her arms, and they were all dressed in traditional African garb and head wraps. The article accompanying the photograph was about how these particular women, identified as refugees, had mixed feelings about the widespread appropriation of the word "refugee" to describe people who were displaced by Hurricane Katrina.

The term "refugee," and the delineation of who has a rightful legal claim to refugee status, varies widely across international bodies and domestic immigration

policy. The 1951 Convention Relating to the Status of Refugees (the "Refugee Convention") specifically defines those who qualify for refugee status as:

> [A person who] owing to a well founded fear of being persecuted for reasons of *race, religion, nationality, membership of a particular social group or political opinion*, is outside the country of his origin 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. [italics mine]

In the U.S., refugee status is a rare and coveted entity.[16] Under current immigration policy, individuals can be granted refugee status only if they've applied from outside the U.S. (once in the U.S., individuals are eligible to apply only for asylum). The refugee application process is often long and grueling and relies on the ability of the person applying to be able to reach a U.S. Embassy or to be in a refugee camp with a U.N. presence. As stated in the earlier, different conflicts have different amounts of international presence; even though refugee camps inhabitants may have had "acute" migrations, leaving with little or no planning, this requirement still prioritizes the particular acute refugee groups from conflicts that draw greater humanitarian attention (i.e., have established refugee camps with aid workers present to collect and process applications). This requirement also selects for the "anticipatory" refugee, who has the time and resources to safely travel and arrange for the necessarily procedures at a U.S. embassy well before their departure leave.

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[16] Since the 1980 Refugee Act, the annual number of refugee admittances has been as high as 207,116 in 1980 and as low as 27,100 in 2002. A maximum number, or "ceiling," of refugees allowed admittance every year is set by the U.S. Department of State, which also sets quotas for geographic regions (broken down as Africa, East Asia, Europe, Latin American and the Caribbean, and the Near East and South Asia). In Fiscal Year 2006, the ceiling for refugee admittance was 70,000 and the actual number of refugees who were admitted was 41,277 (U.S. Department of State 2006a).

Applicants for refugee admission are categorized into three specific groups: people who individually apply for refugee status, groups that are identified by the U.S. Department of State as deserving of special humanitarian attention (for example certain nationalities, clans or ethnic groups, sometimes in specified locations), and the immediate family members of refugees or asylees already in the U.S. They undergo extensive health screenings and a 13-step security screening that involves the Department of Homeland Security, U.S. embassies, the FBI, the CIA and the U.N. High Commission for Refugees (Pojmann 2003).

Those who are granted refugee status are escorted to the U.S., where they are eligible for certain short-term benefits and services to aid in their resettlement process. Refugee settlement and benefits are coordinated by the Office of Refugee Resettlement, part of the U.S. Department of Health and Human Services and are subcontracted to a variety of non-government organizations, including church groups and community organizations. (You can sometimes see groups of arriving refugees who have been met at the airport by the voluntary agency in charge of resettling them. They are usually easily spotted by the matching t-shirts that they've been given that say "Catholic Charities," etc.) Benefits are provided typically for up to eight months and include housing, medical care, food, and a caseworker's assistance. They are provided because, unlike immigrants who enter through family or employment ties, refugees are not required to demonstrate self-sufficiency (Bruno 2006). Refugees *are*, however, ultimately required to pay back the costs of their airfare and resettlement.

The "Refugee": A person fleeing Communism or countries in the Middle East

Historically, refugee admissions have reflected U.S. political interests and military engagements, particularly foreign policy objectives to discredit or destabilize Communist governments. As an illustration, over three-quarters (77 percent) of the over 2.7 million refugees in the U.S. are from either the former Soviet Union or Southeast Asia (Singer and Wilson 2006). From the initial stages of international refugee discourse post-WWII, policies adopted by the U.S. diverged sharply from the guidelines and procedures supported by the international community, as represented by the United Nations (Newland 1995; Salehyan 2001). In 1947, the U.S. opted not to fund or participate in the International Refugee Organization – later replaced by the United Nations High Commission for Refugees (UNHCR) – which was created to better organize refugee camps and facilitate the repatriation or resettlement of refugees displaced by WWII. The U.S., however, had an active refugee resettlement agenda of its own; over the next ten years nearly one million WWII refugees were admitted through various ad hoc refugee policies, such as the Displaced Persons Act (1948), the Refugee Relief Act (1953), the Refugee-Escapee Act (1957), and the Hungarian Refugee Act (1958), all of which the U.S. created specifically to admit refugees from Communist countries.

The sharpest divergence between early U.S. refugee policies and those of the international community was the definition of a refugee. The U.S. did not become a signatory of the 1951 U.N. Refugee Convention, which, as stated above, defined a refugee as a person who, regardless of her country of origin, had a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a

particular social group, or political opinion. Rather, the U.S. adopted a definition of refugee in the 1957 Refugee-Escapee Act that characterized a refugee as, "a person fleeing persecution in Communist countries or countries in the Middle East."[17] The Communist-centered definition was employed for multiple refugee groups over the next 20 years, including Hungary, Poland, Yugoslavia, in hopes that by admitting refugees from Communist countries en masse, the U.S. would demonstrate the supposed hardships of Communist control (Salehyan 2001).

In addition to publicly discrediting or embarrassing Communist governments, another goal of U.S. refugee policy was to initiate a "brain drain" of professionals from Communist countries. A National Security Council Memorandum characterized the Refugee Relief Act of 1953 as a means to "encourage defection of all USSR nationals and 'key' personnel from the satellite countries," and suggested that it would "inflict a psychological blow on Communism" and damage the Soviet economy through the hemorrhage of skilled professionals (Newland 1995: 191). In the decades that followed, the U.S. welcomed skilled refugees from additional countries, such as Iran, as well as "first wave" cohorts of Cuban and Vietnamese professionals.

It is unclear how successful these measures were in upsetting Communist countries' economic or political systems. In some respects, these efforts have actually advantaged these states (Newland 1995). There were economic gains for these countries in allowing mass exits of their population, including the collection of "exit fees" (applied to Soviet Jews and ethnic Chinese from Vietnam, for example) and seizure and

[17] While the U.S. later signed an amended refugee document, the 1967 Protocol Relating to the Status of Refugees, it did not adopt the U.N. definition of "refugee" into federal law until the 1980 Refugee Act

redistribution of the assets of those who left. Furthermore, once refugees settled in the U.S., they often sent remittances to families remaining in their home country, creating a major monetary flow back into the country, as was the case with Cuba and Vietnam, among others. Yet, while encouraging large numbers of discontented citizens to leave may in some ways be beneficial to the existing system of government, there are also significant drawbacks, including the likelihood of remittances going to anti-regime supporters and the ability of opposition groups to act more freely in exile.

Non-refugees: The asylum "roulette wheel"

Even after the Communist-centered definition of refugee was abandoned, individuals who are not fortunate enough to obtain refugee status and its accompanying benefits face a judicial system where successful asylum claims are inconsistently distributed, with unequal treatment of asylum-seekers from similar conflicts. For example in the 1980s Nicaraguan refugees fleeing Marxist Sandinista "totalitarianism" were welcomed and frequently granted refugee status in the U.S. Yet, those fleeing similar conflicts in El Salvador and Guatemala were systematically denied entry and rejected as "economic" migrants rather than true refugees. Unlike Nicaragua, El Salvador and Guatemala were U.S. allies in Central America and throughout the 1980s received billions of dollars of military support in the form of equipment and training. Those who received US military training were in turn accused of committing human rights violations against their own citizens. Salehyan (2001: 25) argues that, "accepting refugees from El Salvador and Guatemala, from a U.S. perspective, would damage relations with its Central American allies as well as implicate the U.S. in its tacit support of atrocities committed by government forces during the civil wars." Thus, Salvadorians and

Guatemalans could enter the United States only temporarily, and many were subsequently denied asylum (Zhou 2004).

Currently, asylum-seekers suffer the even greater hardships and lack credibility in the U.S. immigration court system, a situation the Canadian federal courts acknowledged with the 2007 decision. Under the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA), asylum claimants who have been caught entering the United States under false pretenses (e.g. with false documents) are immediately remanded to a detention facility until their asylum case can be heard by an immigration judge; this may take anywhere from weeks to months. The detention facilities are often glorified prisons or actual prisons housing criminal inmates.

In addition to confinement in poor living conditions, asylum-seekers face difficult legal processes that can exhaust time and resources. In order to maintain the pretense of "being a safe haven for the oppressed," the government continues to work to discredit asylum claimants themselves, most often labeling them as economic opportunists. "The image of economic migrants and 'bogus asylum seekers' overwhelming Western societies is a regular characteristic of media reporting on refugee issues and political debate" (Newman 2003:7).

The majority of immigrants who apply for political asylum in the U.S. (a total of almost 90,000 in 2004) are undocumented at the time of application (Amon 2006). Those who have entered the country illegally are considered to criminal offenders and their asylum claims become part of the "defensive asylum process." They must file two motions simultaneously: an asylum application and a motion for "Withholding of Removal," which would absolve them of criminal charges (the sanction being repatriation

back to their country of origin). These hearings are adversarial in nature, with evidence exhibits, cross examination, witnesses, etc. In 2004, two-fifths (42 percent) of nationwide applications for affirmative asylum, the procedure open only to those who entered the U.S. with valid papers within the last year, were approved. That year, little more than one-quarter (26 percent) of defensive asylum cases, the procedure for those who arrive with false or no documentation and which constitute the majority of asylum applications, were approved (Amon 2006).[18] Moreover, under IIRAIRA, if an Immigration Judge or the Board of Immigration Appeals makes a finding that a frivolous application was filed by the applicant, then that s/he will be barred permanently for any other immigration benefits.

The prospect of being granted asylum seems grim overall[19] and the variation between immigration judges and jurisdictions is significant. Asylum decisions vary widely, depending on an applicant's nationality, jurisdiction, and the gender and professional background of the immigration judge hearing the case. While cases were distributed to the 218 immigration judges on a random basis, the denial rate can range from 96.7 percent for Judge Mahlon F. Hanson in Miami, to 9.8 percent for Judge Margaret McManus of New York (TRAC 2006). Female immigration judges, over one-fourth of whom worked for immigrant/indigent population rights organizations before their judicial appointment, grant over half (53.8 percent) of asylum claims that come

[18] Heightened concerns of terrorism have only increased the political volatility of these asylum claims. Pointing to Ramzi Yousef, who entered the country by filing an application for asylum and was subsequently convicted of the 1993 World Trade Center bombing, a representative of the Immigration and Customs Enforcement Agency of the Department of Homeland Security admitted, "Since 9/11 and the creation of Homeland Security, we are scrutinizing asylum claims far more carefully" (Amon 2006: 4).

[19] Even once asylum has been granted, asylees are not afforded government support or resources mandated by international refugee guidelines, even though they have met the same criteria. Because the U.S. designates them as asylees, by the letter of the law, they are not eligible for refugee benefits.

before them. In contrast, male judges (less than one-tenth of whom ever worked for such organizations) grant less that two-fourths (37.8 percent) of asylum cases (Ramji-Nogales et al. 2007). Even when controlling for applicant nationality and presence of legal representations, for example looking only at Chinese asylum-seekers with legal representation, judges' denial rates range from 94.5 to 6.9 percent. The denial rates were consistent between courts as well; a Chinese asylum seeker in Atlanta Immigration court had a 7 percent chance of success while the same individual had a 76 percent chance of being granted asylum in Orlando Immigration Court (Ramji-Nogales et al. 2007).

Victims and perpetrators in immigration court

Perhaps one of the most dramatic cases of asylum applicants being recast as criminal perpetrators concerns a 2004 Court of Appeals case, *Olowo v. Ashcroft.* Esther Olowo, a Nigerian woman who was a legal resident in the U.S., faced deportation proceedings as a result of aiding the illegal entry of an undocumented six year old child of a friend into the U.S. in 2000. She argued for cancellation of removal based on her fear that her twin daughters (who were 10 years old at the time of her arrest) would face harm if she was ordered to return to Nigeria. She argued that her children would be subjected to female genital mutilation (FGM), a cultural tradition practiced by her community, the Yoruba tribe, that she was subjected to as a child. Furthermore, she argued that she would be unable to prevent this from happening due to social pressures.

The U.S. immigration courts have deemed an immigrant's well-founded fear of FGM can be grounds for cancellation of removal. Here, the mother, who had been subjected to the procedure when she was a child, did not argue the traditional argument

regarding fear to herself, but rather she argued that, under the "de facto" theory of deportation, if she was deported her daughters would also be de facto deported. Her only alternative would be to relinquish custody and leave her daughters behind, in this case most likely to the care of the state foster care system. Moreover, under the 2005 "Border Protection, Anti-Terrorism, and Illegal Immigration Control Act," (HR 4437) instances of document fraud/false passports are considered to be "aggravated felonies" where non-residents, including legal permanent residents like Esther Olowo, may be deported and barred from re-entry to the U.S. for life, despite the presence of minor children in the U.S. In sum, if she left her 10 year old children in the U.S. as wards of the state, Esther Olowo would likely not be able to see them again unless they were somehow able secure the resources to travel outside the U.S. to see *her*.

However, attempting to take her children with her to Nigeria was seen as an act of child endangerment. In their decision, the Court of Appeals not only rejected the argument that their decision would result in the de facto deportation of her children but instructed the Department of Homeland Security to make a report against the mother to Illinois' Department of Children and Family Services (DCFS) as well as order the court's clerk to submit a copy of the decision to DCFS alerting them that the mother had threatened to return to Nigeria with the children and had the "intention to allow her daughters to face FGM in Nigeria" (Olowo v. Ashcroft 2004: 34). The decision continued: "The notion that Ms. Olowo's daughters will be removed to Nigeria and subjected to this brutal procedure offends our sense of decency, and allowing Ms. Olowo to make this decision unilaterally disregards the legal rights of the children." (Olowo v. Ashcroft 2004: 34).

Converging jurisdictions: When the medical and the legal intersect

Wei Ling at JFK airport

Thus far in this chapter I have been examining the "traumatized refugee" archetype by looking at how the concepts of "trauma" and "refugee" have been constructed, with the goal of contextualizing the relationship of the two concepts within the experiences of the survivors of political violence who participated in this research. Before returning to that analysis, however, I want to introduce Wei-Ling, a girl I actually met prior to starting my own research at PSOT.

Wei-Ling was not, so far as I know, a survivor of political violence. She was an undocumented immigrant apprehended at JFK airport. Yet my experience with Wei-Ling warrants inclusion in a discussion of survivors of political violence because it was an instance where the converging medical and legal jurisdiction – which I later found to be so prominent in the lives of the individuals in my research – first came to light for me as a researcher, literally unfolding in front of me. When I met Wei Ling she was a 16-year old victim in a smuggling case who, along an adult male and another 13-year old girl, had been stopped by Customs and Border Patrol (CBP) officers at JFK airport with forged documents. Within 18 hours and right before my eyes, she became an adult detainee. This occurred a few months before I formally began my own data collection, and it was a significant catalyst in sensitizing me as a researcher to this particular issue.

In June 2004, I worked as a field researcher for PSOT, which was contracted by the government ("U.S. Commission on International Religious Freedom") to conduct a large-scale multi-site evaluation of secondary inspection procedures at ports of entry across the U.S. Customs and Border Patrol (CBP) had recently been turned over to the

Department of Homeland Security, and the goal of the project was to evaluate the procedures that individuals who entered the country illegally and had been detained at ports of entry went through. In particular, the Commission was interested in instances where immigrant detainees stated a fear of persecution if returned to their countries.

For almost 30 hours a week I worked in Terminal 4 of JFK airport in the secondary inspection area, where people were sent if a problem had been detected in the large "primary" inspection area. Secondary inspection was a classroom sized area with about 40 chairs where people waited to be seen. It contained a long counter in the front of the room where interviews were conducted by three or four CBP officers. There was one carpeted room with no furniture directly behind the counter and an adjoining corridor that led to supervisors' offices on either side and three or four formal "holding cells" for violent detainees in the rear.

Most people had minor issues, and they spent a minimal amount of time in secondary inspection. In some cases, an individual's name matched the name of someone on the government "no-fly" list, and they needed to answer a few questions or provide additional identification. Often Muslim women wearing a *niqab*, or face veil, were not able to reveal their faces to male officers in primary inspection; there was usually a female CBP officer on duty in secondary inspection and in these cases the woman would be ushered into the corner behind the counter where she would briefly lift her veil for the officer to match up against her passport.

My job was to observe CBP officials conducting interviews with adult detainees who had been flagged in primary inspection and were likely to be sent back to their country, most often because of fraudulent documents. The observations involved standing

behind the counter, behind the CBP officer, during the 10-20 minute interview with a checklist in my hand and checking off whether s/he completed certain elements of the more of less structured list of questions. If they expressed a fear of being persecuted (one of the items on the interview list), CBP made arrangements for them to be sent to the nearby detention facility, the Wackenhut Federal Detention Center[20] in Jamaica, Queens ("Wackenhut"), until they could have an appointment with an immigration judge.

Whether they were being deported or sent to detention, these individuals were stuck at the airport for a long time. If they were being deported, CBP protocol was that they could only be sent back on the same airline they came in on; thus they had to stay in the airport sitting in a chair until the next available flight, sometimes as long as 24 to 36 hours (I would see the same people sitting there across multiple "shifts"). If they were being sent to detention they had to wait until at least 9pm when the transport to Wackenhut collected detainees from the various terminals of JFK. If they were processed after 9pm, they had to stay in the airport until the next bus. If there was no room in the detention facility, they had to stay in the airport until a spot opened up. People with children were generally allowed to wait in the carpeted room, but most detainees sat in one of the 40 chairs. The only way you could tell them apart from the "regular" people waiting to be seen was that they had shackles around their ankles. All adult detainees, whether they are getting deported or sent to Wackenhut, are shackled from the moment they "fail" their secondary interview.

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[20] While the average length of stay at the 200-bed Wackenhut facility was about 109 days (and it takes about 6 to 8 months to see an immigration judge), Warren Lehrer and Judith Sloan's 2003 book, *Crossing the BLVD: Strangers, Neighbors, Aliens in a New America*, chronicled the story of Bovic, a Zairian man who fled the civil war to claim asylum in the U.S., only to spend over two years at Wackenhut before being released. Moreover, about one month after my assignment at JFK, in late July 2004, detainees at Wachenhut staged a highly publicized hunger strike. One year after that, in July 2005, the facility was closed; detainees apprehended at JFK were instead routed to county jails in Batavia, NY and Elizabeth, NJ where they were held with local inmates.

Aside from observing the brief interviews between detainees and CBP officers, my job was also to conduct lengthier semi-private[21] interviews with detainees who had gone through the CBP process and were awaiting deportation (primarily because they couldn't explain the false documents) or being sent to detention (most often because they expressed fear of being returned). At the beginning of each shift the researcher would check in with the supervising CBP officer, who would direct us to detainees whom we might interview. In the interviews, which lasted as long as 3 hours, we asked structured psychological scales for depression, anxiety and PTSD as well as about their experience with CBP procedures.

This is how I met Wei Ling; a CBP supervisor had pointed her out as someone to interview. She spoke fairly good English, which was a relief because using the phone interpreters during these interviews was awkward. Her parents in China had wanted to send her to the U.S. to stay with relatives, but they could not do this through regular channels. They paid for a broker who produced fraudulent documents and arranged for Wei Ling, another 13-year old girl from China, and a man in his 40's from Malaysia – both of whom also wanted to get to the U.S. but for whatever reason would not do so legally – to fly into the U.S. together as a "family." But once they got to JFK their documents did not pass inspection. Because the case involved minors traveling with an adult who wasn't related to them or really known to them, it was considered a smuggling case. Upon being apprehended, she and the other girl were separated from the Malaysian man (whom I also later interviewed). They had been staying in the carpeted room, which they had to themselves as they waited for an open spot in "family detention" (where

[21] We were in the supervisor's office, but for my own safety I was asked to leave the door at least halfway open, which was problematic when using a phone interpreter because the interviewee and I had to shout into the speakerphone and everyone outside could hear us.

people with children and unaccompanied minors were held). There wasn't anyone really "in charge" of the girls, but the carpeted room was just off the CBP counter and the door was always open so CBP authorities could see them at all times. Various CBP officers would pop their heads in occasionally to check on them and bring them McDonald's during dinnertime. At some point, someone gave them papers and markers and other things to occupy their time.

When I was interviewing her, Wei Ling was in fairly good spirits. About 40 minutes into the interview, as she was talking about school and the subjects she was interested in (one of the questions in the interview guide was about occupation), it suddenly occurred to me that she was talking about high school. Flipping back in my notes to the date of birth she's given me at the beginning of the interview I realized that she was 16 years old. As we were only allowed to interview adults, I had to end the interview. She went back to her friend in the carpeted room. I checked with the CBP supervisor who had referred me to her and found out that although Wei-Ling said that she was 16, her forged passport listed her age as 18.

By the end of my shift that night, Wei Ling's case had drastically changed. I had been in the office interviewing other detainees (this was when I interviewed the Malaysian man who had "smuggled" the girls in), and was not paying attention to what was going on in the main secondary inspection room. Apparently the forensic dentist employed by CBP, "Doc Alfred" as the officers referred to him, had examined Wei Ling's teeth and determined her age to be 18. She was taken from the carpeted room and shackled. She had to have her baggage formally searched at the rear of the room and so,

per CBP protocol, she emptied out all her personal belongings in front of the officers and whoever else was in the waiting room and wanted to watch.

When I reentered the main room, Wei Ling was sitting in one of the chairs alone and crying, and I went over to try to comfort her. We hadn't really spent too much time together, but given the circumstances I suppose I counted as a friend. She wasn't extremely fluent in English (though fluent enough that CBP didn't bring in an interpreter) and was very upset on top of that, so she didn't understand what was happening. She told me she didn't know why they had to go through her bags and why she had to wear "these things" (the shackles). And she told me she wanted to talk to her parents, if she gave them (CBP) the number would they call them for her? I knew the answer was no, but I asked anyway. The CBP officer told me that she might be able to arrange for a phone call once she was in the detention facility. I suddenly realized that she was no longer going to family detention with her friend; she was going to be sent to adult detention until the case could be sorted out.

On a personal level, I felt tempted to breach research ethics, and possibly the law, thinking up possible schemes to help Wei Ling. (I didn't speak Chinese but maybe if I quietly sneaked out her phone number, I could call my parents who could call her parents in China? Maybe her relatives here spoke English, could I call them?) Unable to hide my disbelief from the CBP officers, I found that they themselves did not necessarily agree with Doc Alfred's dental assessment. When I spoke to Frank, the CBP officer who had first briefed me on the new situation, he shrugged and said, "Yeah, I know…I have daughters, there's no way she's 18." But the doctor's ruling was a part of her legal case and, as officers of the law, they had to act accordingly. With one dental exam, Wei Ling

went from being a juvenile smuggling victim to a full-fledged adult criminal, possibly even an accomplice smuggler of the 13-year old girl. She was still sitting in the chairs when I left at the end of the night. It was after 9pm and I assumed she was not going to make the transport to Wackenhut that night, but I never saw her again.

Again, while Wei Ling was not a victim of political violence, she was stuck in the vicious intersection of forensic medicine and immigration law that exists in the U.S. The predicament of many of the survivors of political violence in this research reflects a similar intersection, but their struggles more often manifest themselves in immigration courts (rather than at the airport) and concern the validation of trauma through mental health diagnoses (rather than the validation of biological age through forensic dentistry). The medicalization of political violence among clients seeking services at PSOT is institutionalized to the point where there is a constant negotiation—by the individuals and the medical and legal institutions involved — over clients' political (or legal) status and their patient status. The remainder of this chapter looks at the convergence of medical and legal jurisdiction in these individuals' lives.

The stress of legal uncertainty

On a very basic causal level, legal status converges with medical status because it is hugely stressful for people who have been tortured and persecuted to have the threat of deportation looming over their heads. The most prevalent problems identified in group and individual therapy sessions, the issues that caused the most mental distress, were issues such as finding a lawyer, applying for asylum, finding a lawyer, going through the process multiple times. Perhaps the single most important factor affecting the outcome of

an asylum case is the presence or absence of legal representation. While having a lawyer by no means ensures success, 64 percent of those with representation are denied asylum; the denial rate for those without attorneys is far higher, 93 percent (TRAC 2006).

Besa, a 41 year old Albanian woman, arrived in the U.S. three years ago. Her husband's family had been politically active against the Albanian government, and his nephew had been recently killed. One night three men, whom Besa and her husband recognized as party officials, broke into the house they lived in with their two teenage children. The men beat her husband and raped Besa. The family sold their belongings and fled immediately. Besa's husband arrived a few months after she and her children; he had been briefly held in detention in Chicago.

Besa's asylum case was difficult and still going on when I spoke with her, over 6 years after she'd arrived and begun the asylum process. Without adequate representation her case was denied and appealed repeatedly. One of the issues, she reported, was that she'd never told the immigration officials about her rape. She blamed herself for this; she was afraid that her asylum case was being denied because she had not reported the rape to immigration officials earlier, and by introducing it later, her testimony appeared inconsistent. In her interview, Besa described how a second court denial and the inability of her son to attend college because of his immigration status led to a major depressive episode requiring nine days of hospitalization at Bellevue three years prior:

> [The court denial] really came quickly, after less than one year. And the case was denied again…I was blaming myself because I was the first that came here to the country and **I was thinking that I supposed to tell them everything. Why I didn't**?....We only one month to find out where to apply for federal appeal. [Emphasis mine]

> During that time I got sick because my son was doing the application for the college and no college was taking him, even [though] his average was ninety-eight point four.
>
> That way I had the court, and this way I had my son's school…He went to Hunter [College]….They say no, we can't take you because you are not legal in this country….So I got so sick and I got depression and I was crying and crying….We had no where to go.

Haamid, a Guinean man in his mid-50's, went through a two-year process of applying for asylum. His experience exemplified how stressful it is to be undocumented, without resources, and dealing with a complicated, frustrating, and frightening legal process. I will discuss Haamid's story in greater detail later in Chapter 5. Haamid was dismissed from the police force when he refused to arrest and torture political dissidents. The Guinean government was seized in a coup directed by Lasana Conte, and he became involved in anti-Conte political organizing. As a result, he was arrested on multiple occasions where he was beaten with rifle butts (and lost two teeth), tied up in forced positions, hung upside down, burned on the stomach and genital regions with cigarettes. Shortly before he left his country in the late 1990s, Guinean authorities shot and killed his adult son while he walking down the street at dusk. Haamid feared that he had been the intended target.

I describe the specifics of his torture experience to highlight the point that in the three years he had been in the U.S., where he he had been homeless for most of the time, he faced an endless cycle of denials and appeals, Haamid had been ready to give up and return to Guinea.

Haamid's asylum case was complicated by the fact that he didn't speak English well and intially had no legal representation. In addition, he had all of his belongings

including his identification and papers stolen at a bus station shortly after he arrived. He was homeless for much of his first three years here; in his clinical notes his therapist noted, "he was apparently such a pitiable sight that the officers there [in the immigration court] gave him food before sending him on his way." That incident followed his first asylum denial, a year after he initially arrived in the U.S.

In 2001, after a cycle of continuations and denials and appeals, his therapist reported "Pt. not actively suicidal, but is prepared to 'give up' and present himself at the Guinean Embassy to be deported." In a psychological summary of Haamid's case, his clinician stated:

> [Haamid] has felt so hopeless at times that he was prepared to go to the Guinean consulate and **ask to be returned home to die** rather than be exposed to continuing stressors and indignities in the US. This decreased ability to tolerate frustration has even manifested itself during his asylum process. [Emphasis mine]

One month after his therapist wrote that report, Haamid arrived at the Manhattan Courthouse for another asylum hearing, only to find that the case had been contined (delayed) for another three months. Haamid, still homeless and additionally distressed over the events of 9/11 which had recently occurred, threatened to kill himself in the courthouse. His therapist at PSOT was called and spoke to him on the phone before going downtown to the courthouse in person. His notes read:

> Pt seen for emergency indiv therapy treatment session at 26 Federal Plaza. **While there, therapist is asked to testify during asylum hearing.** Pt's case continued until 1/3/02. Pt expresses [suicidal ideation] with vague intent and no specific plan. Pt and therapist spend 2 hrs + together debriefing with legal team and alone.

Zareb, a widower in his early forties from Angola, had recently arrived in the U.S. with his two infant daughters, ages 3 and 1 years old. A physician in Angola, he reported

that because of his political affiliation he was unable to practice medicine, his house was targeted for demolition, and his family had been attacked by the local authorities. His petition for political asylum had been denied a number of times and he was unable to find adequate legal representation. Living in poverty and trying to care for his children, he relied on a local church for temporary housing and often struggled to find the bus fare to travel to the food pantry across town, which itself provided minimal supplies ("only cans, some fruits, and some rice, no salt, no sugar, no oil, no Pampers.") When he sought health care for his children, the social worker assigned to his case reported their situation to the Agency of Child Services with implicit threat of having his children removed - a situation that eerily mirrored events in Angola where the local government tried to kidnap his children. His clinical notes reflected the mental distress that these continued stressors evoked:

> [Zareb] reports significant nightmares…He admits past suicide ideation, and expressed future suicidal thoughts (i.e., if immigration refuses me, I'll kill myself on the spot.")….He complains of professional, academic, and economic disempowerment, and is frustrated with the bureaucratic nature of the immigration system, the shelter system, and the child welfare system. He states, "**It feels like everyone in the world is against me."** [Emphasis mine]

Medical documentation and testimony

It was convenient that Haamid's therapist was at the courthouse talking him through his suicidal ideation; he was also able to provide testimony. Clinicians at PSOT consider providing testimony, in the form of affidavits, clinical summaries, or in-person testimony, to be part of their job. While not all asylum-seekers, including those who report experiences of torture, include a medical diagnosis to support their asylum claims, almost all clients at PSOT who *have* been diagnosed incorporate that diagnosis into their

court cases. With the odds of being granted asylum so tenuous, applicants are likely to introduce any piece of evidence that can affirm a claim.

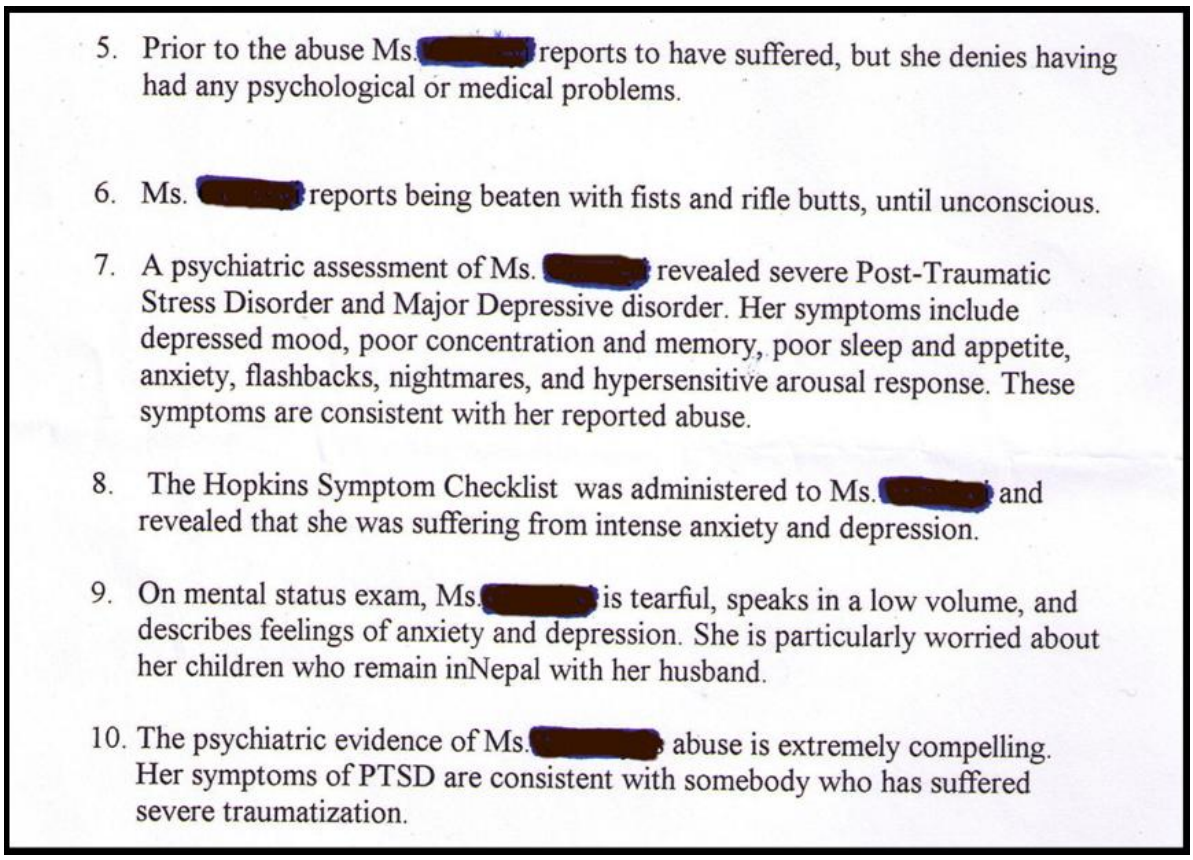
In immigration court the burden of proof rests on the asylum-seekers to substantiate their identity, a "well-founded fear of persecution" for the specific reasons of "race, religion, nationality, membership of a particular social group, or political opinion," and an inability to receive protection from that persecution in the home country. To show a well-founded fear of persecution in their home countries, applicants must both indicate subjective fear and present objective evidence that is "credible, direct and specific" indicating persecution as a reasonable possibility (Ytreberg 2007). Unlike traumatized veterans, the very existence of their war is often suspect. Even when asylum-seekers can established they were tortured or persecuted, they must show that the conflict from which the persecution stemmed remains unresolved. Otherwise, no "well-founded" fear exists, and immigration courts will deny asylum. Unlike survivors of sexual abuse, who must substantiate their victim status in a court of law, asylum-seekers also have to substantiate both their victimization *and* their very identity as evidenced by whatever documents with which they could flee. Furthermore, the consequence of failing to substantiate claims, repatriation, is dire. As a result, medical legitimation—specifically the assertion of PTSD—becomes a crucial tool in securing a tentative political status.

At PSOT, clients may be initially referred to the clinic by their lawyers. In some cases, clients receive referrals from city agencies, shelters, or friends, and the clinic subsequently helps them secure a pro bono immigration lawyer. After a 3-hour intake session and formal acceptance into the program, clients are eligible for psychological, medical, and social services, as well as a letter for submission in their court cases stating

enrollment in the program for services. After patients participate in the program for a while, long enough to establish therapy notes, the clinicians who treat them often write formal affidavits or on occasion appear in court in support of their asylum cases. Though some clients ask for letters from the medical doctors at PSOT (generally to substantiate that injuries documented on their body are consistent with the torture techniques of a certain region or nations), clinical psychologists write almost all the letters.

The letters that the clinicians write to the court are fairly rote: a statement of the patient's presentation, diagnosis, and course of treatment. Figures 2.3 to 2.6 present pieces of an affidavit that is typical of the thirteen that I reviewed. Figure 2.3 below shows the diagnostic portion of a typical affidavit.

Figure 2.3. Medical affidavit: Diagnosing PTSD



5. Prior to the abuse Ms. [redacted] reports to have suffered, but she denies having had any psychological or medical problems.

6. Ms. [redacted] reports being beaten with fists and rifle butts, until unconscious.

7. A psychiatric assessment of Ms. [redacted] revealed severe Post-Traumatic Stress Disorder and Major Depressive disorder. Her symptoms include depressed mood, poor concentration and memory, poor sleep and appetite, anxiety, flashbacks, nightmares, and hypersensitive arousal response. These symptoms are consistent with her reported abuse.

8. The Hopkins Symptom Checklist was administered to Ms. [redacted] and revealed that she was suffering from intense anxiety and depression.

9. On mental status exam, Ms. [redacted] is tearful, speaks in a low volume, and describes feelings of anxiety and depression. She is particularly worried about her children who remain inNepal with her husband.

10. The psychiatric evidence of Ms. [redacted] abuse is extremely compelling. Her symptoms of PTSD are consistent with somebody who has suffered severe traumatization.

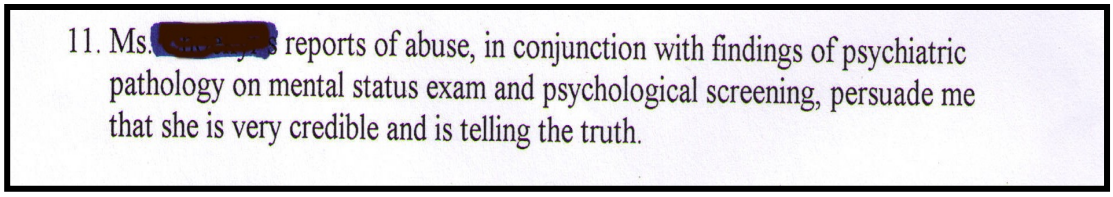
After the course of treatment paragraph, there is often a "non-malingering" clause that states, "I believe that Ms. [client's name] legitimately suffers from PTSD and Major Depressive Disorder" (See Figure 2.4 below). Though I have never seen a clinician express suspicion in an affidavit (presumably clinicians would not write negative assessments), clinicians at times express suspicion in their internal PSOT documentation. For example, the following is an excerpt from an intake interview conducted with one of the participants in the project:

> [The client] demonstrated a wide range of affect, at times appearing histrionic in presenting the details of her life. **She expressed feelings of self-pity and cried dramatically at one point.** Thus, the interviewer harbored some suspicions that the client was dramatizing her history for the interviewer's benefit. These

> suspicions, however, are the interviewer's own interpretation of the session and do not nullify the symptoms expressed by the client. [Emphasis mine]

Such observations are a normal part of psychological evaluation; clinicians often note when they think a client is being disingenuous or playing up or hiding symptoms. In the context of individuals whose "truth telling" is already heavily scrutinized by the legal system, however, it adds another layer of forensic inspection.

Figure 2.4. Medical affidavit: Forensic psychology

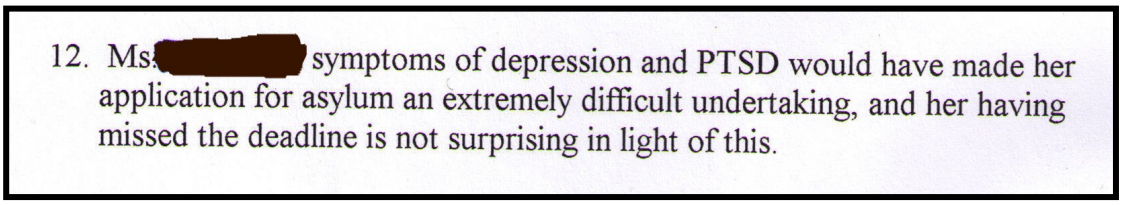


11. Ms. [redacted] reports of abuse, in conjunction with findings of psychiatric pathology on mental status exam and psychological screening, persuade me that she is very credible and is telling the truth.

Clinicians sometimes attempt to provide a medical basis to explain the difficulties clients experience with the legal process; in a sense, they provide a "doctor's note." For example, a letter might include a detailed description of a specific PTSD Criterion C (avoidance and numbing) symptom, "the inability to recall an important aspect of the trauma." In asylum hearings, a person may be denied asylum if their oral testimony differs in the slightest from their written testimony. There are a multitude of reasons why this might be, including that clients may not have access to a lawyer to help them write their testimony in English, and there are no court appointed interpreters to assist in the oral testimony. Clinicians are likely to highlight Criterion C when they have ascertained that clients have not or might not be able to deliver reliable testimony, regardless of reason. In Figure 2.5 below, the clinician's affidavit attempts to present the late

submission of the client's court paperwork as a consequence of her psychological distress or dysfunction.

Figure 2.5. Medical affidavit: Medical claims to address court performance


12. Ms[redacted] symptoms of depression and PTSD would have made her application for asylum an extremely difficult undertaking, and her having missed the deadline is not surprising in light of this.

Letters, presented as a medical recommendations, often close with an assertion that clients should not be repatriated. For example, in Figure 2.6, a clinician details how a client's treatment with psychopharmaceuticals and therapy has been partially successful (the documents are very careful to claim that the client has not "fully recovered"), but that being returned to her country of origin would be detrimental to her psychological progress. Another affidavit, attesting the client was no longer symptomatic, closed with, "PTSD can be a chronic and reoccurring disorder that requires long-term treatment. I believe that the stress of being returned to [country of origin] would cause her symptoms to resurface. Furthermore she is not likely to receive treatment for her PTSD in [country of origin]."

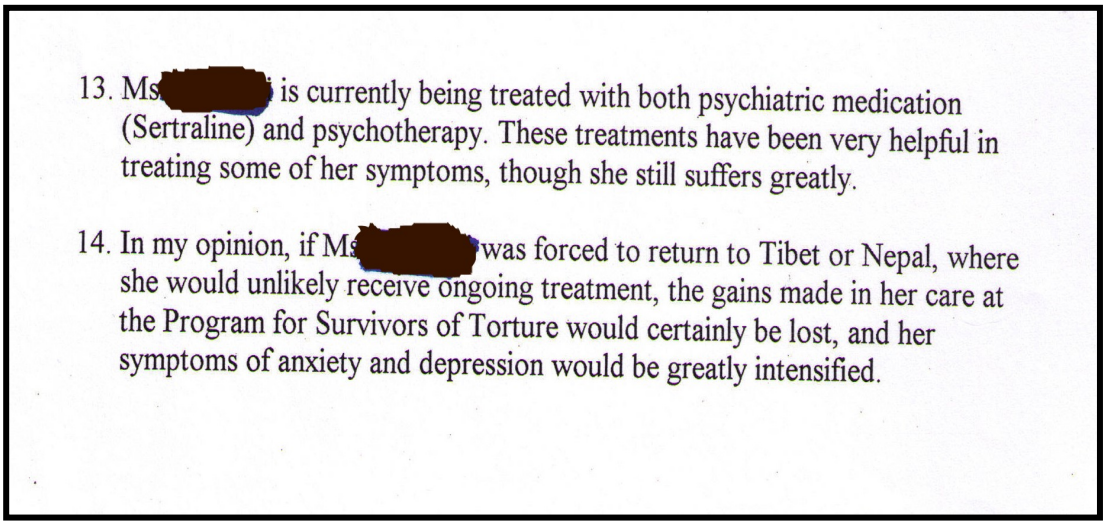
Not only does the PTSD diagnosis act as social currency, but unlike the paradigm of rehabilitating soldiers and repairing the lives of crime victims, "recovery" for this population has potentially disastrous consequences. From a legal perspective, it may be more beneficial for asylum-seekers to be "noncompliant" with their medical regimens because too "well" clients risk losing their patient status. They become subject to the

negative sanctions associated with criminal legal statuses.[22] This "medical non-compliance" represents a marked departure from the traditional "sick role" paradigm, which necessitates that, as a condition of receiving social benefits, a patient must be willing to get well (Parsons 1951).

These "medical recommendation" clauses seemed the most discordant to me when I was first reading through the affidavits. It was absurd, I thought, people who have been tortured by the government would have more serious problems than being stressed out and not getting their meds if they were deported. The research director at PSOT explained that the rationale behind this clause is to provide a compelling medical reason for the client not to be repatriated. Often the conflict that the asylum-seeker claims to have been subjected to is either unreliably documented or not documented at all. Immigration authorities frequently regard intra-state violence, especially in less visible countries, as suspect. Thus, one legal strategy is to present the consequences of repatriation as a medical harm rather than overt violence.

[22] One illustration of this legal dilemma was the proceedings leading to the January 6, 2004 execution of Charles Singleton, a man diagnosed with paranoid schizophrenia, in Arkansas for a murder committed in 1979. In 1986 the Supreme Court ruled that execution of the mentally ill constituted cruel and unusual punishment. The state of Arkansas concluded that if Singleton were given anti-psychotic medication he would be "sane" and therefore eligible for execution. Lower courts ruled in Singleton's favor, but the decision was later overturned, and the United States Supreme Court let the decision to execute Singleton, who had been on death row for longer than any other Arkansas inmate, stand.

Figure 2.6. Medical affidavit: Medical treatment and recommendations



13. Ms[redacted] is currently being treated with both psychiatric medication (Sertraline) and psychotherapy. These treatments have been very helpful in treating some of her symptoms, though she still suffers greatly.

14. In my opinion, if Ms[redacted] was forced to return to Tibet or Nepal, where she would unlikely receive ongoing treatment, the gains made in her care at the Program for Survivors of Torture would certainly be lost, and her symptoms of anxiety and depression would be greatly intensified.

The DSM-IV provides a fairly flexible guide for defining a traumatic event. For an undocumented immigrants in the U.S. going through the extremely adversarial process of petitioning for asylum and fighting deportation, asserting their experiences of political violence as a "medical event" (represented by proxy as a PTSD diagnosis) often provides the only credible substantiation that it existed in the first place. Other evidence can trigger a myriad of doubts involving the event, as well as identity (is the defendant who she says she is?), timelines (do the dates match up?), and claims of political conflict (was there really a civil conflict in her country and, if so, is it still going on to the extent that she cannot safely return?). If a medical professional can testify that an individual is traumatized, then logically a traumatic event must have occurred. The authority of objective medical science will always stand up in a court of law where other narratives, including victimhood narratives, fail.

Given the precision with which some asylum cases are judged, framing the dangers of deportation as a mental health issue may not be such a far-fetched strategy. For Zareb, a widower in his early 40s from Angola who arrived in the U.S. with his two

infant daughters, a 2005 court decision disputed whether or not there was any political conflict in Angola during the period he specified. He reported that due to his political affiliation the local government targeted his house for demolition and harassed his family. The immigration court denied his initial asylum application stating that country conditions did not support his claim that as a member of a government opposition party he would have been targeted by the government after the summer of 2004. The court statement included a long quote from the 2005 edition "Freedom in the World," an annual comparative assessment of the state of political rights and civil liberties by the independent NGO Freedom House. It stated that a ceasefire was in force between the opposition party and the ruling political party after 2003 and that while the ruling party had most of the seats in the Assembly, the opposition party currently held nearly one-third of Assembly seats (Freedom House, 2005).

In Zareb's rebuttal statement, which was prepared by a staff clinician, he cited irregularities in the election process in Angola and implored to the judge to consult more "on the ground" NGOs such as Amnesty, Human Rights Watch, Global Witness, International Red Cross, and Doctors Without Borders for documentation of human rights abuses, corruption, and a lack of real democracy. The question of what constitutes the most reliable legal authority in regard to a country's political conditions often arises in political asylum hearings, where opposing documents and reports may be cited. Thus in addition to negotiating the complexities of trauma and memory, as well as language and narrative, [23] on an individual level, claimants are called upon to substantiate their countries' state of warfare. In failing to provide conclusive evidence for their political

[23] Zareb's asylum case was also rejected in part because, in describing the demolition of part of his house in Angola by local authorities, he confused the phrases "burned" and "bombed" with "bulldozed."

victimhood, asylum-seekers confront questions of whether they are a "legitimate" victim and often fall back on their status as patients—preferably chronically ill so that the chain of treatment will not be broken.

Meeting narrative demands

The interplay of law and medicine is evidenced throughout the doctor-patient interaction. Insofar as treatment of survivors of political violence can be interpreted as both a political and healing event (McKinney 2007), the clinicians who treat this population step outside the medicalization model of apolitical care while at the same time preserving the objectivity of their diagnostic assessment. Clinicians at PSOT acknowledge that a medical claim represents beneficial and protective elements in an asylum-seeker's court case. At minimum this may mean that they are attuned to the need for punctual and precise clinical notes, in case they may be asked to prepare an affidavit or other court documents. While occasionally voicing frustration at the volume of letters of support for asylum cases they are asked to write, clinicians accept this task as part of the holistic endeavor of treating their clients.

Often negotiating conflicting narrative demands (e.g., the primacy of the experiential truth of psychiatric narratives and the factual truth of legal testimony) is also integrated into the treatment and care of clients. While, "contemporary psychiatric practice is rooted in taking patients' stories at face value as accounts of their experience," the legal system holds a truthful story to be, "fixed and isomorphic to a single historical sequence of events…[where] any deviation from this fixed account is evidence of dissimulation designed to claim the valued status of refugee" (Kirmayer 2003: 167). Clinicians often spend sessions preparing their clients to testify, employing therapeutic

techniques such as Narrative Exposure Therapy, which in part helps the client tell the story of their traumatic experiences in a chronological and sound manner.

At times, clinicians and legal advisors collaborate on what strategies best interweave their clients' experiential and testimonial narratives. In one instance, a therapist and a legal liaison were discussing the case of Fujo, a Sierra Leonean woman who had undergone female genital mutilation (FGM). Fujo had disclosed this information to both parties, and despite that she did not apparently consider the FGM to be her most pressing therapeutic issue, the legal liaison encouraged the therapist to discuss with her the possibility of disclosing the experience in court. As discussed earlier in relation to Esther Olowos's case on behalf of her daughters, the fear of FGM is considered to be grounds for granting asylum. Having already undergone the practice is not by itself grounds to receive asylum but may bolster Fujo's claim of past persecution (she would also have to substantiate that she has a well-founded fear of further persecution). Depending on the sympathies of the judge to whom she was assigned, this disclosure may lead to a more successful outcome.

Conclusion

Mario Colucci (2006) writes that medical imperialism employs two strategies; hiding the "dead body" and showing the "miserable body." In the case of undocumented immigrants seeking political asylum, a confluence of social, medical and political forces work together to hide the figurative and (literal) "dead body" of political victimization and prompt the "miserable" traumatized body of the patient into existence.

The medical and legal knowledge and inquiry into the lives of asylum-seeking survivors of political violence converge on overlapping, occasionally competing, jurisdictions. The results of this convergence reveal the failures of both paradigms to capitulate the lived experience of these individuals. The denial of international humanitarian and human rights provisions that the individuals in this research experience in the U.S. represents the limits of cultural and political relativism. Human rights operate under the rationale that the values, norms and political system of a sovereign nation may be superseded in pursuit of securing and protecting a universal standard of living and system of rights for its citizens.

Likewise, medicalization represents, at least in part, the scientific endeavor of uncovering the universal body, in this case, universal representations of trauma. Foucault asserts that biopower, the identification by the state of "threats to life" affecting the citizenry, relies particularly on statistical and demographic forms of knowledge such as mortality and morbidity rates, incidence and prevalence of disease – essentially the work that both Kevin and I do. Above all biopower is aimed at normalization. What is a normal reaction to a horrifically abnormal event?

In reality, the "event "is ongoing; survivors of political violence often sustain multiple oppressions, including the post-migration denial of basic asylum rights and the usurping of victimization claims with representations of illegality. These oppressions create experiences and narratives that may not singularly conform to the needs or paradigms of clinical, legal, or political systems of understanding. Kirmayer (2003) refers to these deficits as "failures of imagination" in that they represent experiences that are medicalized, politicized, sensationalized, etc. without ever really containing the

totality or the "truth" of the lived experience. Rather, the ideal of medical knowledge to discover the universal or normative body and the goal of human rights and humanitarian principles to assert a universal human dignity create both an apolitical patient and a contested political victim. Presumptions of truth are used to strengthen or disempower political claims. In the case of undocumented asylum-seekers who struggle against the specter of illegality and criminality, the presumption of value-neutrality engendered by medical knowledge can be asserted as a political tool to upset competing narrative claims.

The medicalization of political violence is a tool that serves to mediate the conflicting statuses where survivors of political violence are victims of humans rights violations in the international arena and perpetrators of immigrant offences (i.e., being undocumented) in the domestic arena. On a conceptual level, this medicalization can be interpreted as a disempowering phenomenon. The representation of the "traumatized refugee" dislocates the primacy of the individual's political claim and transforms the experiences that signify political victimhood (i.e., deliberate acts of persecution) into apolitical medical events (i.e., Criterion A of a PTSD diagnosis).

It is because this medicalization is so powerful, however, that, at institutional and doctor-patient levels, it acts as currency that may be traded on an individual's behalf, for instance as a counterpoint to the specter of criminality embodied by the undocumented immigrant. In an immigration court, medical testimony (e.g., the diagnosis of PTSD) can succeed where conflicting documentation of political strife (e.g., the political situation in Angola) fails. Thus the negotiation of these individuals' identities, as victims of human rights abuses, as patients of PTSD, and perpetrators of immigration offenses is fluid and often engenders intertwined, yet competing, demands.

CHAPTER THREE: Trauma by the Numbers: Post-Migration Immigration Status and Mental Health Outcomes

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Introduction

As discussed in previous chapters, numbers matter. Whatever the etiological value of such psychological scales as the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist, these measures do represent currency. They can facilitate clients' access to health care and social services, and can serve as a legal asset in the courtroom. For researchers at clinics like PSOT, which funded entirely on grant monies, quantitative research represents validation that they are successfully serving a population in need.

To date, data the PSOT client database (in smaller samples than the 1,360 cases presented in this dissertation) has been analyzed in over 10 peer-reviewed journal articles, including one authored by Kevin, the student researcher discussed in the previous chapter. I first ingratiated myself with the research staff at PSOT by offering to help organize or "clean" what was, at the time, was a very sloppily managed database and create the larger 1,360 sample. When I was first familiarizing myself with the database, in part by reading the previously published work, I began to see the potential in utilizing the quantitative psychological measures to forward the concept of "trauma" as a post-migration socially-circumscribed phenomenon, rather than exclusively a reaction to pre-migration violence. The post-migration variables available were sparse – in contrast, the pre-migration variables detailing the particulars of clients' detention and torture experiences were exceedingly elaborate and nuanced – but I felt there was enough

substance there to do a good piece of quantitative research, one that would speak to a certain population of health researchers who need diagnostic scales to be convinced.

Moreover, after spending well over 100 hours across a number of months at the clinic cleaning and preparing these data for analysis, as well as observing the research environment at the clinic, I recognized that there were more research questions that could be addressed than there were researchers to pose them. The fundamental value of research hinges the questions one elects to pursue. As the only sociologist in a team of psychology researchers, I was the one person at PSOT who could commit time and energy to that analysis. My colleagues were all highly trained researchers (most were more statistically skilled than me). But despite their genuine interest in and support of the concept, they were all incredibly overworked and busy, and this particular analysis would not yield the type of publications or grants that the psychology graduate students like Kevin needed to forward their individual careers, or that the research director needed to keep the clinic funded. As such, this chapter represents my contribution to a sociology *in* medicine approach to studying trauma, as articulated in the language of psychological distress.

There are 1,360 total cases contained in the PSOT client intake database, 875 of which include the psychological measures used in this research; the remaining 485 records may have been collected during periods when the clinic did not collect those particular measures, or the data for those records may simply be missing. In addition, of the overall 1,360 sample, neighborhoods data (in the form of zip codes) were available for 1,305 cases. This chapter focuses on the sample of 875 records and frames PSOT clients' post-migration experiences as predictor variables in hierarchical regression

models. It looks at the relative effects of these experiences on their mental health "outcomes," as articulated by the diagnostic criteria for PTSD, depression and anxiety.

Advocates, clinicians, attorneys, and academics all concur that immigrants who have experienced political violence face extraordinary obstacles to mental health and well-being upon resettlement. In the mental health literature, these obstacles are evidenced by an elevated prevalence of affective disorders such as PTSD, depression, and anxiety among refugees and asylum-seekers (Keyes 2000; Porter and Haslam 2005; Nicholl and Thompson 2004). In the U.S. the prevalence of these disorders distinguishes these individuals from the larger immigrant population, which has relatively low levels of psychological dysfunction overall (Kandula 2004).

However, the causes of these high prevalence rates, and the character and scope of the trauma they may indicate, are unclear. Research on the psychological effects of torture and political persecution on resettled immigrants often focus on samples of legally designated "refugees," who are afforded certain rights, protections, and economic benefits in countries of resettlement such as the U.S. As discussed in the previous chapter (Chapter 2), in reality a large proportion of immigrants who experience political violence enter the U.S. through other means and are undocumented for much of their residence in the U.S.

Moreover, research on the mental health of refugees and asylum-seekers focuses largely on pre-migration traumatic events with little regard to post-migration deprivation and the structural needs of asylum-seekers in countries of resettlement (Summerfield 1999). As discussed previously, in the U.S., survivors of political violence who are undocumented experience the harsh conditions associated with being undocumented,

such as financial and legal instability, limited access to medical care and social services, and the fear of being deported. As illustrated by the experiences of Besa, Maamid, and Zareb in Chapter 2, applying for political asylum in the U.S. is a complex and prolonged legal process that can span multiple years and exhaust limited financial resources. These post-migration stressors may have a profound effect on a population that is already at risk of deleterious mental health due to their pre-migration physical and emotional traumas.

Background

Mental health outcomes and the post-migration environment

Literature on mental health outcomes among survivors of political violence focuses heavily on pre-migration experiences of political violence and loss as predictors of deleterious mental health among immigrants—generally refugees and asylum-seekers—in post-migration environments within both the developing world (de Jong et al. 2001; Crescenzi et al. 2002; Holtz 1998; Shrestha et al. 1998; Tang et al. 2001), as well as in Western countries such as the U.S. (Eisenman et al. 2003; Fox et al. 2001; Gerritsen et al. 2006; Keller et al. 2003, Nicholson 1997; Robertson et al. 2006). Research uniformly indicates that, across all resettlement settings, experiences of torture and political violence can have devastating effects on the emotional health and well-being of survivors (Keyes 2000; Nicholl and Thompson 2004; Porter and Haslam 2005; Schweitzer et al.. 2002). Studies that do account for the effects of the post-migration environment indicate that factors significantly related to poor mental health encompass both social network conditions, such as low levels of social support and separation from one's family, as well as structural hardships, such as financial difficulties, lack of access

to health and welfare services, difficulties with immigration processes including obtaining legal status, and the threat of repatriation (Schweitzer et al. 2003; Silvoe et al. 2000).

Further, among studies that do look at the effect of post-migration environment on the mental health outcomes of individuals resettled in Western countries, most focus on individual-level social factors, such as those associated with acculturation and social support, rather than structural conditions like employment, welfare access, and immigration status. However, in a meta-analysis of 56 studies of the mental health of refugees, asylum-seekers, and other displaced persons, Porter and Haslam (2005) found that numerous structural post-migration conditions moderated mental health outcomes. For example, worse outcomes were observed among those experiencing restricted economic opportunity, regardless of resettlement location. Looking at Bosnian refugees in the Netherlands, Knipscheer and Kleber (2001) found that the ability to perform adequate occupational skills for functioning in their post-migration society was a significant predictor of mental health status, and that respondents reported issues such as financial troubles and daily hassles and stressors as their worst mental health problems. Nicholson (1997) found that, among Southeast Asian refugees in the U.S., the degree of current stress had direct effects on PTSD, depression and anxiety. Post-migration stressors that affected this sample included difficulties regarding legal status, housing, finances, employment, the loss of welfare entitlements, and crime victimization.

One of the most stressful post-migration hardships found in Western countries, including the U.S., is the detention of asylum-seekers in prisons or prison-like government facilities. As discussed in Chapter 2, since 1996, asylum claimants who are

caught entering the United States under false pretenses (e.g. with false documents) are immediately remanded to a detention facility until their asylum case can be heard by an immigration judge; this may take anywhere from weeks to months. Looking at a sample of 70 detainees—three-quarters of whom had been tortured before immigration—being held in detention facilities in the U.S., Keller et al.. (2001) found high rates of PTSD, depression and anxiety among asylum-seekers which worsened the longer that individuals were in detention. As Silvoe (2002: 1437) writes, "instead of providing special care for the most traumatized individuals fleeing persecution, western countries may be subjecting them to the very conditions that are likely to hinder psychosocial recovery."

Thus a select, though growing, number of studies about mental health outcomes among survivors of political violence focus on post-migration hardships, specifically post-migration hardships encountered by individuals resettled in Western counties. Those that do so indicate the importance of these experiences in predicting the prevalence of mental health problems among refugees, above and beyond pre-migration factors (e.g. war, torture, persecution) and their associated effects on mental well-being.

In the U.S., exposure to political violence is a health problem that afflicts an unknown number of individuals. A rising number of the over 12 million refugees and asylum-seekers worldwide are seeking refuge in Western countries (Nicholl and Thompson 2004). There are approximately 2.7 million refugees from over 65 countries resettled in the United States, with as many as 200,000 additional refugees admitted each year (U.S. Department of State 2007). However, as discussed previously, these numbers may represent only a fraction of individuals who have been exposed to political violence.

Eisenman et al. (2003) found that over half of the low-income documented and undocumented Latino immigrants presenting at primary care clinics in the Los Angeles, California area had experienced some form of political violence. However, only 3% of these individuals reported these experiences to their health care providers, often despite suffering chronic pain and limitations in physical and mental functioning.

In summary, studies with survivors of political violence often focus on pre-migration stressors without contextualizing these experiences in the post-migration environment that these individuals face as immigrants in countries of resettlement. In the U.S., they are often immigrants without state welfare benefits, who face complex and often adversarial legal struggles. The current study seeks to fill gaps in these bodies of literature by examining the role of post-migration hardships on immigrants who have survived political violence, but do not necessarily have the legal designation of "refugee" or "asylee." These individuals must cope with a history of traumatic experiences within a hostile post-migration environment. Survivors of political violence encounter hardships associated with being an undocumented immigrant (e.g., financial and housing instability, inadequate access to health care and social services) as well as hardships specific to their experiences of political violence, including negotiating the tenuous process of obtaining political asylum. This research looks at the relative effect of these structural deprivations on mental health outcomes among these individuals.

Data and Methods

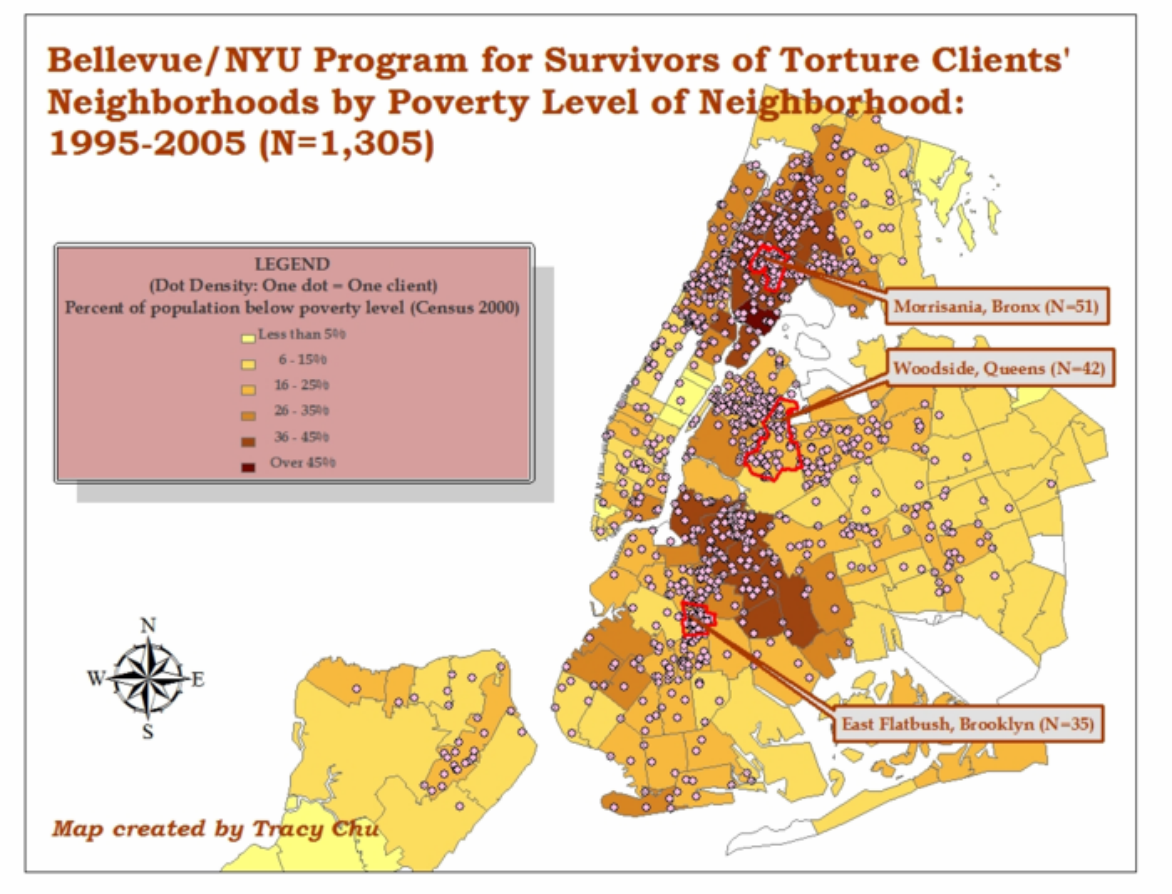
Sample and data

This study was approved by the Institutional Review Board of the New York University School of Medicine, although the archival nature of this analysis precluded obtaining informed consent. The models presented in this analysis utilize client intake data from approximately May 2000 to December 2005 (N=875).

The data employed in this study were drawn from a convenience sample of 875 PSOT clients from a larger client intake database of 1,360. Because intake procedures, as well as the rigor with which they were electronically recorded, have changed over time to accommodate the shifting needs and goals of the clinic, not all clients were administered one or both of the psychological scales being used as outcomes variables for this analysis. Thus only 875 of the 1,360 individuals in that database are represented in the statistical analyses presented here. Demographically, over three-fifths (63%) of the 875 individuals were men. The average age of clients during their intake interviews was 34 years old. In terms of region of origin, 58% were from Africa, 31% were from Asia, 5% were from Eastern Europe, and 7% were from an "other region." (Full demographic information can be found in Table 3.1 below).

To better contextualize PSOT clients in NYC overall, I am also presenting Figure 3.1., which looks at a separate sample of 1,305 clients (the number for whom residential information were available), that was drawn from that same overall dataset of 1,360 cases. Figure 3.1 shows that clients reside in a diversity of neighborhoods of socioeconomic levels across NYC; the most prevalent neighborhoods that PSOT clients live in are Morrisania in the Bronx, Woodside in Queens, and East Flatbush in Brooklyn.

Figure 3.1. PSOT clients come from a diversity of neighborhoods in the 5 boroughs of New York City (NYC), most prominently Morrisania in the Bronx, Woodside in Queens, and East Flatbush in Brooklyn



Procedures

Data were collected during an initial intake session, typically lasting 1 ½ to 2 hours. All intake interviews were conducted by psychologists, psychiatrists, or supervised psychology interns. When necessary, interviews were conducted with the assistance of trained interpreters.

These intake sessions consisted of semi-structured interviews in which the administrating clinician collected demographic information, such as age, place of birth, religion, level of education, as well as information about their current legal status, employment, and income. The intake interviews also included an unstructured narrative

in which clients described their experiences of torture, persecution and other traumas, and clinicians inquired about the occurrence of specific types of trauma, e.g. witnessing violence against family, being forced to live in hiding, being forced to work (i.e., enslaved labor). The incidents reported in both the open-ended and itemized portions of the interview were later coded according to the Huridocs codebook (Dueck and Aida 1993), a detailed classification system developed by the Human Rights Documentation Systems International to facilitate systematic documentation of human rights abuses.

Finally, each client was administered two self-report symptom rating scales, the PTSD symptom portion of the Harvard Trauma Questionnaire (Mollica et al. 1992; see below) and the Hopkins Symptom Checklist (Derogatis et al. 1974; see below). Because data collection forms were completed by the clinician conducting the intake evaluation, inter-rater reliability for the data coded on these intake questionnaires was not available.

Dependent variables

The dependent variables in this study measured levels of psychological distress as denoted by scores on the HTQ and the HSCL. The HTQ is a measure of trauma experience and response that includes a 16-item scale designed specifically to measure severity of PTSD in refugee populations (Mollica et al. 1992). Clients were asked to rate how much particular symptoms have bothered them in the past week using a 4-point scale, where 1= "Not at all" and 4 = "Extremely." The use of the HTQ in previous research with refugees and asylum-seekers has supported the validity of PTSD classifications, as defined by the Diagnostic and Statistical Manual of the American Psychiatric Association Version (DSM-IV), based on a cutoff score of 2.5 (Hollifield et

al. 2002). In this sample of 875 respondents, the Cronbach's alpha for the 16-item HTQ was .881. The mean HTQ score was 2.34; using a cut-off score of 2.5, over two-fifths (42.1%) of the sample had clinically significant PTSD symptoms.

The HSCL is a 25-item self-report inventory consisting of two subscales measuring depression (15 items) and anxiety (10 items). Like the HTQ, the scale for each question includes four categories of response ("Not at all," "A little," "Quite a bit," "Extremely," rated 1 to 4, respectively). The HSCL has been used widely in research and has been found to have consistency and validity both for raw scores and classifications based on a cutoff score of 1.75 (Winokur et al. 1984). In this sample, the Cronbach's alpha for the 15-item depression scale was .866, and the Cronbach's alpha for the 10-item anxiety scale was .838. The mean score for the depression scale was 2.30, and the mean score for the anxiety scale was 2.20. Using the cut-off score of 1.75, almost four-fifths (78.6%) of the sample had clinically significant depressive symptoms and almost three-quarters (73.9%) had clinically significant anxiety symptoms.

Independent variables

Demographic variables

Age is a variable in which respondents reported their actual age in numbers; the mean age of individuals in this sample was 34.2 years.

Female is a dummy variable in which those respondents who identified their sex as female (36.8%) were coded one and men were coded zero.

Region of origin indicates respondents' region of origin and is grouped by the largest categories found within the client sample: Africa (57.6%), Asia - primarily Tibet

(30.6%), Eastern Europe - primarily Albania (4.5%) and Other Region (7.3%). In the multivariate analysis, region was recoded as four dummy variables. For example, for the dummy variable African, those from Africa were coded as one, and those from Asia, Eastern Europe, or Other Region, were coded zero.

In the regression models, clients from Africa were designated as the reference category based on the assumption that Africans are likely to experience greater racial tension and be subject to harsher discrimination in a variety of post-migration contexts, including employment, housing, social services, and health care. Moreover, as will be discussed in Chapter 4, the African immigrants in New York City represent a relatively new and largely heterogeneous community that may not provide the types of material or structural resources (e.g., credit unions, labor niches, voluntary organization) that clients from other regions may be able to access.

Religion indicates respondents' reported religion and includes Muslim (39.8%), Christian (30.3%), Buddhist (26.3%) and Other Religion (3.6%). In the multivariate analysis, religion was recoded as four dummy variables. For example, in the dummy variable Buddhist, those who identified their religion as Buddhism were coded as one, and those who identified their religion as Christian, Muslim, or Other Religion were coded zero.

In the regression models, Muslims were designated as the reference category. Similar to the designation of Africans as the reference category for region of origin, this decision is based on the assumption that, in this particular post-migration environment, those who identified as Muslim would suffer the greatest stigma as a result of their religion, as well a greater lack of resources or support to practice their religion.

Married is a dummy variable in which respondents who reported that they were currently married (58.9%) were coded as one, and those who were divorced, never married, or widowed were coded as zero.

Dependents indicates the number of people, either children or adults, which clients reported as their dependents; the mean number of dependents reported in this sample was 1.7.

High school graduate is a dummy variable in which clients who had at least a high school diploma or equivalent (61.1%) were coded as one and those with less than a high school education were coded zero.

Torture variables

The experiences of torture and war-related traumas elicited during these interviews were coded in accordance with the Huridocs codebook, a documentation system that encompasses over 70 specific acts or situations in the category of torture. Previous research with a subgroup of the current sample (N=325) indicates the presence of specific factor structures among the various Huridocs codes; these include witnessing trauma, family torture, rape/sexual assault, beatings, and deprivation (Hooberman et al. 2007). Keller et al. (2006) found that certain specific experiences, such as rape/sexual assault, death threats, and family torture, were statistically significant predictors of PTSD in that same subsample. Based on this research, multiple Huridocs items were collapsed into 5 dummy variables representing broad categories of experience: Witnessing trauma, violence against family, rape and sexual assault, beating and deprivation.

Witnessing violence refers to victims being forced to watch or listen to the torture of others, including family, friends, colleagues, or other prisoners; as well as having seen dead bodies either in or outside confinement. Those who reported this experience (78.9%) were coded one; those who did not report this experience were coded zero.

Violence against family refers to reports that family members were harassed tortured or killed. Those who reported this experience (88.2%) were coded one; those who did not report this experience were coded zero.

Beating refers to blows administered by hand, such as slapping licking or punching; or blows with an object, such as rifle butts, whips, straps, or heavy sticks; and encompasses a total 8 sub-categories. Those who reported any of these experiences (85.7%) were coded one; those who did not report any of these experiences were coded zero.

Rape/sexual assault: Refers to sexual molestation and encompasses a total of 10 sub-categories, including physical assault and touching, electrical shock or mutilation of the genitals, and forced performance of rape. Those who reported any of these experiences (35%) were coded one; those who did not report any of these experiences were coded zero.

Deprivation encompasses 10 sub-categories, including deprivation of food or water for more than 48 hours, deprivation of regular sleep (i.e. less than 4 hours a night for 5 or more days, or more than 24 hours continuously), immobilization and sensory deprivation for more than 48 hours, and isolation for more than 72 hours. Those who

reported any of these experiences (27.8%) were coded one; those who did not report any of these experiences were coded zero.

Number of times detained refers to the number of times an individual was detained by authorities in their country of origin; the mean number of times individuals in the sample were detained was 2.

Years since last torture experience indicates to the number of years since an individual was last subject to torture; in this sample, the mean number of years since last torture experience was 7.1.

Post-migration variables

Months in the U.S. is a continuous variable in which respondents reported when they arrived in the U.S. From this, the number of months that they had been in the U.S. at the time of their intake interview was calculated. The mean for clients in this sample was 23.3 months.

Separated from family is a dummy variable in which respondents reported being currently separated from members of their family—e.g., children or spouse (95.6%)—were coded as one and those who were not currently separated from family were coded as zero.

Legal immigration status is a dummy variable in which those who had legal immigration status (13.9%). i.e., asylum, Green Card, visa, etc., were coded as one and those without legal immigration status, including those for whom asylum is pending[24], were coded as zero.

[24] Individuals coded as zero include those whose asylum status is pending, that is, they have applied for asylum, during which time they temporarily have legal authorization to live and work in the U.S. and after

Work authorization is a dummy variable in which those with work authorization (24%) were coded as one and those without work authorization were coded as zero. It is important to note that even if an immigrant has legal immigration status, they may not have work authorization. In fact, in this sample, about three-fifths (58%) of individuals with legal immigration status did *not* have work authorization.

Weekly income is a continuous variable in which respondents reported their weekly earnings in dollars; the mean weekly income reported was $28.22. This figure includes the 81.5% of the sample who reported no weekly income at all ($0).

English ability is a dummy variable in which those who reported having fair, good, or fluent English ability (46%) were coded as one and those who had no or little English ability were coded as zero.

Hierarchical OLS Regression Models

For this analysis, three Ordinary Least Squares (OLS) regression models were run on each of the three dependent variables—measures of PTSD, depression and anxiety—for a total of nine models (N=875). The first analyses for each outcome (Model I) were run with demographic variables such as age, race, region of origin, as well as characteristics of clients' torture experiences, such as the number of times detained, major categories of violence (i.e., beating, rape/sexual assault, witnessing violence, violence against family, and deprivation) and time since last torture experience.

Because this research is interested in the effect of the post-migration environment on mental health outcomes, Model II contains post-migration variables, such as

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150 days may apply for work authorization. However, if they are denied asylum, their immigration status reverts back to their status at time of application.

immigration status, current separation from family, and personal income. These variables are presented in a separate model in order to observe the changes in the overall predictive power when accounting for these post-migration factors, as well as to see the change in statistically significant predictor variables.

Finally, Model III includes the interaction between immigration status and gender. In the mental health literature, gender is often statistically associated with mental health outcomes; women exhibit more severe symptomology than men, especially when looking at affective disorders such as PTSD, depression and anxiety. This theoretical consideration, combined with this study's focus on key post-migration factors such as immigration status, led to the conceptualization of this interaction. Three interaction terms – men with legal immigration status, women with legal immigration status and women without legal immigration status – were entered into the model. Men without legal immigration status served as the reference category in this analysis based on the assumption that they represent the most economically vulnerable group, in that they are more likely to be a primary income-earner in a household and more likely to seek the type of employment requiring legal immigration status.

Results

Descriptive and bivariate statistics

A summary of the means, standard deviations, and other descriptive statistics for the dependent and independent variables are presented in Table 3.1.

Table 3.1. Means and standard deviations of variables used (N=875)

Independent Variables	Range	Mean	SD
Dependent Measures			
Harvard Trauma Questionnaire (α=.881)	1 to 4	2.342	.628
Met clinically significant cut-off of 2.5+	0= No, 1=Yes	.421	.494
Hopkins Symptom Checklist Depression Subscale (α=.866)	1 to 3.93	2.308	.6237
Met clinically significant cut-off of 1.75+	0= No, 1=Yes	.786	.410
Hopkins Symptom Checklist Anxiety Subscale (α=.838)	1 to 4	2.201	.6573
Met clinically significant cut-off of 1.75+	0= No, 1=Yes	.739	.440
Demographic characteristics			
Age	15 to 72 years	34.161	9.432
Female	0= No, 1=Yes	.368	.483
Region of origin			
Africa	0= No, 1=Yes	.576	.494
Asia	0= No, 1=Yes	.306	.461
Eastern Europe	0= No, 1=Yes	.045	.207
Other region	0= No, 1=Yes	.073	.261
Religion			
Muslim	0= No, 1=Yes	.398	.49
Christian	0= No, 1=Yes	.303	.46
Buddhist	0= No, 1=Yes	.263	.44
Other Religion	0= No, 1=Yes	.036	.187
High school graduate	0=Not a HS graduate, 1=HS graduate or more	.611	.489
Married	0=Not married, 1=Married	.589	.483
Dependents	0 to 17	1.715	2.078
Torture characteristics			
Specific experiences			
Witnessing violence	0= No, 1=Yes	.789	.41
Violence against family	0= No, 1=Yes	.882	.322
Beating	0= No, 1=Yes	.857	.350
Rape/sexual assault	0= No, 1=Yes	.35	.477
Deprivation	0= No, 1=Yes	.278	.448

Number of times detained	1 to 100	1.978	4.17
Years since last torture experience	0 to 45 years	7.078	6.847
Post-migration characteristics			
Months in the U.S.	1 to 312 months	23.31	27.547
Separated from family	0=No, 1=Yes	.956	.205
Legal immigration status	0=No, 1=Yes	.139	.346
Work authorization	0=No, 1=Yes	.24	.427
Weekly income	$0 to $1,200	28.221	94.371
English ability	0= None/Poor, 1= Fair/Good/Fluent	.46	.499
Interaction of gender & legal immigration status			
Men with legal status	0= No, 1=Yes	.087	.282
Men without legal status	0= No, 1=Yes	.541	.499
Women with legal status	0= No, 1=Yes	.052	.223
Women without legal status	0= No, 1=Yes	.320	.467

Table 3.2 presents the bivariate relationships between the independent variables and the three dependent measures of psychological distress (scores on the HTQ, depression, and anxiety scales) using (1) Independent Samples T-tests, with Levene's Test for Equality of Variances, (2) Analysis of Variance Analysis (ANOVA) with Tukey-adjusted post-hoc[25], or (3) Pearson correlations.

The demographic differences found to be statistically significantly in the bivariate analyses were gender, education, region of origin, religion, and marital status. Women had higher scores on all three scales (HTQ: t=-5.743; Depression: t=-6.072; Anxiety: t=-6.416; equal variances assumed for all), and these differences were all statistically significant at the .001 level. Those with at least a high school diploma reported higher rates of distress on all three measures than those who did not graduate high school (HTQ:

[25] A Tukey post-hoc analysis was performed, rather than a Bonferroni or Scheffe analysis, as all pairwise comparisons (12 pairs in each of the above cases) were of analytical interest.

t=-4.241; Depression: t=-3.180; Anxiety: t=-.4.923; equal variances assumed on all), and these differences were statistically significant at the .01 level, with the exception of the anxiety score which was significant at the .001 level. An ANOVA with Tukey-adjusted post-hoc revealed that Asians had statistically significantly lower scores than participants from Africa, Eastern Europe, and "Other" regions on two scales: HTQ and anxiety. On the depression measure, Asians had the lowest mean score of all the regions represented (Mean=2.153, SD=.626) however this difference was only statistically significantly lower than those from Africa ($p<.001$), and "Other" region ($p<.05$) and not significantly lower than those from Eastern Europe. Another ANOVA with Tukey-adjusted post-hoc revealed that, across all measures, Buddhists reported statistically significantly lower rates of mental distress than those who identified their religion as Christian, Muslim, or "Other." Finally, those who were presently married reported statistically significantly lower rates of distress than those who were not presently married (HTQ: t=2.610; Depression: t=2.313; Anxiety: t=2.342; equal variances assumed for all), and these differences were statistically significant at the .05 level, with the exception of the HTQ score which was significant at the .01 level.

The bivariate analyses also looked at differences in mental heath outcomes by individuals' torture experiences and found significant differences in mental health outcomes associated with two of these variables: experiences of rape/sexual assault, and number of times they had been detained. Those who reported having been raped/sexually assaulted had significantly higher rates of psychological distress than those who did not (HTQ: t=-7.676; Depression: t=-6.155; Anxiety: t=-6.378; equal variances assumed for all), and these differences were statistically significant at the .001 level. A Pearson

correlation revealed that the number of times a respondent was detained was positively correlated with higher scores on all three measures (HTQ: r=.088; Depression: r=.077; Anxiety: r=.104) and these correlations were significant at the .05 level, with the exception of the anxiety correlation which was significant at the .01 level.

Of the post-migration variables included in this study, immigration status, work authorization, and English ability were associated with statistically significant differences in the three dependent measures of psychological distress. Those who reported having legal immigration status had lower scores on all three measures than those who did not (HTQ: t=-4.601; Depression: t=3.936; Anxiety: t=3.965; equal variances assumed for all), and these differences were all significant at the .001 level. Surprisingly, having work authorization and greater English language ability was positively correlated with psychological distress. Those who had work authorization had higher scores on the depression measure (t=1.962, equal variances assumed) than those who did not have work authorization, and this difference was statistically significant at the .05 level. Those who had fair, good, or fluent English skills had significantly higher scores on all three measures than with no or poor English ability (HTQ: t=-4.331; Depression: t=-5.158; Anxiety: t=-4.381; equal variances assumed for all) and these differences were statistically significant at the .001 level.

Lastly, the bivariate analyses included the interaction between gender and immigration status by constructing a variable with four categories: men with legal immigration status, men without legal immigration status, women with legal immigration status, and women without legal immigration status. An ANOVA with Tukey-adjusted post-hoc analysis revealed that were two significant differences across all four groups:

Men with legal immigration status had better mental health outcomes than each of the other three groups ($p<.05$), and men without legal immigration status had better outcomes than women without legal immigration status ($p<.05$). In sum, legal immigration status was associated with better mental health among men; men with legal immigration status reported better mental health than men without legal status, as well all women, regardless of immigration status. However, this relationship was not evidenced among women; women with legal immigration status did not have significantly better mental health outcomes than women without. Moreover, among those without legal immigration status, women had significantly worse mental health outcomes than men.

Table 3.2. Bivariate analyses: Mean differences on dependent variables[1]

Independent Variables	PTSD	Depression	Anxiety
Demographic characteristics			
Age[2]	-.058	-.028	-.023
Gender[3]			
Female	2.508[a]	2.474[a]	2.384[a]
Male	2.244[b]	2.211[b]	2.094[b]
Region of origin[3]			
Africa	2.442[b]	2.373[b]	2.261[b]
Asia	2.102[a]	2.153[a]	2.043[a]
Eastern Europe	2.533[b]	2.354	2.365[b]
Other region	2.429[b]	2.403[b]	2.284[b]
Religion[3]			
Muslim	2.433[b]	2.359[b]	2.230[b]
Christian	2.467[b]	2.414[b]	2.413[b]
Buddhist	2.037[a]	2.074[a]	1.979[a]
Other Religion	2.503[b]	2.528[b]	2.413[b]
High school graduate[3]			
Less than a high school diploma	2.239[a]	2.234[a]	2.080[a]
High school graduate and beyond	2.438[b]	2.377[b]	2.308[b]
Married[3]			
Not currently married	2.413[a]	2.365[a]	2.265[a]
Married	2.292[b]	2.264[b]	2.158[b]
Torture characteristics			
Specific experiences[3]			
Witnessing violence			
Witnessed violence	2.35	2.32	2.21
Did not witness violence	2.33	2.30	2.20
Violence against family			
Experienced violence against family	2.33	2.31	2.20
Did not experience violence against family	2.43	2.30	2.24
Rape/sexual assault			
Experienced rape/sexual assault	2.581[b]	2.499[b]	2.410[b]
Did not experience rape/sex assault	2.226[a]	2.226[a]	2.114[a]
Beating			
Experienced beating	2.34	2.31	2.21
Did not experience beating	2.42	2.37	2.25
Deprivation			
Experienced deprivation	2.33	2.28	2.18
Did not experience deprivation	2.36	2.34	2.23
Number of times detained[2]	.088*	.077*	.104***

Years since last torture experience[2]	.006	.006	.02
Post-migration characteristics			
Number of months in the U.S.[2]	.058	.048	.039
Separated from family[3]			
Is currently separated from family	2.355	2.313	2.197
Is not currently separated from family	2.227	2.292	2.274
Legal immigration status[3]			
Does not have legal status	2.383[a]	2.339[a]	2.240[a]
Has legal status	2.080[b]	2.095[b]	1.980[b]
Work authorization[3]			
Does not have work authorization	2.345	2.322[a]	2.218
Has work authorization	2.272	2.215[b]	2.107
Weekly income[2]	-.014	.018	-.006
English ability[3]			
No or poor English ability	2.257[a]	2.207[a]	2.113[a]
Fair/good/fluent English ability	2.453[b]	2.426[b]	2.308[b]
Interaction of gender and legal immigration status[4]			
Men with legal status	1.930[a]	1.943[a]	1.849[a]
Men without legal status	2.294[bcd]	2.248[bc]	2.138[bc]
Women with legal status	2.313[b]	2.348[b]	2.202[bd]
Women without legal status	2.531b[d]	2.492[bd]	2.410[b]

[1] Within each variable category and dependent variable, only those mean scores that do not share a common superscript differ from on another at the .05 level. Those mean scores without a superscript, or those that share a common superscript, do not differ at the .05 level.
[2] Pearson correlations (two-tailed) were used to calculate the statistical significance of mean differences. Number presented in table is the correlation coefficient where * indicates p<.05, ** indicates p<.01 and *** indicates p<001.
[3] T-tests were used to calculate the statistical significance of mean differences.
[4] ANOVA with post-hoc analysis (Tukey) was used to calculate the statistical significance of mean differences. A Tukey post-hoc analysis was performed, rather than a Bonferroni or Scheffe analysis, as all pairwise comparisons (12 pairs in each of the above cases) were of analytical interest.

Post-traumatic Stress Disorder

Table 3.3 presents the various OLS regression models to predict PTSD symptomology, as denoted by higher HTQ scores. As shown in Model I, which does not control for post-migration characteristics, that three variables were significant predictors of PTSD: religion, gender, and experiences of rape or sexual assault. Specifically, controlling for all other variables in the model, identifying as a Buddhist was associated with lower PTSD scores than identifying as a Muslim. Women had statistically significantly higher PTSD scores than their male counterparts. Those who reported being raped/sexually assaulted had higher scores than those who were not.

Those who identified their religion as Buddhism scored on average .393 points lower on the HTQ than those who identified their religion as Islam; and that relationship was significant at the .05 level. This was the most powerful predictor in this model (beta=.283). The next most powerful predictor variable in the model was the experience of rape/sexual assault (beta=.194). Controlling for all other variables in the model, individuals who reported being raped/sexually assaulted scored .248 points higher on the PTSD measure than those who hade not been raped or sexually assaulted; and that relationship was significant at the .001 level. Finally, women scored .211 points higher on the HTQ than men; and that relationship was statistically significant at the .01 level (beta=.159). Model I has an adjusted R-Square of .162; the independent variables in Model I explain 16.2% of the variance in the dependent variable, HTQ scores.

Table 3.3. Unstandardized regression coefficients for Harvard Trauma Questionnaire (HTQ) N=768 (Standardized Betas in parenthesis)

	Model I: No post-migration	Model II: Post-migration	Model III: Legal Status by Gender
Demographic Characteristics			
Age	-.005	-.003	-.003
	(-.071)	(-.046)	(-.047)
Female	.211**	.156*	---
	(.159)	(.118)	
Region of origin (Ref: African)			
Asian	.075	.204	.198
	(.056)	(.147)	(.143)
Eastern European	-.118	-.220	-.222
	(-.039)	(-.075)	(-.075)
Other region	.077	-.040	-.042
	(.028)	(-.014)	(-.014)
Religion (Ref: Muslim)			
Buddhist	-.393*	-.504*	-.500*
	(-.283)	(-.354)	(-.352)
Christian	.009	.086	.086
	(.007)	(.062)	(.062)
Other Religion	-.305	-.087	-.08
	(-.083)	(-.022)	(-.021)
Married	.003	-.070	-.066
	(.002)	(-.052)	(-.05)
Dependents	-.012	-.003	-.003
	(-.039)	(-.011	(-.012)
High school graduate	.09	.077	.077
	(.071)	(.06)	(.06)
Torture Characteristics			
Witnessing violence	.108	-.015	-.014
	(.071)	(-.009)	(-.009)
Violence against family	-.086	-.051	-.051
	(-.041)	(-.022)	(-.022)
Beating	-.016	-.103	-.103
	(-.007)	(-.045)	(-.044)
Rape/Sexual Assault	.248***	.292***	.293***
	(.194)	(.226)	(.226)
Deprivation	.020	-.023	-.024
	(.015)	(-.017)	(-.017)
Number of times detained	.011	.020	.020
	(.030)	(.058)	(.059)

Years since last torture experienced	.007 (.069)	.010 (.108)	.010 (.109)
Post-migration Characteristics			
Months in the U.S.	---	.000 (,009)	.000 (.011)
Separated from family	---	.168 (.069)	.171 (.07)
Legal immigration status	---	-.426*** (-.231)	---
Has work authorization	---	.104 (.072)	.104 (.-72)
Weekly income	---	.000 (-.059)	.000 (-.059)
English ability	---	.132 (.102)	.131 (.102)
Interaction terms			
(Ref: Men without Legal Status)			
Men with legal Status	---	---	-.443*** (-.210)
Women without legal Status	---	---	.149 (.109)
Women with legal Status	---	---	-.234 (-.069)
Constant	2.367***	2.254***	2.253***
Adjusted R^2	.162	.221	.218
*** p<.05**	****p<.01**	*****p<.001**	

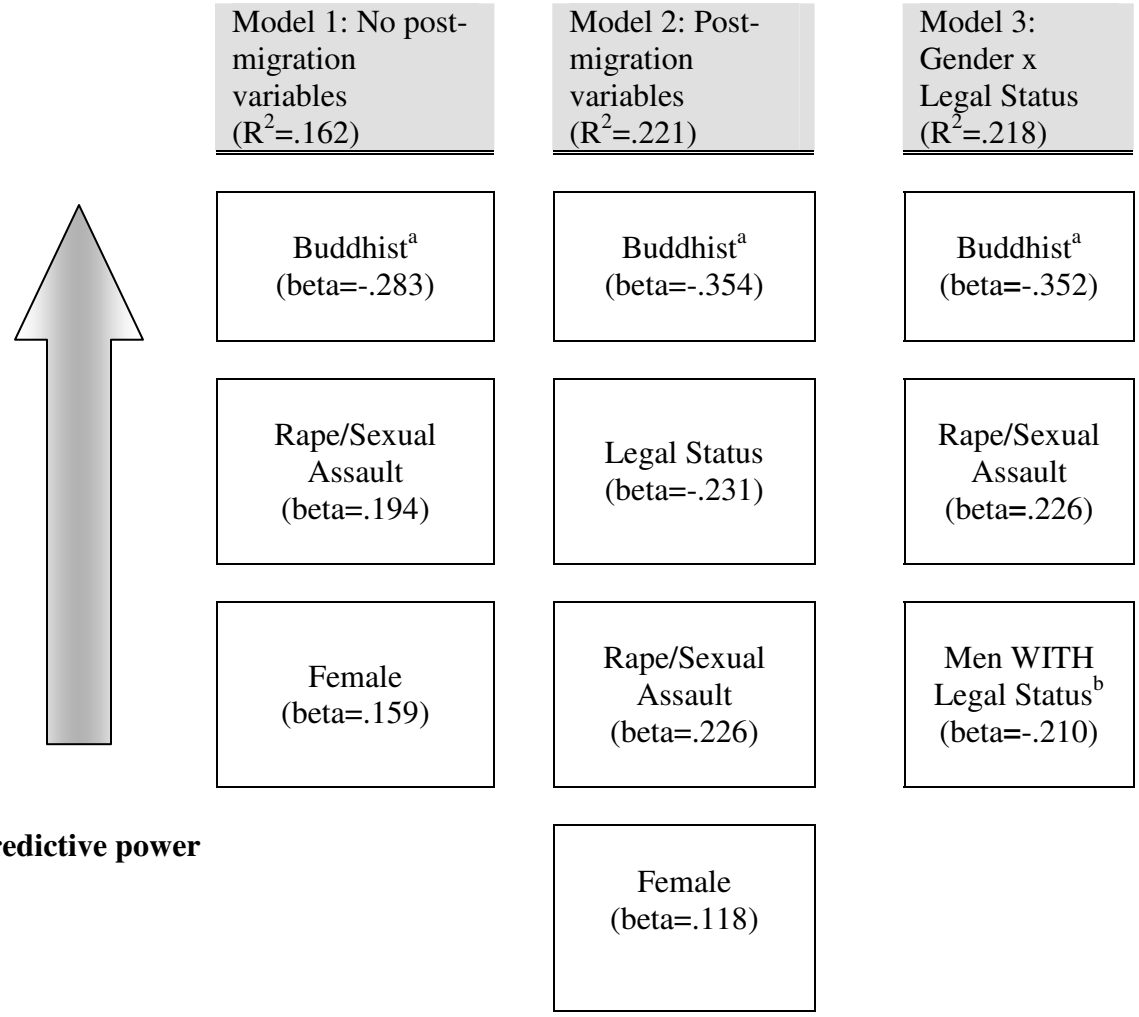
With the addition of the post-migration variables in Model II of Table 3.3, the adjusted R-Square increases from .162 to .221—the independent variables in Model II explain 22.1% of the variance in HTQ scores. An ANOVA between Models I and II indicates that this R-Square change is statistically significant (p<.01). The addition of post-migration variables explains significantly more of the variance in PTSD symptoms than pre-migration variables alone.

Among these post-migration variables – which include current weekly income, current separation from family, work authorization and English ability – the single significant predictor of PTSD was immigration status. Controlling for all other variables in the model, being a Buddhist (when compared to Muslim) remained the most powerful predictor of HTQ scores (beta=.-.354); Buddhists reported less severe PTSD symptoms than their Muslim counterparts (b=-.504; p>.05). However legal immigration status was the second most powerful predictor in the model (beta=-.231), slightly more powerful than having experienced rape/sexual assault (beta =.226). Controlling for all other variables in the model, those who had legal status (e.g., had asylum, had a Green Card, citizenship, Temporary Protected Status, etc) scored .426 lower on the HTQ than those who did not have legal immigration status; and that difference was significant at the .001 level. Rape/sexual assault was the next most powerful predictor of HTQ scores (beta =.226); controlling for all other variables in the model, those who reported being raped/sexually assaulted scored .292 points higher on the HTQ (p<.001). Finally, gender remained a statistically significant predictor in this model (beta =.118). Controlling for all other variables in the model, women scored .156 points higher on the HTQ than men (p <.05).

In sum, the addition of the post-migration variables to the model explained significantly more of the variance on PTSD than the baseline model, which excluded these variables. Though variables that were significant in the first model (i.e., Buddhism, rape/sexual assault, and gender) were still significant with the addition of the post-migration variables, legal immigration status became the second most powerful predictor of PTSD, more powerful than gender and as powerful as rape/sexual assault.

Model III of the PTSD analysis introduces the interaction of gender and immigration status, creating four categories: men without legal immigration status (this represented the largest category and was used as the reference category in this model), men with legal immigration status, women without legal immigration status, and women with legal immigration status. The only statistical significance associated with this interaction was the finding that, controlling for all other variables in the model, men with legal immigration status scored .443 points lower than the reference group, men who did not have legal immigration status; and that difference was significant at the .001 level. This was the third most powerful predictor variable in this model (beta =-.210). The most significant predictor in this model was Buddhism (beta =-.352); Buddhists scored .5 points lower than their Muslim counterparts, who were the reference group ($p<.05$). The second most powerful predictor was rape/sexual assault (beta =.226; people who reported being raped/sexually assaulted scored .293 points higher on the HTQ than people who did not ($p< .001$).

Figure 3.2. Statistically significantly predictors of PTSD, ordered by highest standardized Beta's (N=768)



[a] Ref: Muslim
[b] Ref: Men WITHOUT Legal Status

An illustration of the statistically significant predictor variables for PTSD symptomology of each of the three models, ordered by the standardized Beta's within each model, is presented in Figure 3.2. Overall, the regression models looking at PTSD symptomology revealed that, as illustrated in Model II, the post-migration factor of immigration status was a statistically significant predictor of PTSD, more powerful than gender and slightly more powerful as rape/sexual. Further, the interaction between gender and legal status in Model III revealed

gender differences in the benefits of immigration status; though men who had legal immigration status fared better than men without legal immigration status, women — regardless of immigration status — did not have statistically significant differences in PTSD scores when compared to men who did not have legal status.

Table 3.4 presents the various OLS regression models to predict depression and anxiety, as denoted by higher scores on the HSCL subscales.

Table 3.4. Unstandardized regression coefficients for depression and anxiety subscales of the Hopkins Symptom Checklist (HSCL) (Standardized Betas in parenthesis)

	Depression (N=860)			**Anxiety (N=869)**		
	Model I: No post-migration	Model II: Post-migration	Model III: Legal Status by Gender	Model I: No post-migration	Model II: Post-migration	Model III: Legal Status by Gender
Demographic Characteristics						
Age	-.004	-.005	-.006	-.006	-.009	-.009
	(-.058)	(-.075)	(-.079)	(-.09)	(-.121)	(-.12)
Female	.235***	.161*	---	.227***	.199**	---
	(.175)	(.121)		(.164)	(.144)	
Region of origin (Ref: African)						
Asian	.117	.360*	-.343	-.001	-.065	-.062
	(.087)	(.264)	(.251)	(.000)	(-.046)	(-.044)
Eastern European	-.296*	-.275	-.285	-.196	-.271	-.27
	(-.093)	(-.089)	(-.092)	(-.059)	(-.084)	(-.083)
Other Region	.103	.082	.079	.154	.078	.079
	(.036)	(.029)	(.028)	(.054)	(.026)	(.026)
Religion (Ref: Muslim)						
Buddhist	-.348*	-.581**	-.571**	-.194	-.193	-.194
	(-.249)	(-.414)	(-.407)	(-.135)	(-.132)	(-.133)
Christian	.053	.161*	.161*	-.013	.025	.025
	(.039)	(.116)	(.116)	(-.009)	(.017)	(0.17)
Other Religion	-.178	.210	.228	-.151	.160	.158
	(-.046)	(.054)	(.059)	(-.04)	(.039)	(.039)
Married	-.058	-.087	-.076	-.018	-.025	-.027
	(-.045)	(-.067)	(-.059)	(-.014)	(-.019)	(-.02)
Dependents	-.007	.002	.001	-.001	.013	.013
	(-.023)	(.006)	(.005)	(-.005)	(.046)	(.047)
High school graduate	.065	.039	.037	.195**	.112	.112
	(.051)	(.031)	(.029)	(.148)	(.084)	(.085)

Torture Characteristics						
Witnessing violence	.066	-.002	.000	.101	.058	.058
	(.042)	(-.001)	(.000)	(.063)	(.034)	(.034)
Violence against family	.048	.114	.114	.022	.114	.114
	(.023)	(.051)	(.051)	(.010)	(.049)	(.049)
Beating	.038	-.035	-.032	.069	.046	.046
	(.017)	(-.015)	(.014)	(.03)	(.02)	(.02)
Rape/sexual assault	.158**	.226**	.228**	.157**	.204**	.204**
	(.122)	(.175)	(.176)	(.117)	(.151)	(.151)
Deprivation	-.026	-.032	-.032	-.017	-.031	-.031
	(-.02)	(-.024)	(-.024)	(-.012)	(-.022)	(-.022)
Number of times detained	-.011	.015	.015	.013	.017	.017
	(-.033)	(.049)	(.05)	(.038)	(.053)	(.053)
Years since last torture experience	.006	.007	.008	.007	.008	.008
	(.064)	(.075)	(.08)	(.075)	(.086)	(.086)
Post-migration Characteristics						
Months in the U.S.	---	-.002	-.002	---	-.001	-.001
		(-.072)	(-.069)		(-.053)	(-.053)
Separated from family	---	.169	.182	---	-.061	-.063
		(.068)	(,074)		(-.024)	(-.024)
Legal immigration status	---	-.242*	---	---	-.299**	---
		(-.132)			(-.157)	
Work authorization		-.07	-.071	---	-.069	-.069
		(-.048)	(-.048)		(-.045)	(-045)
Weekly income	---	-8.98E-005	-9.06E-005	---	.000	.000
		(-014)	(-.014)		(-.019)	(-.019)
English ability	---	152*	.150*	---	.165*	.165*
		(.121)	(.119)		(.126)	(.126)

Interaction Terms						
(Ref: Men without legal status)						
Men with legal status	---	---	-.294** (-.143)	---	---	-.292* (-.136)
Women without legal status	---	---	.139 (.102)	---	---	.202* (.142)
Women with legal status			.062 (.017)			-.118 (.032)
Constant	2.227***	2.147***	2.142***	2.050***	2.214***	2.214***
Adjusted R^2	.107	.184	.184	.101	.159	.156

*** p<.05 **p<.01 ***p<.001**

Depression

Looking at Model I, which does not control for post-migration variables, the following four variables are statistically significant predictors of depression (in order of predictive power): Buddhist (as compared to Muslim), Female, Rape/sexual assault), and Eastern European (as compared to African;). Controlling for all the variables in the model, Buddhists had lower scores on the depression scale than Muslims (b=-.348, p<.05); this was the most powerful predictor in the model (beta=-.249). Women had higher scores than their male counterparts (b=.235, p<.001); this was the second most powerful predictor variable in the model (beta=.175). The next most powerful predictor variable was rape/sexual assault (beta=.122); those who experienced rape/sexual assault had significantly higher scores than their counterparts who had not experiences rape/sexual assault. (b=.158, p<.01). Finally, Eastern Europeans had lower scores the depression scale than their African counterparts (b=-.296, p<.05); this was the fourth most powerful predictor of depressive symptoms in the model (beta =-.093). In all, the adjusted R-square for Model I was .107; the independent variables in the model explained 10.7% of the variance in the depression outcomes.

With the addition of post-migration variables in Model II, the adjusted R-square rose to .184. An ANOVA between the Models I and II indicates that the R-Square change is statistically significant (p<.01). The addition of post-migration variables explains significantly more of the variance in depression symptoms than pre-migration variables alone.

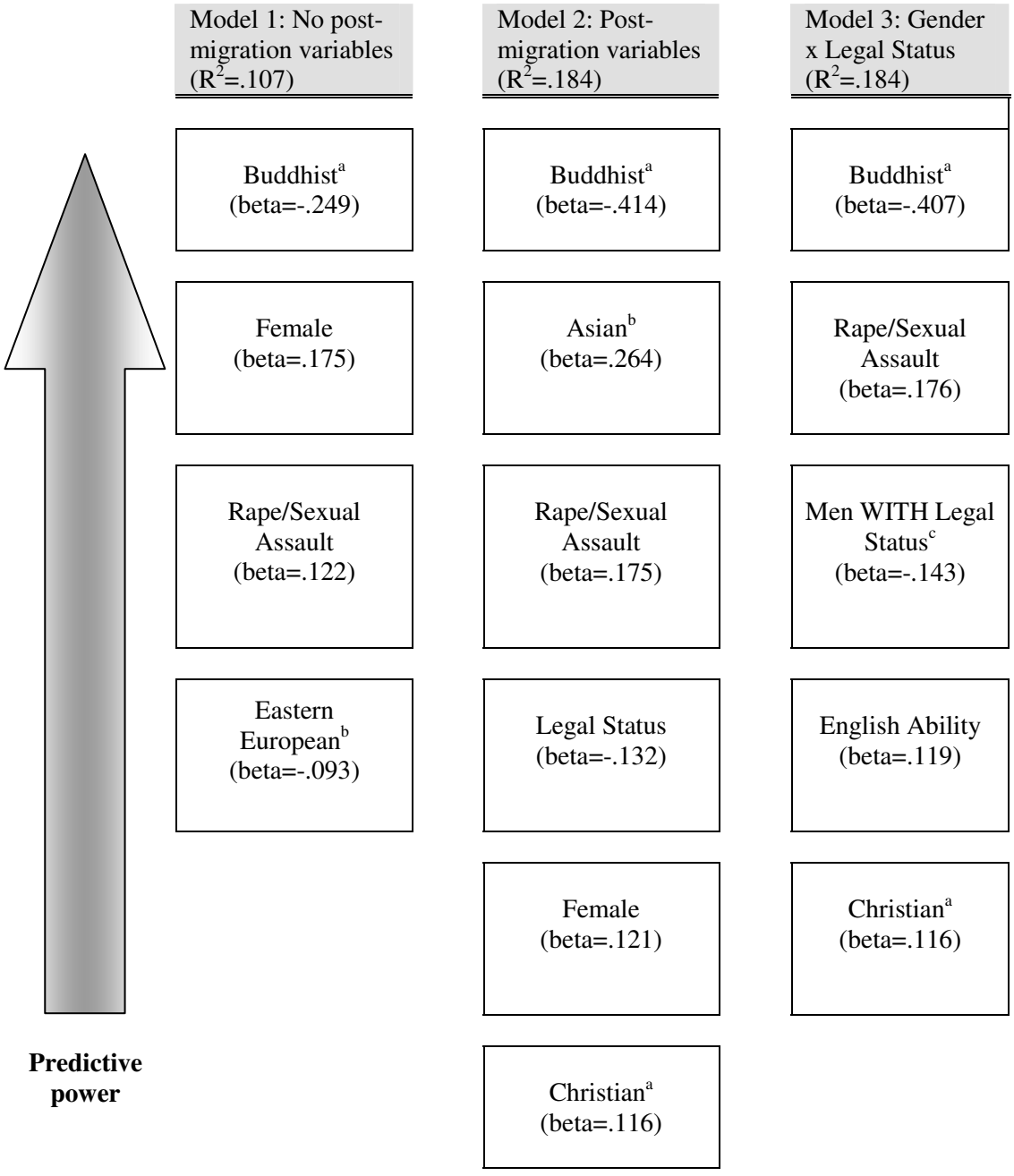
In Model II, Buddhism, when contrasted with Islam, remained the most powerful predictor variable in this model (beta=-.414); Buddhists scored .581 points lower in the depression measure than their Muslim counterparts (p<.01). Unlike Model I, Eastern Europeans did not have significantly lower scores than the reference category, Africans. However, Asians

have statistically significant *higher* depression scores than Africans (b=.36, p<.05) and this was the second most powerful predictor of depressive symptoms in this model (beta=.264). Rape/sexual assault remained positively associated with depression (b=.226, p<.01) and was the third most powerful predictor variable (beta=.175). Unlike the post-migration model in the PTSD analysis, immigration status was not a more powerful predictor than rape/sexual assault. Rather, it was the fourth most powerful predictor of depressive symptomology (beta=-.132), behind Buddhism, Asian, and rape/sexual assault. Controlling for all other variables in the model, those with legal immigration status scored .242 points lower on the depression measure than their counterparts who did not have legal status; and that difference was statistically significant at the .05. The remaining significant variables in the model were Female and Christian. Controlling for the other variables in the model, women had statistically significantly higher scores on the depression scale than their male counterparts (b=.161, p<.05), and Christians had significantly higher scores on the depression scale than their Muslim counterparts (b=.161, p<.05).

With the addition of the interaction terms, Model III shows that men with legal status scored .294 points lower on the depression measure than their counterparts who did not have legal status, and that difference was significant at the .001 level. This was the third most powerful predictor variable in the model (beta=-.143). The most significant predictor was Buddhism (beta=-.407); when compared to the reference group, Muslims, Buddhists had significantly lower scores on the depression measure (b=-.571, p<.001). Rape/sexual assault (b=.228, p<.01) was the second most powerful predictor (beta=.176). Other significant predictors in the model were English ability, which was associated with a higher depression score (b=.150, p<.05) and was the fourth most powerful predictor (beta=.119); and Christian, which was also

associated with a higher depression score than that reference group, Muslim (b=.161, p<.05) and was the fifth most powerful predictor variable in the model (beta=.116).

Figure 3.3. Statistically significantly predictors of depression, ordered by highest standardized Beta's (N=860)



[a] Reference category: Muslim
[b] Reference category: African
[c] Reference category: Men WITHOUT Legal Status

An illustration of the statistically significant predictor variables for depression outcomes of each of the three regression models, ordered by the standardized Beta's

within each model, is presented in Figure 3.3. Overall, the regression models looking at depression outcomes revealed that, when controlling for post-migration variables in Model II, immigration status was a statistically significant predictor of depression scores. Also in Model II, being Asian (when compared to being African) and being Christian (as opposed to Muslim) were statistically significantly associated with higher depression scores. As was the case in the analysis of PTSD outcomes, the interaction between gender and legal status in Model III revealed gender differences in the presumed benefits of immigration status; though men who had legal immigration status fared better than men without legal immigration status, women — regardless of immigration status — did not have statistically significant differences in PTSD scores when compared to men who did not have legal status. Furthermore, when controlling for the interaction of gender and immigration status in Model III, English ability became positively associated with depression scores. This is consistent with the bivariate findings, in which greater English language ability was positively associated with poor mental health. In addition, while when controlling for post-migration factors in Model II revealed that Asians were significantly more depressed than their African counterparts, after controlling for the interaction of gender and immigration status in Model III, this difference was no longer evident.

Anxiety

Looking at the Anxiety Subscale of the HSCL (also presented on Table 3.4), unlike the PTSD and depression outcomes, religion was not statistically significantly associated with increased or decreased measures of anxiety across any of the three regression models.

In Model I, which did not include post-migration variables, women had statistically significantly higher scores on the anxiety subscales than men (b=.227, p<.001) when controlling for all other variables in the model; this was the most powerful predictor in the model (beta=.164) Those with a high school education or greater had higher anxiety scores (b=.195, p=<.01) that those who did not; this was the second most powerful predictor in the model (beta=.148). Finally, the third most powerful predictor was rape/sexual assault (beta=.117); those who had experienced rape/sexual assault had higher anxiety scores than their counterparts who did not have such experiences (b=.157, p <.01). The adjusted R-square for this model was .101; the independent variables explained 10.1% of the variance in anxiety outcomes.

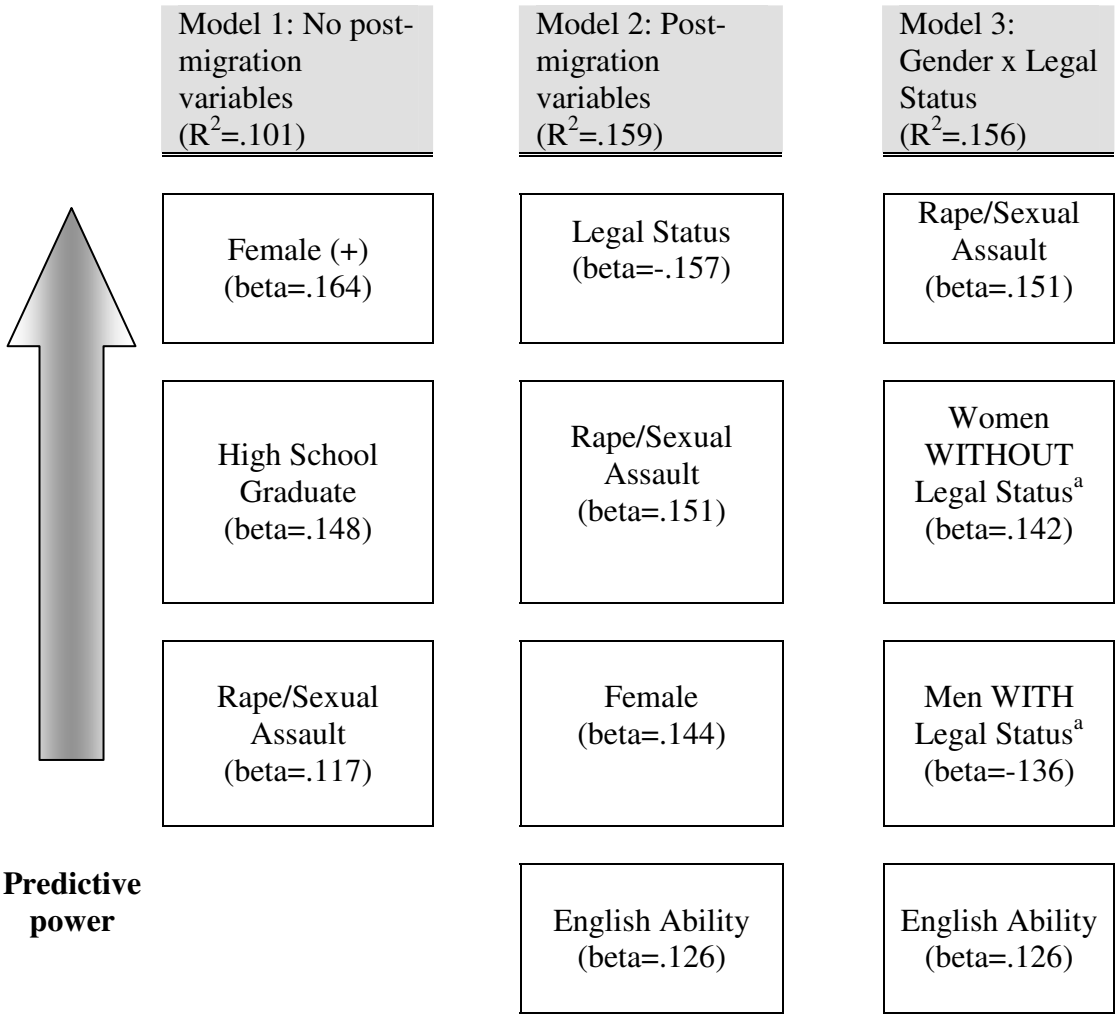
With the addition of the post-migration variables in Model II, the adjusted R-square rose to .159 An ANOVA between the Models I and II indicates that the R-Square change is statistically significant (p<.01). The addition of post-migration variables in Model II explains significantly more of the variance in anxiety symptoms than the pre-migration variables in Model I alone.

When controlling for post-migration variables, the most powerful predictor of the anxiety scores was having legal immigration status (beta=.-157), which was associated with a lower anxiety score (b=-.299, p<.001). This was slightly more powerful predictor

of anxiety than the experience of rape/sexual assault (beta=.151), which was associated with a higher anxiety score (b=.204, p<.01). Female was the third most powerful predictor of anxiety scores in this model (beta=.144); women scored .199 higher on the anxiety measure than their male counterparts (p<.01). Finally, as was the case in the depression model, having greater English language ability, i.e., fair, good, or fluent skills, was associated with higher anxiety scores than those who had poor or no English skills (b=.165, p<.05); this was the fourth most powerful predictor of anxiety (beta=.126).

With the addition of the interaction terms in Model III, rape/sexual assault became the most powerful predictor of anxiety scores (beta=..151); individuals who had experienced rape/sexual assault scored .204 points higher on the anxiety measure than their counterparts who had not had these experiences (p<.01). Unlike the interaction models looking at PTSD and depression, there was a statistically significant difference between women and men without legal immigration status; women without legal status fared worse than their male counterparts (b=.202, p<.05); this was the second most powerful predictor of anxiety in this model (beta=.142). As with the interaction models looking at PTSD and depression, men with legal immigration status had statistically significantly lower scores on the anxiety measure than their counterparts who were undocumented (-.292, p<.05)l this was the third most powerful predictor of anxiety (beta=-.136)/ As was the case when in the previous model, English ability was a statistically significant predictor of anxiety; controlling for all other variables in the model, those who had fair, good, or fluent English ability exhibited higher anxiety scores than those who had poor or no English language ability (b=.165, p<.05); this was the fourth most powerful predictor in this model (beta=.126).

Figure 3.4. Statistically significant predictors of anxiety, ordered by highest standardized Beta's (N=869)



[a] Reference category: Men WITHOUT Legal Status

An illustration of the statistically significant predictor variables for anxiety symptomology of each of the three models, ordered by the standardized Beta's within each model, is presented in Figure 3.4. Overall the regression models looking at anxiety symptomology revealed that, as illustrated in Model II, the post-migration factor of immigration status was the most statistically significant predictor of anxiety, more powerful than the other significant predictors in the model: rape/sexual assault, gender,

and English language ability. However, when controlling for the interaction between gender and legal status in Model III, rape/sexual assault became the most powerful predictor of anxiety, and English ability also remained a statistically significant predictor of higher anxiety scores. Further, women without legal immigration status had higher anxiety scores than men without legal status, and men with legal immigration status had lower anxiety scores than men without legal status.

Discussion

This analysis looked at mental health outcomes in a convenience sample of survivors of political violence with the aim of understanding the role of post-migration variables in predicting symptoms of PTSD, depression and anxiety. For all three measures, the addition of post-migration factors to predictive models (i.e., Model II for each measure) significantly increased the amount of variance explained in the outcomes as compared to predictive models that included demographic and torture-related variables alone (i.e., Model I for each measure).

The major finding was that post-migration immigration status was the most significant of the post-migration variables in predicting all measures. In the models which controlled for post-migration variables (i.e., Model II) post-migration immigration status was as powerful, or slightly more powerful, a predictor of lower PTSD and anxiety symptoms than the torture-related variable, rape and sexual assault (see Figures 3.2 and 3.4, respectively). These findings indicate the profound degree to which the post-migration environment can affect health. Rather than solely mediating the effects of pre-migration traumas such as rape/sexual assault, post-migration environment may also

constitute an independent threat to mental health and well-being. The only other important post-migration variable was English ability (see below for discussion), which was a significant predictor of greater depression and anxiety, though not PTSD. Though having work authorization was significantly associated with having higher depression scores in the bivariate analysis, this difference was no longer significant when controlling for all other variables in the regression model. The other three post-migration factors included in the analyses—months in the U.S., weekly income, and separation from family—were also not significant predictors of mental health outcomes.

Moreover, there is an interaction effect between gender and immigration status across all three measures. While men with legal immigration status had significantly lower rates of PTSD, depression, and anxiety than men who were undocumented, women with legal status did not have significantly different outcomes than men without legal status, suggesting legal status is more beneficial to the mental health outcomes of men than women. One possible explanation is the relationship between immigration status and the ability to obtain regular employment in the formal sector workforce. The ability to work in the formal economy may be more important to men because existing work opportunities in the informal sector may be more readily available for immigrant women than men (Foner 1999). Yet immigration status no doubt represents more than just work opportunity, as work authorization was at not a significant predictor of mental health status in any of the regression models. In addition, while the benefits of having legal status may be gendered and may have more protective effects on mental health among men, women without legal status had significantly higher rates of anxiety than their male

counterparts. Thus, even if having legal status is not as beneficial to women as men, the detrimental effects of *not* having legal status can be more severe among women.

Rape and sexual assault was a significant predictor of all measures and, when accounting for the interaction between gender and immigration status, it was the most powerful predictor of anxiety. Previous work with a sub-sample of these data indicate that, in addition to rape/sexual assault, there were four other distinct torture-related experiences that influenced clinical outcomes - witnessing torture, the torture of family members, physical beating, and deprivation (Hooberman et al. 2007). Though all five factors were entered into the present analysis, across all models the other four factors dropped out and only rape/sexual assault were significant torture-related predictor of PTSD, depression, and anxiety, replicating Hooberman et al.'s findings This supports research on the devastating effect of rape/sexual assault on both men and women, and the need for specialized care in addressing this particular type of traumatic experience among survivors of political violence (Swiss and Giller 1993; Oosterhoff et al. 2006).

Religion remained the powerful predictor of PTSD and depression across all regression models, though it was not a significant predictor of anxiety. Those who identified as Buddhist, the majority of whom were from Tibet, had markedly better PTSD and depression outcomes than their counterparts who were Muslim. This finding is consistent with previous research both with Tibetan refugee populations in India (Crescenzi et al.. 2002; Holtz 1998; Terheggen et al.. 2001) as well as previous research with Tibetan clients from this clinic (Keller 2006) that Tibetan Buddhists appear less prone to such symptomology than other survivors of torture, despite experiencing comparable traumatic experiences. Interestingly, those identifying as Christian had

significantly worse depression and anxiety outcomes than their Muslim counterparts. This contradicts the assumption that, due to the social stigma associated with Islam, being a Muslim would be associated with the most deleterious mental health outcomes among the religions represented in this sample, and indicates that perhaps potentially protective elements of religiosity may not lay in the social acceptability of any given faiths.

Although region of origin was statistically significantly associated with mental health outcomes in the bivariate analysis, these differences all but disappeared when controlling for other variables in the regression analysis. An ANOVA with Tukey-adjusted post-hoc had revealed that Asians had statistically significantly lower PTSD and anxiety scores than participants from Africa, Eastern Europe, and "Other" regions on two scales, and statistically significantly lower scores on the depression measure than Africans and those from Other Region, though not Eastern Europeans. In the multivariate analysis however, the only statistical association between region of origin and mental health was found in the depression models. In the pre-migration model (Model I) of that analysis, Eastern Europeans were statistically significantly less depressed than the reference group, Africans. When controlling for post-migration variables in Model II of the depression analysis, this difference between Eastern Europeans was no longer evident. Rather, Asians now had statistically significantly *higher* depression scores than the reference group, Africans. This finding was contradicted the bivariate findings in which Asians had lower depression scores, and also challenges the body of immigrant health literature that forwards the notion that Asian immigrants typically "under endorse" psychological measures.

Another interesting finding was the association of English ability with increased depression and anxiety. In their review of research on refugee mental health, Porter and Haslam (2005) found that those who were more educated and had higher pre-displacement socioeconomic status (SES) had worse mental health outcomes, indicating that these characteristics represented "a greater loss of status rather than protective effect" (610). Though this study did not include a measure of pre-migration SES as an independent variable, it did include an education measure – having a high school diploma. Being a high school graduate was not significantly statistically associated at all with PTSD symptoms. While it was significantly associated with higher depression scores in the bivariate analysis, this relationship was no longer evident when controlling for other variables in the regression models. Being a high school graduate was a significant predictor of anxiety in the regression model that included pre-migration variables only, however this significance disappeared when controlling for post-migration variables in Model II of the anxiety analysis. The seemingly greater importance of English language ability, rather than education, as a predictor of poor mental health in this study is interesting and may indicate that, in this post-migration setting, language serves as a proxy for SES or intellectual capital in a way that education does not.

Limitations

There were a number of limitations in this study. First, these data were drawn from a convenience sample and cannot be used to statistically generalize to any larger population. However, due to their immigration status and the nature of their experiences, individuals who have been exposed to political violence often represent a hidden or hard-

to-reach population. As such, it would be difficult to identify an accurate sampling frame from which to draw a representative sample. A second limitation is the possibility of selection bias; this sample of individuals seeking treatment may be more distressed and symptomatic than torture survivors in the community who have not sought treatment. Thus, some degree of overestimation is likely in terms of the severity of psychological symptoms observed in this study. Moreover, a large proportion of clients is referred to the clinic by their lawyers and is involved in active legal cases. As such, the importance of immigration status may be especially prominent among these individuals. A third notable limitation is the availability of a pool of predictor variables. This analysis of secondary data as was limited to items elicited through standardized intake procedures, and a number of potentially important variables – including pre-migration socioeconomic status and post-migration experiences of detention in the U.S. – were not available for study. Despite these limitations, this study draws upon the largest and most diverse sample of survivors of political violence resettled in the U.S. The findings from these analyses can contribute to the design of larger and more structured studies of mental health that look critically at post-migration structural barriers to mental health in this population.

Conclusion

The findings in this study provide quantitative support for the assertion that post-migration hardships may transcend the experiences of torture and political violence in the traumatization of survivors of political violence. Trauma is not just the torture event, it proceeds into post-migration settlement. In a critical review of psychological instrumentation used to assess refugee trauma and health status, Hollifield et al. (2002: 618) point to the fact that, clinically, "the legal definitions that distinguish 'refugee' from 'asylee' from 'internally displaced persons' are not necessarily predictors of trauma experiences or health status." This chapter argues that legal status is a meaningful distinction. Despite similarities in pre-migration experiential events, such as the torture and forced migration, the post-migration conditions that survivors of political violence are subject to vary widely and are predicated on the legal rights and allowances afforded or denied to them, as well as the availability of social welfare assistance in countries of resettlement. On a broader level, it is both pre-migration traumas and a heavy reliance on social services that distinguishes these individuals from other immigrants (Hein 1993), yet despite these increased vulnerabilities they often must negotiate both the hardships of being undocumented and seeking political asylum in an antagonistic legal and social service system.

Mental health research on post-migration hardships and their effect on psychological outcomes most often look at social factors, with a call for psychosocial intervention to enhance those social factors that are protective of mental health, e.g., increased social support, local network size and network satisfaction (Schweitzer et al. 2002). However, the individuals in this study also face multiple levels of structural and

bureaucratic obstacles to material and legal stability in addition to a lack of social resources and support. In the U.S., the political climate and concomitant polices of deterrence that affect undocumented immigrants generally, and survivors of political violence specifically, represent considerable barriers to mental health and well-being. The findings presented in this research indicate that factors such as immigration status may represent a valuable and important starting point in developing conceptual models that encompass the complexities this population's particular needs. For example, theories of "cumulative adversity" (Kuniak 2005) and "polytrauma," (Hollifield et al. 2002) acknowledge the experiences of multiple health-harming events and conditions in multiple contexts over time.

On an intervention level, psychosocial interventions that help survivors of political survivors adjust to post-migration life by supporting and strengthening social and cultural networks are no doubt of paramount importance. However, a holistic understanding of the mental health of this population necessitates addressing both the social and structural deficits that these individuals confront in the U.S. Innovative clinical interventions can also serve to facilitate their negotiation of existing social service and legal institutions, for example by converging medical and legal narrative demands in the form of testimony-based modalities of treatment (Kirmayer 2003; McKinney 2007). Ultimately, the understanding of trauma among survivors of political violence requires a re-imagining of "the therapeutic process as both a political and a healing event" (McKinney 2007:266), with the acknowledgement that health-harming politics are not solely located in pre-migration violence, that they also permeate the post-

migration experience in the form of hostile immigration and social welfare policies that constitute ongoing adversities and violations of human rights.

Though the major findings in this research relate mental health to immigration status, anecdotal evidence suggests that having legal status in the U.S. may not always lead to a better life or better mental health. A clinician at PSOT cited the story of an individual named Suresh, Bangladeshi man who was granted asylum in the U.S. However, even with legal status, Suresh found both the inability to practice his trade (he was a medical professional) or otherwise obtain any type of material security, as well as the everyday hardships of immigrant life in the U.S. so daunting that he attempted to re-apply for asylum from Sweden, a country known for its more liberal social welfare provisions for refugees and asylees. When he was told he could not apply for asylum to another country because he'd already been are granted asylum in the U.S. he launched a month-long hunger strike in protest, resulting in his eventual hospitalization for multiple system failure.

Suresh is only one story; his experience illustrates how having legal immigration status may be only one piece of a much wider and more multifaceted picture of post-migration life for survivors of political violence in the U.S. The remainder of this dissertation is devoted to the stories of people like Suresh, stories that no quantitative measure – no matter how validated, culturally competently administered, or cautiously interpreted – could capture.

CHAPTER FOUR: African Survivors of Political Violence

Introduction

Immigrants from Africa constitute the largest region group among PSOT clients; over half (53%) of all clients in the full client database (N=1,360) are from countries in Africa. These clients come from a cross-section of African nations, though the majority tends to be from West African countries such as Sierra Leone (18%), Guinea (14%), Mauritania (10%), and Cameroon (9%). As mentioned earlier, one of the clinical co-directors is herself from Sierra Leone, and founded a community-based organization originally for immigrants fleeing the 1991-2000 civil war in Sierra Leone.

This chapter is devoted to the experiences of the fifteen survivors of political violence from Angola, Cameroon, Congo/Zaire, Guinea, Sierra Leone, and Togo. Demographic and interview information about these fifteen individuals is presented in Table 4.1. I n order to contextualize the experiences of the African survivors of political violence, I will present a brief overview of African immigration to U.S. and African immigrant communities in NYC. I will then discuss three themes that emerged from the interview and content analysis of clinic files: (1) the creation of social networks, (2) reactions to racial encounters and post-migration poverty, and (3) assertions of immigrant identities. Finally, I will consider these findings within the framework of nominalist and realist interpretations of the refugee experience (i.e., to what extent are these experiences unique to refugees), as well as the Kunz's model of flight patterns and refugee typologies, especially in the relationship between vintage groups.

Table 4.1. Demographic and interview characteristics of African research participants (N=15)

	Number	Percent
Demographic Characteristics		
Country of Origin		
Angola	1	7%
Cameroon	2	13%
Congo/Zaire	3	20%
Guinea	3	20%
Sierra Leone	3	20%
Togo	3	20%
Gender		
Female	9	60%
Male	6	40%
Average age = 44 years (ranges from 31-56 years)		
Immigration Characteristics		
Average number of years in the U.S. = 4.5 (ranges from <1 to 8 years)		
Current immigration status		
Asylum granted	13	87%
Permanent resident[a]	1	7%
No status	1	7%
Employed?		
Yes	8	53%
No	7	47%
Interview Characteristics		
Interviewed in native language or with interpreter	9	60%
Interviewed in English	6	40%

[a] Admitted through the Diversity Visa Program

Background

PSOT clients from Africa exist within a larger backdrop of African migration. Africans constitute one of the fastest growing immigrant groups in the U.S., with over one million documented immigrants known to be in the U.S. African immigrants in the U.S. (Greico 2004). In a disconcerting headline, a 2005 *New York Times* article heralded

the annual flow of African migrants as exceeding the number of African slaves making the middle passage during the peak years of slavery (Roberts 2005). Post-colonial destabilization has been increasingly marked by violent intra-state conflicts and has resulted in multiple refugee crises throughout sub-Saharan Africa. Though African immigrants are a heterogeneous population, representing a wide spectrum of professional and occupational statuses, as well as legal statuses, a large number of African migrants in the U.S. have emigrated from political "hot spots," including the West African coastal nations of Senegal, Sierra Leone, Nigeria, Cameroon, and Ghana (Kalipeni and Oppony 1998). The African immigrants in this project are among those who came to the U.S. as a result of such political conflicts, though they are not representative of all immigrants from these particular countries.

Modern African migration to the U.S. is a relatively recent phenomenon; the legal avenues through which African immigrants come to the U.S. are varied, resulting in substantial heterogeneity within the African immigrant population. The 1965 Immigration Act allowed educated Africans, primarily from North African nations and South Africa, to migrate to the U.S. Political and economic strife in 1970s and 1980s resulted in an increase in immigration from sub-Saharan African nations under protective migration policies (e.g., refugee and asylum policy). In the following decades, family reunification and sponsorship became a prevalent vehicle for African immigration to the U.S.

In the 1990s the Immigration and Naturalization Service's (INS) Diversity Visa Lottery Program, which was enacted in a 1990 law to diversify the immigrant admittances to the U.S., became a mechanism through which new African communities

were established. Commonly referred to as the "Green Card Lottery," this program increased the diversity of African nations represented in the immigrant community by enabling individuals with no existing familial ties, protected status, or employment visas to immigrate to the U.S. Previous to this program, a country's Anglophone background and political and economic ties to the U.S had been important predictors of the major sending countries to the U.S. (Gordon 1998). These factors are not necessarily as significant among those emigrating through the Green Card Lottery.

There is also educational heterogeneity among African immigrants. Recipients in the Green Card Lottery are required have at least a high school education. The earlier waves of African immigrants, largely admitted through employment policies, tended to be college-educated (Gordon 1998). Non-Visa Lottery immigrants (admitted through family reunification, as refugees, etc), may have little or no formal education.

African immigrants' refugee status and exposure to political violence

As with all immigrant groups, it is difficult to estimate how many of African immigrants in the U.S. discussed above are like the PSOT clients, that is, have been exposed to political violence and/or have left their country of origin as forced migrants. The U.S. Committee for Refugees and Immigrants (2006) reports that four of the ten leading refugee-producing countries and nearly half of the world's displaced persons are African. In Fiscal Year 2004, 55 percent of individuals admitted for resettlement in the U.S. as refugees (about 29,000 individuals) were from Africa[26] (Humanitarian Policy & Practice Committee 2002). As discussed in Chapter 2, it is clear that official refugee

[26] In contrast, in Fiscal Year 2004, about 7 percent of admitted refugees were from Latin America, 5 percent from the Near East/South Asia, about 18 percent from Europe and Central Asia, and about 15 percent from East Asia.

status, while by definition denoting a well-founded fear of persecution, is not an exhaustive indicator of experiences of persecution or exposure to political violence.

The high proportion of refugees from Africa, however, highlights that post-colonial Africa has been the site of numerous wars and intra-state conflicts. Consequently, the likelihood that migrants, regardless of immigration status, from these conflict areas have been exposed to political violence is higher than that of migrants from other areas. Moreover, the INS Green Card Lottery – one major vehicle for African migration to the U.S. – emphasizes migration from underrepresented countries, many of which (coincidentally) include African nations in conflict areas, including Sudan, Sierra Leone, and Guinea.

Africans in New York City

NYC is the home of one of largest and fastest growing African communities in the U.S. There are an estimated 92,000 documented Africans immigrants in New York; the number of African immigrants more than doubled between 1990 and 2000 (New York City Department of City Planning 2004).

African immigrants permeate the ethnic landscape of NYC; their ethnic identities are at times evident, at other times indistinct. As a transnational urban center, NYC offers opportunities in the form of informal sector niches and social and cultural networks. In certain venues, such as the Malcolm Shabazz Harlem Market on West 116th Street, Africans' ethnic identities are prominent as merchants trade fabrics, clothing, and decorative pieces from or inspired by Africa. Beyond the Harlem Market, African vendors can be found throughout commercial sectors of the city, selling general

ware such as CDs and DVDs, jewelry and purses, and cell phone accessories. In African American neighborhoods, including Harlem, African women often work as hair braiders in salons that advertise "African Hair Braiding" in their windows. Though Africans often occupy these low-paying informal sector niches, they may also hold positions across the socioeconomic spectrum. In hospitals African immigrants are employed throughout the institutional hierarchy, from housekeepers to medical assistants to physicians.

The representation of Africans across socioeconomic strata indicates that, as with African immigrants in the U.S. overall, African New Yorkers emigrate through legal mechanisms representing a variety of immigration and foreign policy priorities. In the 1990's, most (51 percent) documented African immigrants living in New York City have been admitted through family reunification policies. The next largest admittance category is the Diversity Visa Program. Almost two-fifths (37 percent) of Africans settling in New York City in the 1990s were admitted though this program, and, over the course of 15 years, new African communities (for example Ghanaians and Nigerians) have emerged that would not have been established through either family reunification or employment pathways (New York City Department of City Planning 2004). These individuals are, on average, less educated than those previously admitted (Gordon 1998), and as stated earlier, often from conflict areas. In addition, many Africans have also settled in New York under explicit protective statutes. A community of Liberians has been established on Staten Island largely through the Temporary Protected Status program, and Sierra Leoneans have settled Central Harlem and the South Bronx as refugees and asylum seekers.

In NYC, racial and class segregation affect new immigrants as they do native-born residents, with immigrant groups following trajectories of opportunity and mobility that diverge along ascribed racial and ethnic lines. For example, in recent years, Sudanese refugees have settled in the predominantly low-income Black neighborhood of Bedford-Stuyvesant, while Georgian Jews have joined other immigrants from the former Soviet Union in the middle-class community of Brighton Beach. As a "new" immigrant community, Africans may not have the benefit of existing regional or ethnic communities established by previous waves of immigration. In addition, while all immigrants, particularly non-White immigrants, face challenges integrating into new societies, African immigrants are further confronted by the U.S.'s dyadic polarization of race and may be swept into structural conditions of material and social inequality that plague native-born African Americans.

It is against this backdrop that African survivors of political violence, including the 15 individuals in this research, live their lives as New Yorkers. Figure 4.1 below shows that the neighborhoods with the highest number of PSOT clients hail from Africa. Crotona/Tremont and Morrisania in the Bronx and Bedford Stuyvesant in Brooklyn (highlighted in yellow) have a medium density of African immigrants. Figure 4.2 shows that the neighborhoods that PSOT clients from Africa most often live in (again highlighted in yellow), particularly Crotona/Tremont and Morrisania in the Bronx, are among some of the poorest neighborhoods in NYC.

Figure 4.1. PSOT clients from Africa live in neighborhoods, such as Crotona/Tremont (Bronx), Morrisania (Bronx), and Bedford-Stuyvesant (Brooklyn), which have a medium density of African immigrants

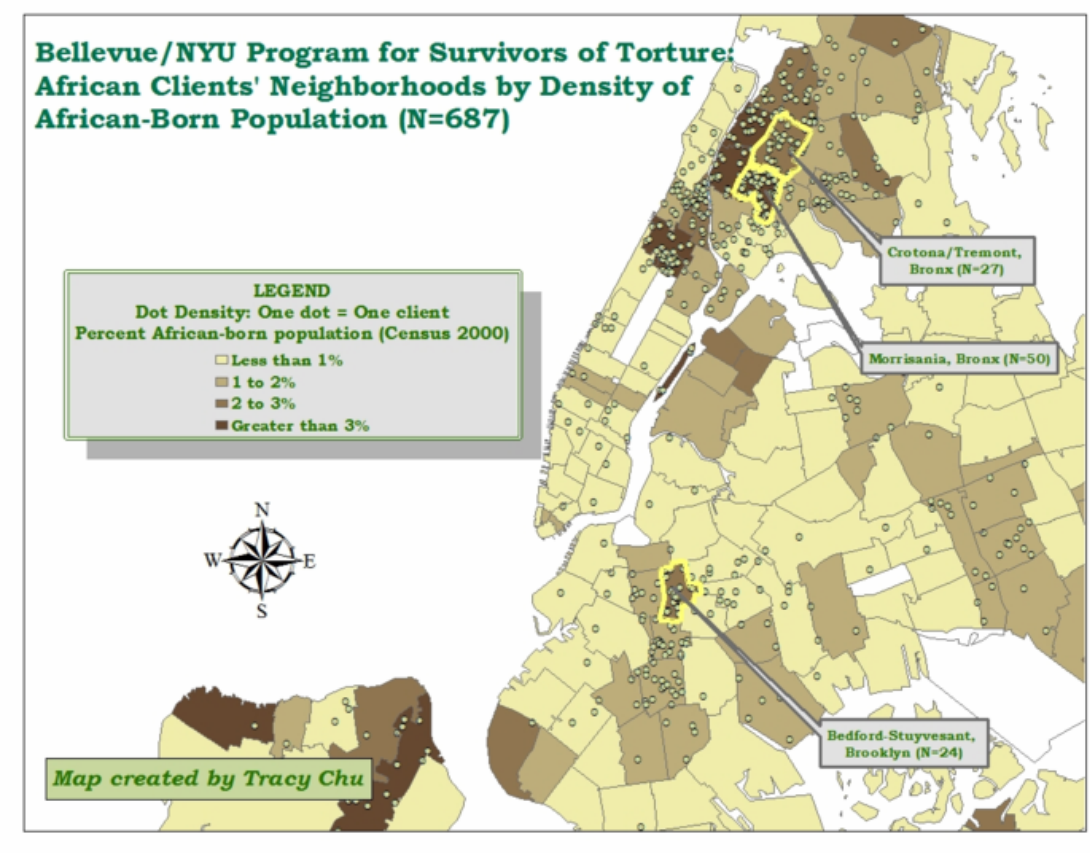
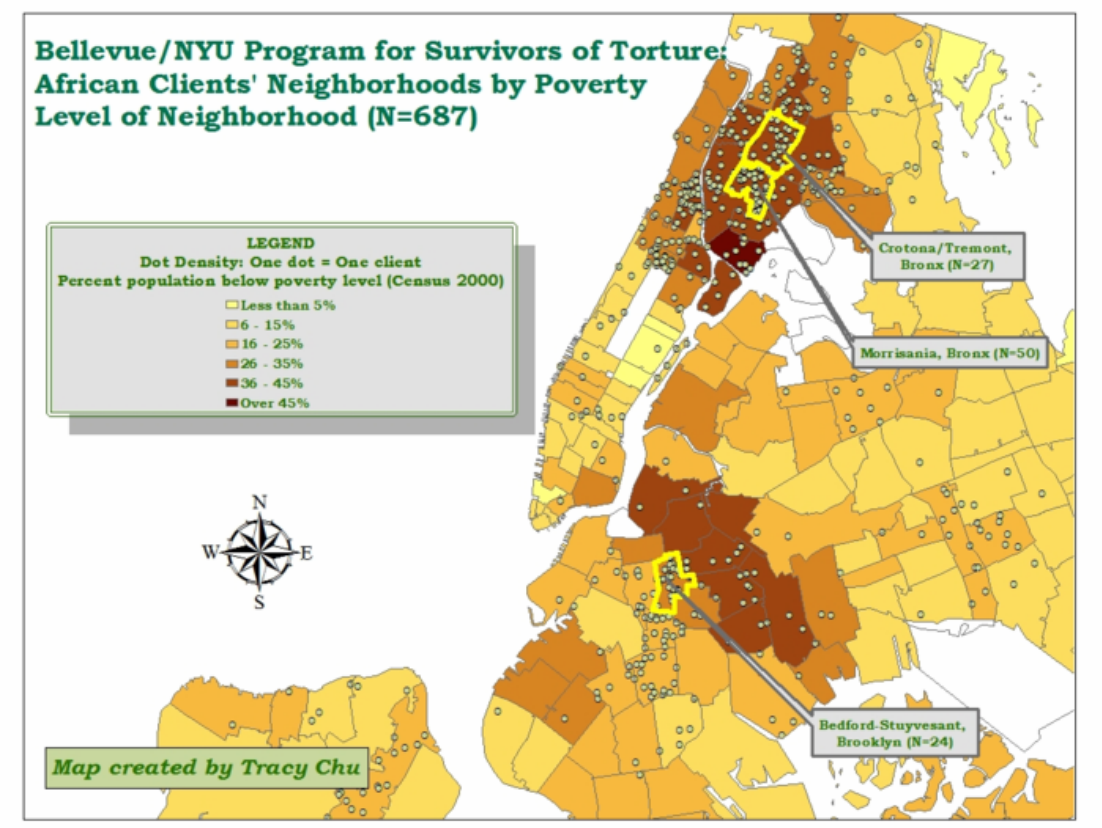


Figure 4.2. PSOT clients from Africa live in some of the poorest neighborhoods in NYC, including Crotona/Tremont (Bronx) and Morrisania (Bronx)



Creating social networks from chaos

In late January 2008, violence erupted in Kenya where a recent presidential election marred with voting irregularities exacerbated longstanding land dispute tensions between ethnic groups. The current President, Mwai Kibaki from the dominant Kikuyu ethnic group, was re-elected through questionable voting procedures, sparking outrage from the opposing political party, represented largely by the other ethnic groups in Kenya, including the Luo, Kalenjin, and Luhyas. In a back-and-forth cycle of attack and retaliation, bands of militias (including the Kikuyu militia allegedly supported by the Kenyan government), killed as many as 1,500 people (including a member of Parliament

who was dragged from his car and shot) and displaced 600,000 from their homes in the course of a few weeks.

About two weeks after the very worst of the violence in Kenya had occurred, I guest lectured about African immigrants in an undergraduate course, "American Ethnicity." It's always a struggle to engage a classroom of strangers, and I had had modest success in the past asking students to call out the most famous African they could think of. Generally, with some gentle nudging students could come up with Barack Obama, though they were more likely to name former Secretary General Kofi Annan or NBA basketball player Dikembe Mutombo. The second step of the exercise was to ask students *which* African country that individual was from, which almost no one could ever name.

On that occasion, I instead pulled up headlines and pictures of Kenya, including a picture of President Mwai Kibaki of the Kikuyu ethnic group shaking hands with opposition leader Raila Odinga, who is a member of the Luo ethnic group. Midway through the lecture I would pull the picture back up and ask if students could remember which man was which, and I would reveal that I had in my notes a reminder to myself that Kikaki was the man in the blue suit. I navigated through all of this very gingerly, trying to make the point that I, and perhaps others in the class, was accustomed to a particular racial paradigm such that I often relied on visual cues to differentiate ethnic groups. Schraeder and Endless (1998: 29) argue that Americans maintain undifferentiated images of Africa that include stereotypical imaged "poverty and famine, corruption and 'tribal warfare.'"[27]

[27] See also: Keita, Maghan. 2001. "Conceptualizing/Re-conceptualizing Africa: The Construction of African Historical Identity." *Journal of Asian and African American Studies* 36:331-337 and *Issue: A*

The point of the exercise was to open a dialogue about how, just as our U.S.-rooted imagination envisioned a monolithic African identity that transcended individual countries, so too do our U.S.-trained eyes often fail to discern immediately phenotypical differences between ethnic groups. Moreover, conflicts between groups that seem phenotypically similar (be they religious groups such as Protestants and Catholics in Northern Ireland or ethnic groups such as Hutus and Tutsis in Rwanda) are not how we are used to understanding between-group strife, certainly not racial or ethnic strife. What then happened, I asked, when these individuals migrate to the U.S. where they find themselves placed under a "pan-African" umbrella with individuals from opposing side political parties, ethnic groups, or tribes?

'Where are the Africans?" African social networks as an asset

Adanna, a woman in her early 40s, left Sierra Leone in a manner that was unplanned, turbulent, and centered on immediate escape. Throughout the 1990s, Adanna and members of her politically active family had been systematically detained and tortured by armed rebel groups in Sierra Leone that opposed the democratically elected president. She fled her village in the late 1990s in the midst of a rebel attack on her village in which her father was killed. Separated from her husband and children in the chaos of the attack, she walked into the bush for two days to neighboring Guinea, took a bus for another two days and eventually obtained passage onto a boat in exchange for the cash and jewelry she had been able to grab before she fled her home. During the month-

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Journal of Opinion, 22, 1,(Winter/Spring 1994), [Ed: Beverly Hawk], a special issues devoted to the topic of the media and Africa,

long boat ride she encountered no one who spoke her languages, slept near the engines to the point where her hearing was damaged, and washed dishes in exchange for food.

When she stepped off the boat a month later, she had traveled from Guinea to Maryland. She had $400 in U.S. money, no idea of the location or safety of her husband and children, no idea where in the U.S. she actually was, and no ability to communicate with her month-long traveling companions. In Kunz's kinetic parlance, she had endured an acute refugee migration and was faced with regrouping from the migratory "plunge." Her first inquiry: Where are there Africans?

> Once I was off of the ship, the man [who had assisted in my passage] walked with me for a few minutes until I was out of the area where the ship was docked. He left me on the corner of a street and started walking away. I turned the corner and walked in the other direction. I saw another man when I turned the corner. I walked up to him and I asked him if he knew how I could find African people. Because the Krio language is in some ways similar to English, I was able to speak to him and understand him, but it was difficult. The man said I should go to New York City. He told me that I could take the bus. I still had the four hundred ($400) United States dollars that I had brought with me...This man walked me to the bus station. On the way, he bought me a pair of shoes with some of my money because all I had on was a pair of slippers. At the bus station, I gave him more of my money and he bought me a ticket and helped me get on the bus to New York City. While I was at the bus station I heard someone on the loud speaker say that I was in Baltimore, Maryland. It was not until I heard this that I knew where I was.

Once in New York, she once again queried a stranger about where to find Africans:

> He told me that I should go to the markets in Harlem on 116th Street. He told me that I could take the subway there, but I did not understand what he meant by "subway." I asked him, "Can you show me?" which the same phrase in Krio is as it is in English. He showed me where the subway was downstairs in the bus station. He bought me a token. He then showed me how to get through the turnstiles and told me to get on the next train. I got on the next train and asked a man who looked African how to get to Harlem markets. He did not speak Krio, but spoke English slowly so that I could understand. He told me that he was going near there and that he would take me there….When I got to the markets, I met a woman who spoke Fula, who let me stay with her for a little while. I later met

> other people at the Harlem markets who let me stay with them for a few days or a few weeks at a time.

Given Adanna's ordeal in Sierra Leone and the bewilderment she faced upon arriving in the U.S., the strategy to locate other Africans was perhaps a logical course of action. Moreover, whatever her national, linguistic, or ethnic group preferences, she grasped the practicalities of the situation; she did not ask for Sierra Leoneans, she asked for Africans.

"You don't know who is who": Risk and co-national networks

Though the turbulent circumstances of Adanna's flight made her immediate connection to social networks a vital resource upon her arrival in the U.S., these types of pre-migration ordeals and experiences of persecution can also condition individuals to be hesitant in establishing social network ties. Some of the African survivors of political violence described an element of risk in interacting with co-nationals (i.e., people from their particular country), though not necessarily others from Africa. These individuals were vigilant of the possibility that co-nationals they encounter in NYC could be on the opposing side of the political conflict that caused their flight. With family still in their country of origin, co-nationals could represent a threat rather than an ally.

Elewa is a Cameroonian man in his early 30s who was detained and tortured multiple times for his activities with the government opposition party. Now a medical technician, he told me that he found solace in speaking to other Africans at the hospital where he works about politics, painful migration experiences, and life in the U.S. He stressed, however, that his friends were from South Africa and that he was uncomfortable

speaking to others from Cameroon, “For me, I don't deal too much with people from my country because you don't trust everyone…You don't know who is who.” The political leadership that Elewa’s party opposed is still the dominant political party in Cameroon. The political actions that incited his persecution by the Cameroon government may still endanger family members, including two sons who are still there. Moreover, in this case Elewa’s distrust was grounded in personal experiences of betrayal; he believes that it was his friends and acquaintances in Cameroon who informed the government of his actions, leading to his eventual detention and persecution.

Haamid is the Guinean man in his mid-50s whose experience seeking asylum was detailed in Chapter 2. In the late 1990s, he was an active member of a political party in opposition to current Guinean president Lansana Conte. He was arrested and over the course of three years and on three occasions he was detained and tortured for as long as four months before he fled to the U.S. His experiences on arriving in the U.S. were indicative of how distrust of co-nationals often markedly affected respondents’ experiences of resettlement, and in his case pointed to the discomfort that a cosmopolitan environment such as NYC could evoke. The following is from an account in his legal file.

> After arriving at J.F.K. Haamid stayed for a time in New York City, but he felt unsafe here then because he was alarmed at the number of Guinean government representatives ("embassy people," was his term) passing through. He explains that he assumed things in the U.S. worked the way they did in Guinea, and he was afraid of being spotted and disappeared by these people. [A few months later] he set out for Chicago where he heard there were Africans but which seemed reassuringly in the middle of nowhere. He traveled by bus.

The transnationalism of NYC is reflected in the diversity of African immigrants residing there. Guineans of all statuses, including high ranking government officials, can

be found walking the streets, as immigrants, tourists, or visiting diplomats. In contrast, in smaller cities and towns with sizeable concentrations of African immigrants, the African population often consists primarily of refugees – likely limited to certain status groups – that have been settled by the Office of Refugee Resettlement. Haamid's sense of caution registered that not all Guineans but certainly those Guineans at the embassy-level represented a potential threat. His experience of politcal violence, including his own employment history as a lower-level government authority, made him attuned to such threats, and he was willing to endure a fair amount of hardship, travelling to Chicago where he did not know a soul:

> He knew no one in Chicago....He slept for a time in an abandoned bus...Then he was taken in by a Mauritanian and his family, but since he had no way of working it was hard for him to stay in the Mauritanian's apartment for free forever, so after a while he started spending the night in the Mauritanian's car instead. It was freezing cold.

In addition to the diversity of its populace, the transnational movement of information into and out of NYC can also be problematic. For example, upon his return to NYC, he became very involved in the NYC-based branch of his political party. He never attends local party demonstrations, however, because of an incident where another Guinean expatriate was photographed at a similar demonstration, and his picture was subsequently published in a Guinean newspaper. Once again, what would ordinarily be a beneficial aspect of life in NYC, the interconnectedness of immigrant communities with their native country, is often problematic for individuals with experiences of political persecution, imbuing their lives with a sense of implicit surveillance.

Yet despite their suspicions of co-nationals and, in some cases, active avoidance of them, Elewa and Haamid benefited from the transnational nature of the city and the

large presence of African immigrants. For Elewa, Africans from countries other than Cameroon were a source of comfort and solace. The sizable African diaspora in NYC and in his workplace proved beneficial. Though Haamid was hesitant to appear in public party demonstrations, the city provided a conduit for political activity and expressions of nationhood (i.e., he was able to connect with local Guineans and find a local Guinean party branch in NYC), as well as the danger of political surveillance (i.e., the threat of being reported on in the Guinean media).

As an even more dramatic illustration of how the transnational city affords inadvertent benefits, a chance street encounter with a fellow Guinean in NYC facilitated Haamid's reunification with his wife and children many years after his immigration. For his safety and that of his family, Haamid had to flee his home in the city of Kindia in complete secrecy; he was unable to even tell his wife, Farisa, that he was leaving. As far as they knew he had simply vanished, perhaps the final "disappearance" or culmination of his political persecution. Farisa went to the military settlement in Kindia inquiring about her husband and was herself tortured. Upon release, she took her children and fled to the bush where she remained in hiding for 3 years before returning to Kindia, where she was still unable to find any information about her husband. She assumed he had been killed and performed the appropriate Guinean death and mourning rituals for him.

In the years that he lived in the U.S., Haamid was unable to find or safely contact his family back home. One day, after three years in the U.S., a street vender stopped Haamid on the street. He recognized Haamid from Kindia and told him, "Oh, I was just in Kindia; I saw your wife and children." Farisa had just returned from hiding and was once again living in Kindia. The vender, who frequently traveled between Guinea and

NYC, then served as an information conduit between the couple – on his next trip to Guinea he informed Farisa that her husband was indeed alive and living in the U.S. and arranged for her first telephone contact with him in over three years. Four years later, after Haamid was granted asylum and was able to successfully petition to bring his wife and children from Guinea, the family reunited in NYC.

"They think we sleep in tree-tops, they think we are animals": encountering race and the African archetype

Beyond negotiating between-group distinctions, the survivors of political violence in this research also face discrimination from mainstream society as Africans and as Blacks. As Black immigrants, Africans confront precarious intersections of nationality, race, and ethnicity that are circumscribed by both real and imagined identities. Africa is a complicated figure in Western imagination, at once seen as being close to nature, violent, and pathological (Schraeder and Endless 1998). More often than not, the conceptualization of "African" is simplified by the overlay of Blackness as a blanket racial/ethnic ascription. This can present a problem when racial/ethnic identity is constructed differently in home countries. In addition to navigating the particular race ascribed to them – i.e., Black rather than African, African rather than Kenyan, Kenyan rather than Luo – in the U.S., African immigrants may also face diminished employment and economic opportunities (Roberts 2005).

At the time of our interview, Adanna, the 50 year old Sierra Leonean who docked in Maryland before traveling to NYC almost ten years ago, continued to have a very difficult time securing housing and employment, despite that she was granted asylum and

brought her three (then teenage) children to the U.S. When I spoke with her, she was embroiled in a number of legal disputes. She had worked as a housekeeper in a hotel until she injured her back on the job, and she was in a legal battle over her Workers Compensation payments. Her landlord had let her building fall into such disrepair that she had no working bathroom, yet he was trying to evict her from the apartment she shared with her two (now adult) sons.

Adanna also recently had her 22-year old daughter and two young grandchildren move into a family shelter. They had been living in the apartment, but Adanna was cognizant that the Agency of Child Services could take custody of her grandchildren because of the condition of the apartment ("I watch the TV," she said), She arranged for the three to move into the shelter until the dispute was resolved. In addition, she reported her grandson had recently been denied treatment at a hospital emergency room. She expressed her frustration with all of the institutions causing these hardships.

> They think [that]…new people coming from Africa, they sleep on top of the tree. They [don't] think we have everything in Africa that they have in America….They think we're animals. We don't know nothing, we live like animals in the bush. Most of the people here think this. They think we don't have electricity in Africa…because they don't know.

Adanna's engagement with multiple state and municipal agencies and multiple legal processes was common among the African immigrants in this project. Another example of a racial encounter in an institutional setting was the medical treatment of Binah. Binah is a Cameroonian woman in her mid-50s who, like Elewa, had been a member of the opposition party. She had been arrested and tortured by the Cameroonian government multiple times over the course of 12 years before she fled to the U.S in 2004 where she was granted asylum after a 1 ½ year legal process. When she arrived in the

U.S., Binah was assisted by various Cameroonians in the NYC area and was able to find a lawyer to process her asylum claim but was forced to be somewhat nomadic as no one could afford to take her in permanently.

Binah was quite ill when arrived in the U.S., with many physical and emotional scars from her experiences of political violence: her eyes had sustained damage from the long periods she was held in the dark. She reported loss of hearing in her left ear, chronic headaches, insomnia, rumination, heart palpitations, and frequent nightmares. She also sometimes feared authority figures she encountered in the United States, particularly those in blue uniforms because Cameroonian authorities also wore blue. Her treatment at PSOT was fraught with a "strained therapeutic alliance" between her and her therapist. Her legal proceedings were postponed numerous times because her lawyer felt she was unable to reliably testify in a clear and coherent manner. The lawyer and her therapist conferred about her case which culminated in Binah having a number of additional cognitive and psychiatric evaluations across multiple sessions. The following is from her therapeutic notes:

> A critical point in the testing was when this therapist introduced the dissociation questionnaire towards the end of the second testing session….She…became enraged and tearful about speaking about the past. She expressed anger with this examiner and repeatedly stated that **she didn't understand why "whites" have to ask about the past.** Binah described **her cycle of feeling better and sleeping well until "a white" starts asking her questions about the past that make her have headaches and nightmares**.….She explained that one day she would like to be able to talk about her scars in a joking way, while sitting around and laughing with family members, but that she wasn't yet ready. [Emphasis mine]

The cultural dissonance that Binah's outburst indicated is perhaps a common immigrant predicament in seeking care - a situation of cultural misunderstanding and frustration with racial underpinnings. Yet, the enormity of what she was going through,

the multiple stressors that were acting upon her, made her outburst about "whites" and their insistence on bringing up painful details of the past in non-familial settings (both necessities of her psychiatric treatment and her legal trial) made this particular racial encounter seem like a more profound statement on the post-migration hardships of refugees.

Reflecting on his experiences in Angola, Zareb, a man in his early 40s, emphasized, "You understand, the racism between black is more terrible than the racism between white and the black." In NYC, relations between African immigrants and African Americans can become complicated when the immigrants, who often reside in African-American neighborhoods, operate small businesses, including those serving African American clientele, that are in competition with African-American business owners[28] In a 2001 New York Times entitled, "Bargain Braiders Battle for Heads: Hair Stylists From Africa Arrive, Driving Down Prices," Williams reports that competition from immigrants have caused prices to drop so low that African-American-owned salons have been forced to close. Such encounters also manifest among the African survivors of political violence in this research. Abla, a woman in her mid-thirties from Congo worked as a braider in one such salon. When asked is she ever experienced any racial tension in any area of her life, she reported, "sometimes with the [African American] girls I work with, there are little conflicts…. I think that just some of the girls thought they were so much more superior than anybody else…..Because of their English they could establish a

[28] For more in-depth discussion of African business communities in NYC, including relationships with their African-American clientele, see: Abdullah, Zain. 2005. "Negotiating identities: The incorporation of West African Muslims in New York City." *The Journal of Islamic Law and Culture* 10:1-33 and Stoller, Paul. 2002. *Money Has No Smell: The Africanization of New York City*. Chicago: University of Chicago Press.

better relationship with the client and the clients come in and they'd be the ones to talk to them and they get more clients."

Post-migration poverty

The clinicians and staff at PSOT readily acknowledge that African clients were more likely subject to extended periods of destitution than clients from other regional groups (e.g., Tibetan, East European). For example, for a period of time when he came back to NYC Haamid was homeless and sleeping in the Staten Island Ferry terminal. His therapy notes indicated that he often had problems contacting both his lawyer and his care providers because he would call from payphones and hang up when he got their answering machines in order to get his quarter back. Adanna, who was able to secure occasionally temporary housing through friends she made at the Harlem Market, nevertheless experienced homelessness ("I used to live in the street, I used to sleep in the subway.") Staff sometimes cited this prevalence destitution among African clients as a byproduct of racial discrimination.

Even after being granted asylum status and thus being authorized to work, the majority of the African survivors of political violence in this project exhibited continued material deprivation, including unstable housing and unemployment. For example, Lesedi, a Guinean woman in her early 40s, was granted asylum after fleeing Guinea 1 ½ years before our interview, yet she continued to struggle to support her 4 young children, ages 7 through 12. They stayed in multiple homeless shelters; on one occasion she was thrown out of the shelter system for reasons she still does not know. She described the situation: "One day when we were coming back in they closed the door on me and said

'You can't come back in.'" She also reported that, luckily, there was another African man who was outside and he called the police and said "It's about to start raining there's a woman here with her children who doesn't have a place to stay." In addition, two of Lesedi's children have chronic medical conditions (one has sickle-cell anemia and the other has a heart condition), which require frequent medical attention and consistent monitoring on her part. Though she receives public assistance for the two children with medical needs, it is often not enough to support all four of her children.

> I do get money for the two [ill] children, so that does help me with the health of the two. And actually I don't have any other revenue besides that right now. It's very insufficient….I try to get by with really simple meals and things to eat at home so I try to cook everything at home ….I've been trying to get welfare for the other children but up to this point I [haven't had] any response. Sometimes, when we don't have the Metrocard or something like that, sometimes the bus drivers understand…And so my son will say to me, "Mom, I speak English, just let me talk to the driver and he'll let us take the bus without paying.

"I had to come here" versus "This is our dream": Asserting victimhood as a category of difference

Imena, a woman in her mid-30s, had to leave Togo as inconspicuously as possible. A medical practitioner, Imena had treated political dissidents who came to the emergency room of her hospital after being tortured by government authorities. The Togolese government arrested and tortured her for this and continued to harass her and her two young children for months thereafter. Conscious that she was likely to be recognized on the street, she traveled in full burhka through the city of Lome, seeking an embassy to apply for a visa, and avoiding military personnel and police at all costs. Her legal files states, "The French embassy was near the police station and full of military

personnel around it, so she felt she could not take a chance. The American Embassy is in the midst of the commercial center, full of people moving around, and she went there." A lack of self-selectivity is the signifying characteristic of refugees, forced migrants, etc. Were it not for the physical location of the U.S. embassy, Imena would likely have sought asylum elsewhere.

The African survivors of political violence in this project were well aware that their situation was different from that of other immigrants. They often asserted this divergence, in particular when they felt they were not getting the treatment or respect that they deserved. Shortly after expressing frustration with Americans' images of Africans as animals who "sleep in tree-tops," Adanna added, "You're the one who placed this problem in my head. Bring me…to America. I wasn't planning to come to America. But it's like something forced, I had to come here to save my life." This lack of agency, the fact that she was a product of an acute refugee situation in which she was "pushed" out of Sierra Leone and then "plunged" into life in the U.S., seemed to weigh heavily on her especially in light of how after 8 years in the U.S. and being granted asylum status she was subject to continued constriction and lack of control over her life.

Zareb, the Angolan widower with two infant daughters discussed in the previous chapter, also asserted his experience as extraordinary. Like Binah, Zareb was burdened by many stressors related to resettling in the U.S. Unlike Adanna, who resisted convergence with other immigrants by asserting the involuntary aspects of her journey, Zareb distinguished his experience by pointing to the fact that he *did* choose to come to the U.S.. In fact, he went out of his way to get here:

> It's not easy. Firstly, organized trip to USA, it's not easy…. you have to show you have to have strong reason….explain why you want to go to U.S.A. Yes. I

> did. And materially, practically, how to [take] two babies from Africa to U.S.A., that far, that far? You understand, we pass through whole African continent because Angola is located in central southwest Africa….But I choose to do better for my baby, coming to America, growing them, giving them education….In this way, I abandon my profession. I abandon my life in Angola, plus [the] persecution…. We are in America. We are asylum seeking. This means that we hope to live in America, to be American. This is our dream, but our dream has passed [over] by…immigration decisions.

Further, he mentioned the lack of other Angolans in New York City, again distinguishing himself from other African immigrants and refugees. "The refugees in the USA, we haven't [met any]. No Angolan people here. Mostly from here, Nigeria, Tonga, Togo, Ghana, and South African, Zimbabwe, others part of Africa, but Angola, few, very few…..I never saw someone here in six months…in the United States. I didn't see anyone from Angola. So no relatives, no one who I know."

Discussion

Meeting basic needs

Are the African survivors of political violence in this research disadvantaged because they are Black? When framed within the context of race in the U.S., the nominalist supposition – which argues that the conditions within the host country such as systemic racial discrimination shape the processes of resettlement for all immigrants, regardless of refugee experiences – presents the possibility of downward convergence. The specter of racial discrimination may be so powerful that it works to supersede any meaningful differences between Black refugees and Black immigrants. I felt certain that the experiences of African survivors of political violence would reflect that in the U.S. matrix of oppression there are very few categories of discrimination that trump race, and

very few racial ascriptions as disadvantaging as being Black.

This supposition if only partially borne out by the data. In the client database (N=1,360), clients from Africa do not have a significantly higher or lower income than other groups, nor do they have significantly lower rates of asylum or other legal immigration status. However, Figures 4.1 and 4.2 indicate that African clients live in neighborhoods with fairly high densities of other African immigrants, and that these are some of the poorest neighborhoods in NYC, i.e., Crotona/Tremont and Morrisania, both in the Bronx. PSOT staff report that African clients, including the fifteen in this research, evidence much greater levels of poverty and social service needs than other regional groups. Clients from Tibet or Albania rarely become homeless, yet four of fifteen African respondents here had been homeless and had to either live on the street or in the city shelter system. This heavy utilization of social welfare services, traditionally uncommon among immigrants, is one of the distinguishing features of refugee groups that support a realist perspective (Hein 1993).

Nevertheless, both the qualitative data presented here and the impressions of PSOT researchers and clinicians indicate African clients may experience more post-migration deprivation than clients from other regions. Are these differences due to discriminations? Certainly many of the African respondents expressed frustration with unjust or problematic treatment, at times assessing these situations as prejudice against African immigrants (Adanna), and at other times locating the divide as being between Blacks and Whites (Binah). While these experiences may speak to a nominalist perspective, i.e., the experiences of being Black and an immigrant may trump their experiences of refugee migration, these racial/ethnic encounters almost always place

expressions of disappointment or helplessness within a web of medical, legal, and social service care or administrative bureaucracy that seemed wholly specific to their particular high levels of need.

Migration patterns and contexts of reception

While it is likely that African survivors of political violence may have greater obstacles and fewer opportunities for employment and housing due to their race, other factors – such as the context of exits, the pattern of migration, and the existing immigrant resources in NYC – may also play a large role in why African clients often seem worse off than clients from other regions.

African clients have acute, rather than anticipatory, refugee movements; even journeys that encompass some amount of planning do not necessarily yield better results in terms of a secure resettlement. In certain respects Zareb's migration, as somewhat (though not fully) planned, and his class status as a professional, conforms to the characteristics of an anticipatory refugee. Zareb emphasized that he planned his journey specifically to the United States, and following to a certain degree the kinetic patterns of 'push-permit.' In contrast, Adanna's journey was the epitome of an acute refugee movement; her journey - fleeing Sierra Leone in the midst of violence and chaos to neighboring Guinea and landing in the U.S. largely by chance – followed a 'push-pressure-plunge' pattern of flight. Journeys as diverse as these should yield differential resettlement outcomes. Yet less than a year after arriving, Zareb was homeless, in danger of losing his children to ACS, and facing continued legal challenges. Adanna was similarly situated during her first few months in the U.S., without stable housing and

staying with strangers she befriended at the Harlem Market. Zareb had no social networks to exploit, nor did he have the financial resources or language acumen that Kunz depicts as common conditions of anticipatory migrations.

Related to these acute contexts of exit, African clients may also be disadvantaged in that they often migrated directly from the country of conflict to the U.S. and because there is no strongly rooted African immigrant community to ease resettlement. Fourteen of the fifteen respondents in this project migrated directly from their country to the U.S. In contrast, Tibetan clients (discussed in greater detail in the next chapter), have access to resources in exile communities in India and Nepal and often make multiple migrations. As such, their migration to the U.S. is often secondary; they travel first to India or Nepal, reside there for a number of years (often learning English and earning money) and then to migrate to the U.S. Their migrations are anticipatory in nature, in contrast to the acute migrations of many clients from Africa make.

Once in the U.S., social networks can be as problematic as beneficial. In an ethnography of Salvadorian immigrants in San Francisco, California, Menjivar (2000) argues that co-ethnic support networks, and the social capital presumed to accompany solidarity, can be tenuous when migrants emerge from violent conflicts driven by civilian factions, such as the 12 year long civil war in El Salvador. The findings presented in this chapter, specifically the mistrust or lack of bonding between co-nationals, support Menjivar's observations. Moreover, as discussed earlier, African immigration to the U.S. is a relatively recent phenomenon. Unlike Albanian immigrants who may enter Eastern European or Italian ethnic niches established by previous waves of immigrants, African clients encounter immigrant communities that are "new" and not as deeply entrenched in

the political economy of the city.

"It's not paranoia if it's real"

In considering how individuals viewed co-nationals and how they adjusted their behavior and patterns of social network participation accordingly, the concept of Kunz's vintage groups – a category unique to refugees that may incorporate yet also transcend existing categories of ethnicity, class, and politics – may be helpful. Understanding vintage groups is also helpful in the context of New York City, a transnational urban setting with diverse and emerging African communities and in which multiple vintage groups inevitably interact.

The social networks that these individuals form are influenced by the experience of political persecution and forced migration, even years after migration. When I first began presenting these findings and telling Elewa's and Haamid's stories, I was disheartened when people asked me questions that framed their sense of distrust as paranoia or "baggage" that traumatized immigrants may bring with them to the U.S., where they are presumed to be "safe." I learned to emphasize that vintage distinctions are legitimate, and that perhaps they have cause to be cautious. In describing the "hypervigilance" criterion for PTSD to me, one of the clinicians at PSOT said, "It's not paranoia if it's real." Haamid's colleague in the NYC branch of the Guinean political party had his photo involuntarily published in a Guinean newspaper. During the 2005 African Union summit at the UN, at least two clients received threatening phone calls. Though it was unlikely that the callers got the clients' numbers from the clinic, PSOT staff reviewed their protocol regarding client information. When my colleagues express

disbelief at this risk (with the implicit presumption is that the U.S. is "safe harbor"), I often find myself making an odd "reasonable fear of persecution" argument on their behalf ("Yes, there *are* Guinean officials traveling to NYC who might recognize an opposition member on sight. Yes there *is* a threat.") In a manner reminiscent of clinicians' efforts to assert forensic validity to pre-migration traumas in client affidavits, I assert a legal argument for the anxieties that inhabit their post-migration lives in NYC.

Conclusion

The African survivors of political violence in this work face both personal challenges to their well-being that are both personal (e.g., feelings of mistrust) and structural (e.g., rushed contexts of exit from their home country, immigration insecurity, racism). Menjivar (2000) challenges the "overly romanticized" valuation of immigrant social networks and ethnic solidarity by looking at how ties between Salvadorian co-nationals are impacted, in part, by their pre-migration experiences of civil war. Similarly, this chapter argues that survivors of political violence may also encounter such difficulties in negotiating immigrant communities and resources. Not only may they have a warranted mistrust of co-nationals, but transnational nature of the city and its immigrant communities can present challenges alongside benefits.

Waters (1999:344) argues that the U.S. offers "a universal ideology of inclusion that in reality is based on defining blacks as 'other, the people who can never really be Americans." Does being Black affect the refugee experience, and does it do so in a way that goes beyond the experiences of other African immigrants? Again, the data here are limited in that they do not include a direct comparison of African immigrants who have

not been tortured. Thus comparisons have to be made on existing immigrant literature. Certain aspects of these individuals' lives, such as *some* use of co-ethnic social networks and transnational resources (e.g., Adanna's immediate search for African's and Haamid's eventual if guarded engagement with Guinean exile community) and racial/ethnic frustrations, support a nominalist perspective, in that they resembled those of other immigrants. However, phenomena such as selective association with co-ethnics (including the active avoidance of co-national encounters), racial encounters within a web of heavy social service usage, and the articulation of identity as distinct from other immigrants, supports a realist claim that the refugee experience is unique.

The clients' responses to their hardships often consisted of asserting or "owning" their status in some way – Adanna makes it clear that she was forced to migrate, while Zareb asserts that he was forced to migrate but that he specifically chose to come here despite obstacles because he had such high expectations. Ultimately, they are the authority in articulating their experiences. Their assertions that they are, in fact, different from others, along with the other data presented here (and findings in both Waters' Menjivar's work) indicate a need to, first, look beyond blanket assumptions of functional immigrant social networks and, second, look more widely at structural dysfunctions in the post-migration setting that impinge on these networks and immigrant identity formation.

CHAPTER FIVE: Tibetan Survivors of Political Violence

Introduction

In March 2008, violence erupted during anti-Chinese demonstrations in Lhasa, the capital of Tibet, and spread quickly to adjoining Tibetan regions in Sichuan Province. Protesting nearly a half a century of Chinese rule, these demonstrations were the largest to take place in Tibet in nearly two decades and were, in part, in anticipation of China's hosting of the 2008 summer Olympics. Beijing had hoped that the Olympics would be an opportunity to showcase the country's economic strength and prosperity, but it had also been the source of increased international scrutiny of China's political and economic policies. For example, in the previous month Steven Spielberg had resigned as an artistic co-director of the opening ceremonies in protest over China's continued business relationship with the Sudanese government. China, one of Sudan's major oil clients, had continued to provide the arms, munitions and parts that the government-backed Janjaweed militias used during the four-year genocide in the Darfur region.

Details of the March 2008 events, as well as estimates of causalities, vary widely. Chinese news media are under strict government control, with China taking the additional steps of barring foreign reporters from the sites of protest and blocking the Chinese citizenry from receiving reports from foreign news media and internet sources such as YouTube (Yardley and Sengupta 2008). Tibetan advocates reported, with accompanying photos showing naked and bloodied bodies on the streets of Lhasa, nearly 100 individuals killed by Chinese paramilitary and security forces (Sengupta 2008b). Tibetan protestors were reported to be destroying the property of Chinese residents, defacing businesses and

turning over cars, even "antagonizing" security forces and attacking the Chinese residents themselves. The Dalai Lama, denying claims by Beijing that he orchestrated the protests, said he remained committed to only nonviolent demonstrations. He condemned the violence that had erupted, proclaiming it as "suicidal" for the Tibetan cause, and threatened to resign his political post as leader of Tibet's government-in-exile "if things become out of control" (Sengupta 2008a).

Principle among those following these events were members of the Tibetan exile community, numbering over 140,000, who responded with their own demonstrations in Tibetan communities in India, Nepal, and the U.S. It is because of the presence and activism over the past 50 years of these exiles that the events sparked an international reaction (including Germany threatening to boycott the Olympics and a potential upset for the Chinese-backed presidential candidate in the upcoming Taiwan elections).

Tibetan immigrants in the U.S., especially the contingent brought over by Tibet-specific immigration initiatives in the 1990's, have been referred to as "cultural ambassadors," charged with transmitting Tibetan culture, religion, and forwarding "the Tibetan cause." And it seems that this endeavor has been successful. Tibetan Buddhism has seized the public imagination, openly embraced by celebrities and other New Age enthusiasts who regularly attend Tibetan temple meditations and Tibetan cultural events across the country. Likewise, depending on the region, attendees at advocacy events and rallies organized by such as organizations as *Students for a Free Tibet* may consist largely of non-Tibetans. Even in NYC, home of the largest Tibetan community in the U.S., a "Free Tibet" sticker spotted on the subway is more often than not affixed on the belongings of a young, white student.

What often seems lost in the Western appropriation of the Tibetan cause – in "Exotica Tibet" (Anand 2007) – as demonstrated by the March 2008 violence, are the real life perils and violence associated with oppression and activism in Tibet. The reality for Tibetans living in Tibet is that even minor infractions against government regulations (such as listening to radio broadcasts or media that support the Dalai Lama) can result in detention, torture, and continued blacklisting and persecution that can last multiple generations. Despite the shock of the public at the violence in March 2008, the Tibetan cause has never been bloodless. Those who emerge from this violence and persecution and resettle elsewhere are first and foremost survivors, rather than cultural ambassadors, who must negotiate their own identity and livelihood within the racial and ethnic landscape of their environment.

This chapter looks at the lived experiences of Tibetan immigrants in NYC who have experienced political violence at the hands of the Chinese government. Based on interviews with six Tibetan clients of PSOT, as well as ethnographic work at the clinic, it specifically it looks at their relationship with the Chinese community, as well as the articulations of Tibetan archetypes by non-Tibetan society, and how Tibetan immigrants with long histories of political violence frame and prioritize their diasporic identities. As with my discussion of PSOT clients from Africa in the previous chapter, I will attempt to contextualize these clients in the larger framework of Tibetan immigration to the U.S. In doing so, I am not suggesting that the experiences of Tibetan survivors of political violence in this research are representative of the larger immigrant community. As with the discussion of African immigration, the inclusion this discussion of meant to better situate the experiences of the clients in the overall immigrant discourse.

Theoretical Framework

Exotica Tibet

Tibet was never under direct Western colonial rule (though it was occupied briefly by Britain in 1903-04), however, Dibyesh Anand (2007) asserts that Western images of Tibet, or Exotica Tibet, employ the same essentialist discourse used to articulate the identity of colonial subjects.

> Essentialism is the notion that some core meaning or identity is determinate and not subject to interpretation…. In colonial context, we find essentialism in the reduction of the indigenous people to an "essential" idea of what it means to be "native" – say, Africans as singing-dancing-fighting, Chinese as duplicitous, Arabs as cruel and oppressors of women, Tibetans as religious, and so on. Imperialism drew its strength from representations of natives as quintessentially lazy, ignorant, deceitful, passive, incapable of self-governing, and the native rulers as corrupt and despotic (p25-26).

Among the discursive practices that have informed Exotica Tibet across the 19th and 20th century are processes of racial differentialization/classification, as well as simultaneous infantilization and gerontilization. Racial differentialization/classification of Tibetan identity, which in the early 20th century posited the Tibetan people as "like the Irish," or resembling a "real negro," represented the colonial imperative to identify the characteristics of the Tibetan people and place them along a hierarchical table in which white Europeans were at top and "primitive" Africans and aboriginal populations were at bottom (Anand 2007:32). Tibetans are simultaneously infantilized (especially during British occupation) and, in its modern rendering, gerontified as inherently imbued with pre-ancient wisdom and spirituality.

Anand argues that contemporary Western engagement with Tibet, including "the framing of the Tibet question in terms of Chinese sovereignty and Tibetan autonomy"

serves the political needs of Western states. "Representation of Tibetans as excessively religious has facilitated Western states to call for the protection of 'religious and cultural rights' of the Tibetans while acknowledging Chinese political rule (Anand 2007: 41).

Tibetan diasporic identities

Tibetans, especially in the diaspora, have deployed some of the features of Exotica Tibet as tools for political, cultural and economic survival (Bishop 1993; 2000), thus appropriating an appropriation. This element of collusion, however, exists within a very complex negotiation of collective nationalism and individual identity. Houston and Wright (2003: 217) argue that within a nationalist frame, i.e., the struggle for Tibetan liberation, Tibetan identities can be seem as, "a singular, unified and homogeneous form." Yet, in individual conceptualizations of self, "Tibetan diasporic identities are contested, complex and embedded in not one but multiple narratives of struggle,"

> The political project of freeing Tibet is an unambiguous collective goal….Essentialized categories of language, culture, religious affiliation and even race provide ready building blocks and templates for this objective. Such homogeneous descriptions of culture and identity do not necessarily correlate, however, with the attributes of actual Tibetan refugee life….On the ground, Tibetans put into practice individual performances of identity that may disrupt tidy, stereotyped scripts and remake the collective Tibetan-ness conditioned by forces of nationalism and nation building (Houston and Wright 2003: 223).

Thus Tibetan ethnic identity, as with all identity, is constructed through individuals' lived experiences in which they may, consciously or unconsciously, deploy or contradict ethnic stereotypes. As Min (2002:11) asserts, "members of minority groups do not passively accept an ethnic label driven by members of the dominant group. As

social actors they actively try to negotiate ethnic and racial identities in social interactions."

Tibetans in the U.S. immigration landscape

Portes and Rumbaut's (1996) typology of U.S. immigrant groups specifies four categories of immigrant characteristics, each with a concomitant trajectory of adaptation: voluntary migrants with superior occupational skills, voluntary migrants with lesser skills, involuntary migrants with superior skills, and involuntary migrants with lesser skills. Arriving with minimal education or human capital, Tibetans immigrants fall most readily in the fourth category and thus face the most difficulty in adapting to American culture. It is a similar plight to some Southeast Asian[29] refugees, such as later waves of Vietnamese, Cambodian and Laotian refugees, for whom socioeconomic mobility in the U.S. is limited and who are significantly less successful in employment and education outcomes than non-Southeast Asian immigrant groups (Rumbaut 2005).

In an ethnographic study of Tibetan immigrants in California and Colorado, Yeh and Lama (2006) argue that, while Tibetans indeed occupy the same socioeconomic position of "underclass" Cambodian refugees, the discourse around Tibet (i.e., Exotica Tibet) works to contradict their insertion into American racial bipolarism:

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[29] In this dissertation, I use "Southeast Asia" to refer to Vietnam, Laos, and Cambodia. "Southeast Asian" is sometimes preferred over "Indochinese" to avoid any connection to the usage of the latter term during the period of French colonial rule in Vietnam, Laos, and Cambodia. "Southeast Asian," however, is a broad and imprecise term both geographically and historically, covering as it does a vast region and countries as diverse as Thailand, Burma, Malaysia, Indonesia, Brunei, Papua New Guinea, and the Philippines, none of which share the fateful history of U.S. involvement during the "Indochina" war nor of special U.S. sponsorship of refugees who fled after the collapse in 1975 of U.S.-backed governments in Saigon, Vientiane and Phnom Penh. It should be noted however, that persons from those countries do *not* identify ethnically either as "Indochinese" or "Southeast Asian," nor is there an "Indochinese" or "Southeast Asian" culture as such. Both terms are pan-ethnic constructs imposed from the outside upon extraordinarily diverse populations. (Rumbaut 2005)

> On one hand, Tibetan's racialized class position places them at the lower end of the spectrum of moral deserving and worth. On the other hand, the discursive practices of the transnational Tibet Movement and the traveling of Tibetan Buddhist institutions to the U.S. "whitens" Tibetans by making them seem worthier and deserving of sponsorship (p. 809)

And yet, as will be discussed in the section that follows, Tibetans have historically been anything but "Whitened" by the regard of the U.S. public. If anything, Tibet represents a fascinating contradiction to traditional pressure on immigrants to assimilate; their "value" is in maintaining their cultural "otherness" and proffering the trappings of exoticism that accompany it.

As Asian immigrants, Tibetans are also a party to the "Model Minority" paradigm put forward by the racial discourse of post-1965 immigration policy. The overlaying of the Exotica Tibet stereotype likely exacerbates this expectation. Yet, as involuntary migrants and asylum-seekers (rather than "refugees") they have neither the self-selectivity nor social resources of "traditional" Asian immigrants favored by U.S. immigration policy, nor are they afforded the social welfare that refugee are allocated. They live in poor neighborhoods with minimal resources, and little government assistance. As "societal expectations and structural barriers have a powerful influence on the formation of ethnic and racial identities on the part of minority groups in the United States" (Min 2002: 11), Tibetan immigrants in the U.S. form their diasporic identity while negotiating contradicting expectations and structural opportunities.

Background

The making of a Tibetan diaspora: Modern Sino-Tibetan conflict

The recent protests in Tibet began on March 10, the anniversary of a failed 1959 Tibetan uprising against Chinese rule. Ten years previous, in 1949, the newly founded People's Republic of China launched a military campaign in Tibet, claiming that Tibet had been a territory of China since the 13th century. This military action came after months of repeated requests by China for Tibet to voluntarily "approve," "accept," or "join" the Chinese Republic (UNPO 1997). These requests occurred despite what some argue was Tibet's fulfillment of all current international standards for statehood, namely: a permanent population, a defined territory, a government and the capacity to enter into relations with other States (York 2006, Montevideo Convention on the Rights and Duties of States, Art 1 - see Harris et al. 1991).

Precipitated by rumors of a Chinese plot to kidnap the Dalai Lama, the 1959 uprising resulted in the death of thousands of Tibetans and led to the flight of the then 24-year old Dalai Lama, who established the Tibetan government-in-exile in Dharamsala, India. China instituted a full-scale military occupation, which remains in effect to this day. From that point forward, Tibetan crossed borders in unprecedented numbers, with over 140,000 Tibetans currently living in exile in Bhutan, Nepal, and India, as well as in North America.

Tibetan refugees have fled to escape harsh economic and political conditions imposed by the Chinese, as well as gross human rights violations and continued persecution of their culture and religion. As many as 1.2 million Tibetans – one-fifth of Tibet's original population - have died as a result of Chinese government policies and

actions, including border patrol shootings of Tibetans attempting to leave the country, imprisonment, labor camps, executions, and starvation.

The Chinese government has enacted policies to deplete Tibetan cultural heritage, specifically the adherence to Tibetan Buddhism. In addition to the destruction of 6,000 monasteries and nunneries, and countless Buddhist texts, the Chinese government prohibits the practice of Tibetan Buddhism, including the possession of texts, religious items and images of the Dalai Lama in one's home. These monasteries and nunneries also served as literacy centers and were not replaced by any educational infrastructure; China instead created pathways for select Tibetans students to go to China for education, leaving the majority of the students without schooling. In 1995, six year old Gedhun Choekyi Nyima and his parents were kidnapped by the Chinese government just days after he was recognized by the Dalai Lama as the 11th Panchen Lama, one of Tibet's most important religious figures, making him the world's youngest political prisoner.

In an effort to dilute Tibetan resistance and cultural capital, China has also instituted policies of mass population transfer, building new homes and offering incentives for Chinese citizens, primarily of the majority Han ethnic group, to resettle in Tibet. In the old Tibet area (as distinguished from the Chinese designated "Tibet Autonomous Region" which encompasses less than half the original land area), there are approximately 7.5 million Chinese *in addition* to the 6.1 million Tibetans, for a total population of 13.6 million. This population, in which Tibetans are outnumbered by Chinese, is over double that of the original 1949 population (Canada Tibet Committee 1994).

Economic prosperity in Tibet

Among Tibetan residents, it is primarily the Chinese settlers and not native Tibetans who have benefited from the economic boom in Tibet. The prosperity itself is largely a result of Western-supported Chinese exploitation of Tibet's vast natural resources. As Asia's water tower, the 10 rivers that originate in Tibet sustain 85% of Asia's population, or 47% of the world's population, affecting countries including China, India, Bangladesh, Nepal, Bhutan, Pakistan, Thailand, Myanmar, Laos, Cambodia and Vietnam. With lucrative contracts from companies in Western nations including the U.S., Canada, and Australia for gold and mineral extraction, lumber, and construction, Chinese-governed Tibet has an international economic presence. Yet the same time as profiting from Chinese rule, these same countries have, since 1959, contributed significantly to Tibetan exile communities in South Asia, sponsoring the building of Tibetan settlements and schools (Yeh and Lama 2006).

Most recently, the newly constructed Qingzang Railway ran its first route from Beijing to Lhasa, in the summer of 2006. As the world's highest railway, constructed with sizable contracts with Western companies (e.g., Canada's Bombadier Transportation, which supplied the actual railway cars), the Quigzang has been lauded as a technological miracle and emblematic of China's successes in bringing technology and economic development to Tibet. Traveling 2,525 miles in just under 48 hours, the railway has the capacity of carrying almost one million passengers a year to Tibet, including new Chinese settlers and a burgeoning tourist industry, and the capacity to rapidly transport the minerals and precious metals extracted by the mining industry that is

a part of the China's development strategy, to the environmental detriment of the area (York 2006).

Tibetan-U.S. relations and immigration[30]

Tibetan migration to the West is a recent phenomenon. The majority of the nearly 150,000 Tibetans in exile reside in India, primarily Dharamsala where the seat of the Tibetan government-in-exile is located, as well as Nepal and Bhutan. The vast social and cultural networks and infrastructure of Tibetan communities in these Western-supported locations allows for individuals in exile to maintain proximity to their nation and their relatives who remain behind. Often Tibetan children are furtively sent to school in India, where they are schooled in Tibetan language and culture, as an alternative to the educational system instituted by China primarily to school the Chinese residents of Tibet.

Migrating further West has its attractions for Tibetans. As stated above, while India provides a somewhat stable environment for Tibetans, they are not granted legal status. The Nepalese government further performs regular "crack downs" on Tibetan immigrants in which they are often threatened with repatriation to Tibet. As established targets of the Chinese authorities, this repatriation may lead to their death. These factors, as well as specific immigration policies and human rights documents enacted in the last 50 years, have led many Tibetans to migrate further West, including to the U.S. There are approximately 10,000 Tibetans in North American, the majority of whom (approximately 8,500) reside in the U.S. (CTAC 2002). Due to undercounting of undocumented Tibetans, some estimate the current Tibetan population in the U.S. to number as high as 10,000

[30] For an excellent analysis of the reality versus the romanticization of Tibetan history and culture, including dissenting voices among Tibetan exiles in regard to a "Free Tibet," see Michael Parenti's "Friendly Feudalism: The Tibet Myth" (January 2007).

(Yeh and Lama 2006). The bulk of Tibetans in the U.S. arrived after the 1990's, with the largest contingent of Tibetans in New York City, with the second largest in Minneapolis.

Thus Tibetan migrants have their collective and individual reasons for moving as far West as the U.S. From the perspective of the U.S., Tibetan migration patterns have reflected a complex diplomatic relationship driven largely by either Cold War-era foreign policy objectives or, in the post-Cold War era, the deployment of Exotica Tibet to elicit public sympathy for the Tibetan cause.

In the early 1940's, upon learning that the 8 year-old Dalai Lama enjoyed the study of science and mechanics, President Franklin Roosevelt sent him a gold Patek Philipe watch showing the phases of the moon and the days of the week. Nearly 50 years later, the Dalai Lama continues to evoke the watch as an emblem of the longstanding relationship between Tibet and the U.S. (Sengupta 2008b). The details of this exchange are somewhat more ominous. Roosevelt sent the Dalai Lama this watch, as well as other gifts, in the hands of operatives on a covert mission to Tibet undertaken by the U.S. Army's Office of Strategic Services in 1943. It was the first time the Dalai Lama heard of the U.S.[31] (Laird 2006: 291). Six years later the U.S., concerned by the possibility of Tibet's rich uranium stores being used in Soviet Uranium atomic experiments and alarmed by the spread of communism in general, launched a CIA expedition to Tibet. In this little-documented expedition, the CIA armed the Tibetan resistance, an act that journalist Thomas Laird (2002) argues may have actually precipitated the large-scale Chinese occupation. Soon after the 1959 uprising, Tibetan soldiers were invited to the U.S., specifically Colorado, to be trained by the CIA in guerilla warfare against the

[31] Tibet, however, has historically had political interactions with Western nations, specifically British occupation in 1903-04, and often violent interactions with French, British, and Swiss missionaries in the 20th century.

Chinese. Mediated by Cold War anxiety, this exchange – though –secretive – was one of the first instances of Tibetans on U.S. soil. Laird maintains that the U.S. continued to fund and supply the Tibetan resistance until the 1970s when it established diplomatic relations with China and abandoned the movement.

The Dalai Lama's analysis of U.S.-Tibetan relations over the course of the 20th century, presented in his 2006 biography, authored by Laird, supports the notion that U.S. "interest" in Tibet , be it political military, or humanitarian, could be sorted into two distinct periods: covert Cold War military strategizing and post-Cold War public sympathy for Exotica Tibet:

> The U.S. support for Tibet in the 1950's was not out of moral principle or sympathy but because of the worldwide anti-Communist policies that were there. So because of that, they helped. But once their grand anti-Communist policy toward China changed *(in the 1970's),* then the whole thing changed. But nowadays the kind of support we receive from the outside world is sincere help and support. Because of the public concern and sympathy, now even the administration, in spite of inconvenience, is compelled to show attention (Laird 2006: 300).

When Cold War anxieties ceased to be a motivating force for U.S. support of Tibet, sympathy for Exotica Tibet, what the Dalai Lama refers to as "sincere help and support," became the new rationale for supporting the Tibetan culture while at the same time delicately treading diplomatic waters with China. One of the major avenues through which Exotica Tibet was eventually constructed, fetishized, and ascribed enough cultural value in the U.S. to elicit this support was through immigration.

Until the 1990's it was uncommon for Tibetans come to U.S., far fewer emigrate and resettle as immigrants. Of the handful, however, who *did* take residence in the U.S. (approximately 525 by the mid-1980s), most were clerics and scholars who served as

religious teachers. At this time, the public face of Tibet in the West was exclusively the face of the Tibetan elite, for whom the primacy of Tibetan Buddhism was overwhelmingly salient in their everyday lives and occupations, and who arguably suffered the greatest losses when the Chinese dismantled the religious social order and expropriated land. These Tibetans were crucial in the popularization of Tibetan Buddhism in this country. In this manner, the Western conceptualization of Exotica Tibet, including the New Age appropriation of Tibetan Buddhism, has both influenced and been influenced by the nature of the Tibetan diaspora in the U.S.

Popular support and international attention to Tibet grew after the Dalai Lama received the Nobel Peace Prize in 1989. One year later, the U.S. State Department implemented the Tibetan U.S. Resettlement Project (TUSRP) as part of the wider 1990 Immigration Act. This act allowed for the migration of 1,000 Tibetans currently residing in India and Nepal to the U.S. Selected by lottery, these 1,000 individuals were given permanent-residence status with immigrant visas, rather than given refugee designation. This distinction made them ineligible to receive the federal benefits allotted to refugees, though they were provided with other benefits as TUSRP recipients. As refugee designation often reflects foreign policy priorities (see Chapter 2), the pointed avoidance of calling Tibetans "refugees" was perhaps meant to blunt political reaction from China, with whom the U.S. had established diplomatic relations (and subsequently broken off Tibetan resistance support) a decade earlier.

TUSRP faced certain challenges in settling these 1,000 Tibetans, who were "ordinary" Tibetans, rather than the clerics and scholars of previous decades who had helped in creating a space for the Tibetan cause in U.S. popular culture. Tibetans

themselves were uneasy about the implications that moving so far West and adopting U.S. citizenship might have on the Tibetan national movement. In countries such as India, Tibetans are not permitted to become citizens and remain "stateless," which creates significant practical impediments but also leaves room for a sense of Tibetan nationalism that becoming a citizen of another country would contradict (Hess 2006). Moreover, fifteen years after struggling to unobtrusively insert politically undesirable Southeast Asian refugees into the general population, the government encountered similar resistance despite the presumed desirability of these ambassadors to Exotica Tibet. This was because, in seeking placement sites for Tibetan immigrants, TUSRP coordinators' first approached Chinese communities in Chinatowns across the U.S.; most politely declined.

Tibetans in NYC

NYC has the largest population of Tibetan immigrants in the U.S., as well the most ethnically diverse residents overall and the highest concentrations of both wealth and poverty. This constitutes a unique environment for Tibetans who resettle in the U.S. (irregardless of their experiences of political violence) in terms of racial/ethnic encounters and informal political economies. It is important to note that while Tibetan immigrants are demographically more homogeneous than the African immigrants (i.e., in terms of level of education, occupation, and family structure, etc), there is variability in the population, especially in terms of how they arrived to the U.S. Post-TUSRP, chain migration led to both families of the original 1,000 immigrants to emigrate legally as well as created the social networks and pathways for undocumented immigration.

Among the Tibetan survivors of political violence at PSOT, who represent an unknown proportion of Tibetan immigrants overall, multiple migrations are common. Tibetan clients often only arrive in the U.S. after spending a number of years in Tibetan communities in India or Nepal rather than migrating straight from Tibet to the U.S. A member of the PSOT staff explained to me that these Tibetans often "do better" than those who make the trip directly because they have had the benefit of establishing themselves in India or Nepal, often learning English and accumulating the finances necessary to travel to the U.S. All six of the Tibetans in this study began their life in the U.S. as undocumented immigrants, though they all were eventually able to petition for political asylum. All but one arrived in the U.S. after spending years in Tibetan communities in Nepal or India. As suggested in the previous chapter, these multiple migrations may also be a beneficial factor in their overall better housing outcomes as compared to African clients (see Figure 5.1).

Figure 5.1. PSOT clients from Tibet are not as concentrated in poor neighborhoods as clients from Africa

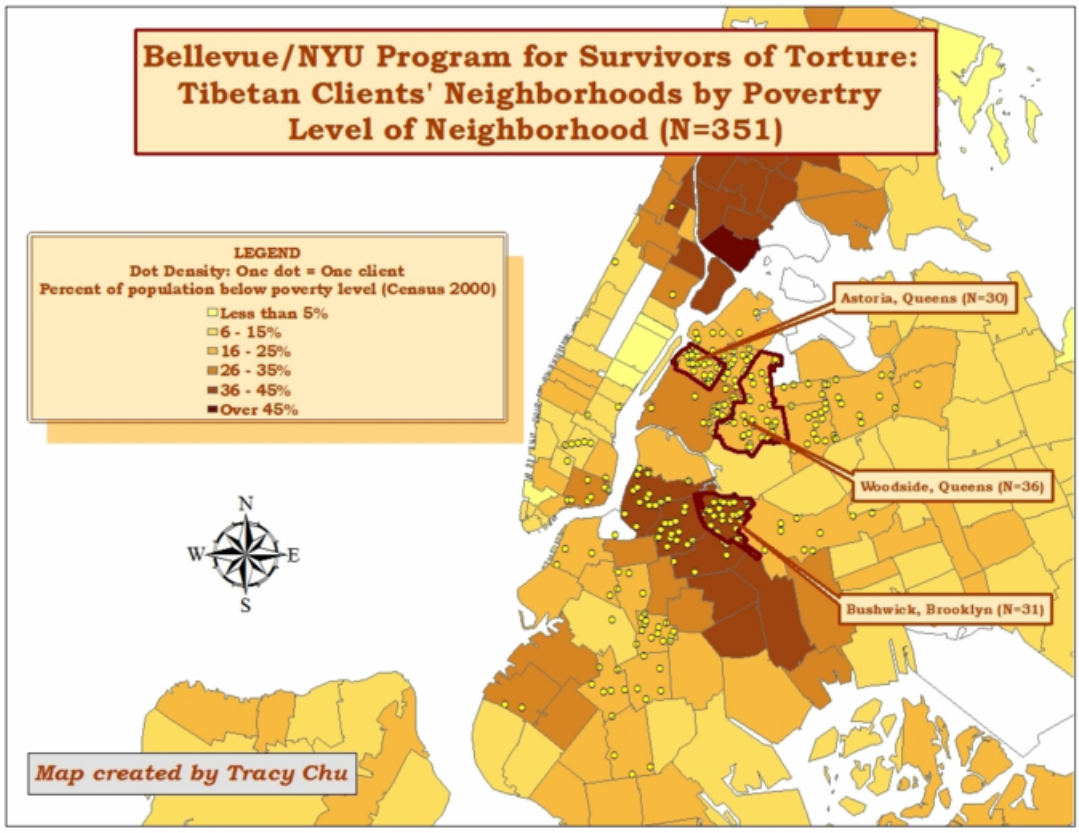
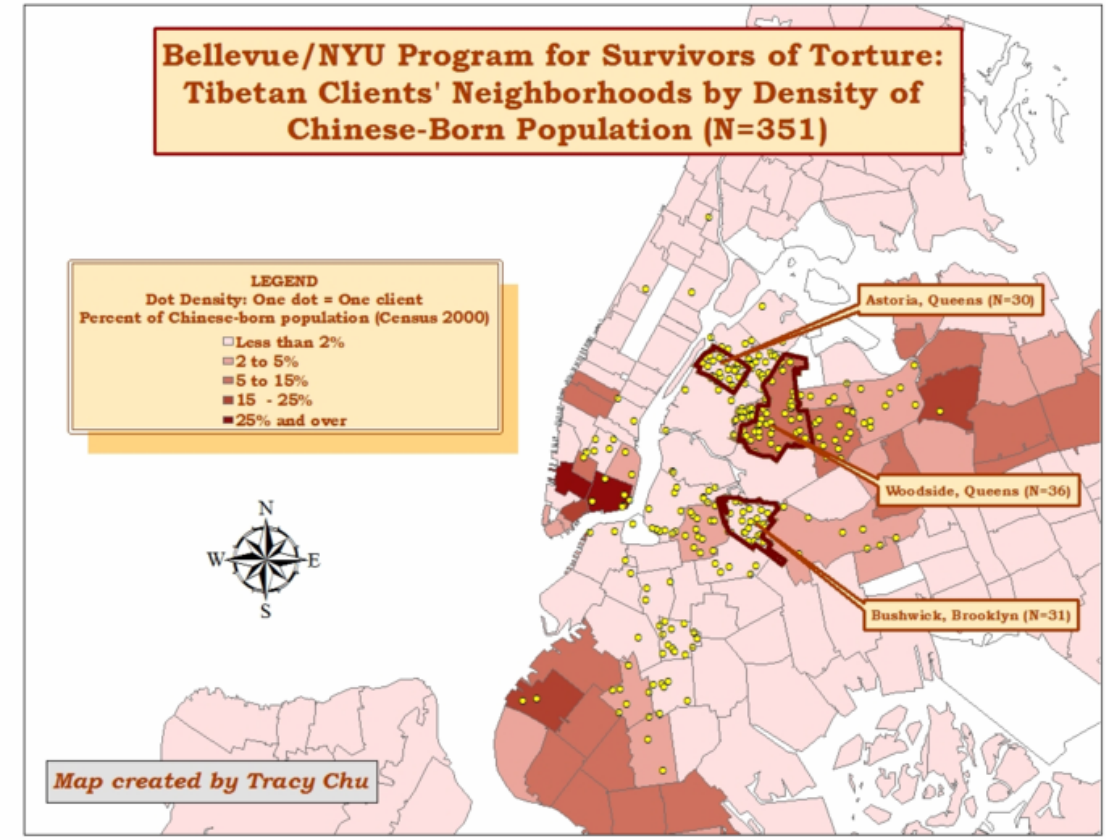


Figure 5.2 shows where Tibetan clients at PSOT live in relation to the Chinese community in NYC. The neighborhoods that Tibetan clients most frequently lived in, Woodside in Queens, Astoria in Queens and Bushwick in Brooklyn, were not necessarily neighborhoods that had heavy concentrations of Chinese. I had originally wanted to design a map similar to the African PSOT client map (Figure 4.1) presented in the previous chapter, in which Tibetan clients' neighborhoods were overlaid with the general Tibetan immigrant population in NYC. Unfortunately, data complied by the U.S. Census lists Tibetan immigrants as Chinese so such a comparison was impossible. However, this current presentation became relevant as will be described below.

Figure 5.2. PSOT clients from Tibet do not live in the neighborhoods with the highest density of Chinese-born residents



Hosting the Chinese sociologist

As a Chinese American researcher, I approached this project with what I thought was a reasonable amount of self-awareness. I'd worked on numerous projects with populations different from myself, e.g., in race, age, disability, sexuality, etc., and thought I was properly attuned to how my presence and actions might be interpreted. And yet I was at least a full year into working at PSOT, though at the beginning of the interviewing stage, before it actually hit me that my ethnicity, that Chinese people in general, might be salient to the lives of the Tibetan immigrants in NYC.

In the late 1980s Dohna, currently in her mid-40's, housed two monks in her home in Tibet during a demonstration against the Chinese. As a result she and her husband were arrested and tortured by the Chinese government and fled to Nepal, where she remained for nearly a decade before coming to the U.S. She was eventually followed by her husband and three children, and the family now lives together in Queens, New York.

I met with Dohna in her home in Queens; she was one of the first people I interviewed for this project. I was considerably nervous beforehand, worrying about things like the tape recorder malfunctioning, whether the interview guide was adequate, and certainly my own effectiveness as an interviewer. I was relieved to find out that Dohna lived a few blocks away from me, I had passed her building many times. I thought to myself, "Well that's one less thing to be worried about – getting lost." When I arrived Dohna ushered me into the small but comfortable and sparsely furnished apartment where she lived with her husband and children. The one area that struck me immediately was the altar set up for prayer with the large photo of the Dalai Lama; it seemed to occupy more of the space than any of the pieces of furniture. As I was setting up the tape recorder and rustling through consent forms we talked about the building and about the neighborhood, how it had changed over the past few years, etc.

During the interview Dohna spoke very passionately about Tibetan politics, becoming especially animated talking about how she explained the Tibetan struggle to her children, who range in age from late teens to early 20's and had grown up primarily outside Tibet (in Nepal). In addition to passing on her personal stories of persecution, just as her parent had to her, she told them about how China committed human rights

atrocities against the Hmong and other minorities. She became especially enthusiastic about watching the popular movie Kundun with them and that they really understood the extent of Chinese oppression after seeing it depicted in that film. When I told her I'd never seen it and expressed interest in doing so, she picked up a DVD from the top of her TV set and offered to lend the movie to me.

After I turned the tape off, I was packing up to leave she paused and looked at me and asked me, somewhat hesitantly, "So, are you…Korean?" I was startled because I had not given any indication that I was Korean, and I don't believe I look Korean. Unsure of the situation, I sputtered a bit about how I was Chinese, how my parents were from Hong Kong (my typical response to questions about my ethnicity). It wasn't until later that I realized that she knew I wasn't Korean, but over the two hours we'd spent together she had made some very strong assertions about how the Chinese (she meant the Chinese government, but she would say "The Chinese"), characterizing them as "awful," "killers," and "bad people." Perhaps in her fervor she didn't take note of my ethnicity, but now that it was over she genuinely seemed concerned that she had offended me.

It was from that point on that I became aware of the possible tension between Tibetan and Chinese immigrants as a sociological entity, and added a specific probe for this in the project's interview guide. I became aware, to the point of anxiety, of the possible tension between me and Tibetan respondents, preparing what I thought would be useful distancing techniques: emphasizing that I was born in the U.S., had never been to China, and that my parents were also fleeing the Communist Revolution when they migrated from China to Hong Kong in the 1950's. In reality, I have yet to encounter a situation that was so awkward that I had to go into such detail about my ethnic identity.

And it remains unclear who I thought I was trying to make more comfortable with this elaborate "distancing" script: the interviewee or myself.

They don't say from it the mouth, but I can see from the face

Tension between Tibetan and Chinese immigrants can be unspoken yet palpable. Pemba is a 32 year old woman who had arrived to NYC about 2 years ago. Like Dohna, her parents were active in the Tibetan resistance movement. In the mid-1990s she participated in a large demonstration against the Chinese government and was detained and torture. Also like Dohna, she migrated to Nepal where she stayed for about 6 years before coming to the U.S. because of threats by the Nepalese government to repatriate Tibetans to China. Her husband, who is chronically ill, and older child (age 2) remain in Nepal. She and her 9 month old child currently live in an apartment with another Tibetan family, where she cooks and cleans in exchange for rent.

When asked about interactions with the Chinese community, she responded:

> I cannot get peace. They don't say from it the mouth, but I can see from the face….When I go to shop in the Chinese shops…. they don't like it. They are just acting polite…But when it comes to their own country, people like Chinese or Philippinos, then they treat them nicely.

What was striking about Pemba's experience was the ever-present and transparent nature of the Chinese-Tibetan tension. The interaction may happen in a public space, without any discernable altercation, or anything that I or another bystander might pick up as a hostile exchange. For Pemba, and perhaps for many Tibetans, no words need to be spoken; their feelings are right there on their faces.

Tibet and China are one: Interactions in the workplace

Kalden, a man in his late 30s, had a history of persecution by the Chinese government throughout his childhood. As a child, his parents owned a small farm and his family was labeled "Ngadak," or upper-class, by the Chinese authorities – a designation which barred them from employment, services and schooling. His father died building roads in a Chinese labor camp. Kalden himself was arrested and tortured throughout his adult life, once because he got caught listening to a broadcast of "Voice of America" that featured the Dalai Lama.

He came directly to U.S. on a tourist visa a few years ago and was able to petition for asylum and bring his 16 year old daughter to join him. She survived what is often referred to as the "Freedom Climb," from Tibet to India through the Himalayas, dangerous both for its physical demands (she suffered frostbite on multiple toes), as well as the risk of being apprehended by border police or attacked by bandits. His 10 year old daughter remains in Tibet, and his wife made it was far as India. In this quote he describes his conflict with his supervisor at one of his first jobs in NYC, as a dishwasher in a Chinese-owned sushi restaurant.

> He was very mean to me…..He told me that Tibet and China are one country, and also I requested a day off on the Dali Lama's birthday, because every Tibetan celebrates the Dali Lama's birthday but he didn't give it to me. [Asked of any other problems with Chinese people] Not all the Chinese are like that, the Taiwanese are nice to us, they talk nice to us Tibetans, and those who are believers of Falun Gong, the Falun Gong from China as well.

Many of the Tibetan clients at the clinic worked within the Chinese informal sector at some point. The men especially often worked in Chinese restaurants or for Chinese construction companies. Kalden's experience indicates the dilemma faced by

many Tibetans, especially those who are undocumented and/or have few marketable skills other than their ability to speak and understand Mandarin. Employment can most readily be found within an informal economy dominated by Chinese immigrants, though it can be problematic, particularly for those who have suffered at the hands of the Chinese government.

What was also interesting about Kalden's quote was the manner in which he differentiated between "the Chinese" (e.g., the sympathetic Taiwanese or similarly-oppressed Falun Gong members), a strategy I immediately recognized from my own efforts to locate my place among "the Chinese." In this respect, Tibetans also navigate the transnational nature of NYC, as indicated by heterogeneity, which does not exist in Tibet, within the Chinese immigrant population .

Exotica Part I: Hiring the "Number One" nanny

Tibetan immigrants, especially men, may encounter Chinese employers and co-workers in the course of seeking readily available employment, often in labor intensive informal sector work. While these interactions are not necessarily acrimonious (Kalden reported that in his current job, "At the workplace I have a couple of Spanish coworkers, and Chinese too, but I have no problem getting along with them,") they may be less than ideal. For Tibetan women, however, a small yet noticeable niche has allowed them to circumvent working in traditionally Chinese-dominated informal labor niches such as factories and restaurants: The Tibetan Nanny craze.

In a 2006 ethnography on child care providers in Brooklyn, Tamara Mose-Brown interviewed a woman, Maria, that she described as a "white upper-class (top 5% income

bracket) woman who organized nannies at one point." During this interview, Maria mentioned a Park Slope parents group on Yahoo Groups. The following is from Brown's fieldnotes (Personal Communication, March 15, 2007):

> Maria asked me if I had heard about this site and I said no, unless it is what I heard from Cissy—a West Indian sitter that I had met in June of 2005 at Carroll Park. Cissy told me about some of the parents on a website having said that the West Indian sitters are taking the "White" children to Jay Street (Fulton Mall, which is mainly a black ethnic enclave and shopping center) and that they disapprove….Maria told me that this may be the same site then where parents were starting a string of emails whereby they were grading "nannies" by race. I asked her what she meant by this and she said that **"West Indian sitters were at the bottom and that Tibetan women were rated #1."** Apparently this "grading system" was based on the fact that a parent was trying to let another parent know that she saw her West Indian sitter use physical means to discipline a child [emphasis mine].

A year after Brown's interview with Maria, the *New York Observer*, a local weekly newspaper, published an article entitled, "Wanted: Tibetan Nannies" about the "Tibetan nanny craze" (Zoepf 2007). In NYC, there was a growing buzz on the parenting websites frequented by well-heeled urban mothers. Rather than comparing them disfavorably to nannies of other ethnicities, these boards were more concerned with delineating the qualities that make Tibetan women ideal child care providers. The following is from the *New York Observer* article:

> One of the site's many enthusiastically pro–Tibetan-nanny subscribers assured fellow mothers that child-care workers from Tibet were **"very balanced and Zen";** yet another explained, "Their personality is such that it makes them amazing nannies. **Very patient, never lazy, soft-spoken and generally very caring."** Several suggested vaguely that the **Tibetan nannies' Buddhist heritage** was the source of their supposed **saintly qualities**, even that a Tibetan nanny could contribute to a child's "spiritual development" [emphasis mine].

In the Tibetan Nanny phenomenon we see a commoditization of Tibetan ethnic identity, essentialized and shaped by Western expectations, as specialized labor. As

representations of Exotica Tibet, Tibetan nannies are subject to a gerontification of their "Buddhist heritage," that services the specific needs of the prospective employer (e.g., soft-spoken, patient, never lazy, etc).

Securing and employing a Tibetan nanny however, presents certain challenges to the parents posting on these internet forums. Some of these challenges are both shocking in their callousness and revealing in their pointed decontextualization of Exotica Tibet from the less tenable political and cultural realities of Tibetan life. Again, the following is an excerpt from the *New York Observer* article:

> Other postings dealt with related topics such as…**whether to hire a Tibetan nanny who was known to be a victim of torture (could she accidentally harm a child while in the throes of a flashback, the subscriber wondered)…**

Ironically, in that parent's valuation of a Tibetan nanny, the possibility of having the nanny impart some of her "Tibetan-ness" to their children, (e.g., facilitating spiritual development in the a child) does not supersede the oppression and torture they suffer for that very Tibetan-ness. The aspect of Tibetan identity that is politicized and victimized is seen as a deficit, a deal breaker.

Beyond blanket avoidance of the politics inherent in the Tibetan Nanny situation, some of the parents reported on in the article actually mimic the actions of the oppressor. One subject of conversation was, "whether Tibetan nannies should be given a day off work in honor of the Dalai Lama's birthday." Here the parents are taking the exact role of the Chinese supervisor in Kalden's story. Though, unlike Kalden's supervisor, denying a Tibetan employee time off is not meant as a point of political contention but because of

the employer's inconvenience. Again, Tibetan-ness is malleable and identity stripped of the inconveniencing factors of political persecution or cultural heritage.

Parents might also have to navigate potential duplicity in the hiring of a Tibetan nanny. Some parents were suspicious that, "some non-Tibetan Asian nannies were pretending to be Tibetan during job interviews in the hopes that it would help their prospects." In 2004, the *New York Times* published a photo essay, "Toiling in the Playground," in which Tibetan nannies gathered in Prospect Park, Brooklyn with their charges and reflected on their life in the U.S. A woman named Lhamo remarked, "In India we're so different from the Indians that you're always an outsider, as if you have "Refugee" written on your face. But here, in the subway, no one knows I'm a refugee looking for asylum" (Gill 2004: 14). This comment on the ability to "blend" more easily into the ethnic landscape of NYC was framed as a positive aspect of living in the city (she felt less like "an outsider") but was problematic for the women posting on the parenting websites who worried about nannies scheming to exploit both this ethnic heterogeneity as well as their own inability to tell Tibetans and non-Tibetans apart.

Exotica Part II: Tibetans! Only they have tattoos and drink a lot

The Tibetan Nanny scene is one instance in which Exotica Tibet is appropriated and deployed, in this case, by seemingly well-to-do NYC parents in a very pointed and focused manner. The goal is to find a good Tibetan nanny. Even in everyday interactions, when I talk about my interest in Tibetan immigrants in NYC, I have found many non-Tibetans have stories to impart about their experiences with Tibetan immigrants. For example, in 2007 I was at a research workshop with other doctoral

students and when I casually mentioned my interest in the Tibetan Nanny scene, one of my colleagues (a Brooklynite, incidentally) immediately said, "Oh hey, my nanny is Tibetan!" As I broached the rest of my research (working at PSOT with torture survivors, etc), he said, slightly taken aback, "Do you think my nanny was tortured?" I told him I didn't know. This was true, of course. I didn't know because I didn't know his nanny, but also because, as with immigrant survivors in general, it is difficult discern how many among the Tibetan community have been exposed to political violence. What I did know, however, was that freedom of movement is severely restricted for all citizens of Tibet (thus many are forced to go on treacherous "Freedom Climbs" across the Himalayas to Nepal) and the fact that she even made it out meant that she endured some type of migration hardship.

The non-Tibetans' anecdotes about Tibetans that I find especially interesting, however, are the ones that are based on situations when Tibetans are contrasted to their inherently peaceful or placid stereotypes. About 2 years ago I was discussing this project with another colleague and he mentioned that his brother, who ran a roofing company in NYC, had recently called him and said he'd just hired a number of Tibetan construction workers. Miming his brother on the phone, he said excitedly, "Yeah, I got Tibetans…only they have tattoos and curse and drink a lot." I knew that Tibetan men often worked in construction in NYC, but I'd certainly never met the kind of people my colleague was describing. But I reacted in the same way as my colleague and his brother, amusement at the thought of tattooed and cursing Tibetan men. In my mind it was a puzzling overlay of a hyper-masculine construction worker "type," on the masculinity

proffered by the Exotica Tibet representation, a masculinity that is perhaps epitomized by the Dalai Lama, the most famous Tibetan man in the world.

I encountered another challenge to Exotica Tibet when I met with Jennifer, a second year doctoral student in clinical psychology, in 2006. Prior to entering graduate school she had held a high-level management position at the clinic and was intimately familiar with the clients and the staff and the mission of the clinic. I had met her towards the end of her tenure at the clinic in 2004. Jennifer's management experience always came through in her interactions; she was straightforward, focused, and to the point. We were meeting about a qualitative research project that she wanted to pursue where she would analyze narratives of Tibetans interviewed in India who had just journeyed over the Tibetan-Indian border. I was there to offer advice about possible qualitative software she could use.

All of Jennifer's previous experience had been with quantitative research (in fact these data were the "remnants" of a quantitative psychological study), and Jennifer was taking her first qualitative research class that semester. She seemed especially focused on a particular lecture on research ethnics. As we discussed the project, Jennifer said, "Ethically, there re some things that we found in the data that I do not want to report or play up… Like violence. Some of these people were telling stories that were really violent...There was just a lot of violence in their lives." I was confused. I assumed she was talking about attacks by the border patrols and the roving gangs of bandits that often prey on groups trying to make it through the mountain pass. These types of traumas endured during these very taxing and dangerous migrations often compounded refugee's

pre-migration experiences of political violence and were an important part of their story. Where was the ethical qualm?

What she meant was street violence in Tibet. It seems that a lot of the Tibetans, particularly young men, had been involved in violent fights and street crimes, sometimes as perpetrators. She repeated, "Ethically, I don't want to talk about that." I know Jennifer, I know she had worked with survivors of political violence for a long time, that this was probably the population she was going to work with for her psychology dissertation, and that she really wanted to advocate for them. I didn't say anything because this was obviously a sincere ethical boundary for her. But I wondered to myself, "Is it a matter of ethics that Tibetans be portrayed as non-violent, that Exotica Tibet be preserved no matter what?"

It is important to note the one-sidedness in all of the exchanges above. In all of the stories, from the Tibetan Nanny Internet boards to the construction workers to the violence-prone Tibetan youth, the expectations and reactions represented are those of non-Tibetan Westerners, moreover non-Tibetan Westerners talking among themselves. Tibetans I have met have always spoken passionately and eloquently about the Tibetan struggle. But there is no indication that Tibetans themselves are actively manipulating the Tibetan archetype, e.g. obscuring their tattooed cursing members from view and putting forward their childcare as mystical in some way.

One day I was casually talking with Deacon, the clinic's Tibetan interpreter, who had been in the U.S. for a number of years. When he suggested that I attend an upcoming *Students for a Free Tibet* rally I sarcastically asked, "Are there going to be Tibetans

there?" Deacon shook his head confusedly and said, "Well…yes, of course." I wasn't sure if my sarcasm was rebuffed because he didn't understand what I was implying (i.e., that these pro-Tibet events were dominated by non-Tibetans) or because that type of cynicism was so far removed from his interpretations of events. Whatever criticism I was bringing to the situation was entirely my own.

Further, there were few, if any, indications of white "patronage" among the Tibetans in this study. In one case, Karma, a woman in her mid-40s, reported that when she first arrived she was aided by a friend of her husband, a Tibetan who was connected to the community in Woodstock, NY (established and financed by white middle-upper class residents), and that she continues to travel to Woodstock from her home in NJ to visit the Tibetan monastery and cultural center there. Yet, neither she nor any of the Tibetan respondents expressed distaste at non-Tibetan interest or appropriation of Tibetan culture; in fact it never came up.

Giving therapy a try

Pemba, the Tibetan woman who reported that she could se derision from Chinese immigrants "in their face," was also the only individual of the interview sample who was who was initially rejected for services at PSOT, though she had indeed been the victim of torture; she had been arrested and beaten by both Chinese and Nepalese authorities for her participation in political protests. Pemba came to PSOT having just given birth to her daughter two months ago and experiencing seizures. She was undocumented and the Medicaid she was afforded because of her child was about to run out. However, it seemed that Pemba made the mistake of openly stating that her reason for pursuing

services at the program was for help with asylum procedures and medical care. The following is from her initial intake documentation:

> This patient was initially denied acceptance into the program for the following reasons: a} The patient was eligible to receive Medicaid given her status and it was thought appropriate not to interrupt ongoing services at Elmhurst, b} **The patient expressed interest in only medical and legal services stating that she did not want to receive psychological services from PSOT**. Accepting the patient **would** have precluded the position for another patient.[32]

Though PSOT offers an array of non-psychological services, Pemba's rejection indicates that they are meant to complement their primary service, psychological care. Though she ultimately was admitted to the clinic, she had to make both a compelling case for her needs and to, essentially, give therapy a try. Again, the following is from her intake documentation.

> Upon receiving the news of the rejection the patient pleaded with the social worker and the interviewer to reconsider. After several ensuing conversations, the patient revealed that services were more difficult to receive at Elmhurst due to the scarcity of Tibetan translators. **She also said that she would explore psychotherapy given the availability of child care.**

Just as with Besa, who had the "strained therapeutic alliance" due, in part, to her dismay at "White people and their questions," there was a disconnect between what Pemba identified as her needs and the needs that the clinic prioritized. She had indeed

[32] Different clinicians have different philosophies about criteria for accepting new clients. One clinician, Jong, adheres very firmly to the need for potential clients to express need for psychological care in addition to having been tortured, because, as Pemba's file implies, otherwise they would occupy a spot that a more "needy" client could have. Another clinician, Herman, believes that if a potential client meets the definition of torture they should be admitted. As senior clinicians, both Jong and Herman supervise at least two or three psychology interns who conduct the actual interviews and then review the cases with their supervisor. I can tell from the language in Pemba's case file that the supervising clinician was likely to have been Jong. Just as the "asylum roulette" described in Chapter 2 is predicated on which immigration judge happens to be assigned to your case, in some instances being admitted to PSOT can also be a matter of which intern happens to conduct your interview.

survived torture, on those grounds she was an eligible client (she later applied for and received asylum with assistance from PSOT). But in order to receive care, Pemba had to more fully occupy the specific "sick role" that the institution demanded and concede to a psychopathology model of trauma.

The one very important thing

Pasang is Kalden's cousin. He is in his late 30s and lives with his wife and 8 year old daughter, as well as Kalden and his 16 year old daughter. Like Kalden, Pasang's parents were targeted for persecution by Chinese authorities because of their role in the Tibetan resistance movement. His father was forced to work at a Chinese labor camp in a different town and was only allowed home every few months. His mother died while his father was away, and 10 year-old Pasang and his 5 year-old sister were too afraid to summon the Chinese authorities. It was 3 days before they called the Chinese officials, who threw her body in the river. This story, living with his mother's body for 3 days and then watching her disposed of without a proper Tibetan funeral, seemed to still haunt Pasang; it was something that he would talk about in his therapy sessions.

At the end of his interview, when he was asked if there was anything else he wanted to share, Pasang said, "Yes, there is one very important thing…our religion, my daughter will be continue our religion, our tradition…She will know our country. It's a very important thing, our religion, our country. So I want her, my daughter, to continue." I highlight Pasang's story, but every one of the Tibetans in this study talked about this "one very important thing." Every one was passionate about passing the Tibetan stories and the culture down to their children.

At first it seemed rote to me, immigrant parents wanting their children to understand their culture. But as stories like Pasang's mother's death came out, I realized that there was an imperative about this intergenerational transmission of culture that was astoundingly poignant and urgent. Pasang, Kalden, Dohna, and Pemba all watched as their parents were persecuted, tortured, and in some cases, killed at the hands of the Chinese authorities. Dohna, whose parents were a part of the original uprisings in 1959, was the most animated when talking about wanting to pass on her stories the way her parents passed on theirs. "[My parents] told me their story and then I knew the Chinese not good. After then I knew how the Chinese people [are], what they do." Like many of the others she inherited the mantle of struggle, just as she inherited the oppression that her family faced as a consequence of being "marked" by the Chinese.

It may be easier to instill "Tibetan-ness" (the religion, the language, the culture, etc) outside Tibet, raising the possibility of an entire generation of Tibetans who have never been to Tibet. For example, Lhadon Tethong, the president of *Students for a Free Tibet*, was born and raised in Canada. Kalden and many other parents risk sending their children over the border to attend Tibetan school in India (in his asylum affidavit he reports having the Chinese authorities who would come to his house and ask where his daughter was and being ordered to "produce her"). Aside from barring their religion, and exorcising Tibetan language and history from official school curricula, the Chinese dominance in Tibet is also reflected in the changing culture. Shortly after he arrived in the U.S., Pasang participated in a therapy group discussion about recent changes in the social behavior and values of youth in Tibet, especially regarding sexual activity and alcohol use. His group leader noted, "[Pasang] believes this is related to establishment of

"dance clubs" sponsored by the Chinese government for the purpose of corrupting Tibetan society."

Discussion

Acting within and against archetype

The themes that have emerged in this research indicate that the archetype of Exotica Tibet is deployed in multiple spaces by non-Tibetans in NYC. Anand argues that elements of differentiation have historically operated in the Western colonial representation of Tibetans as a "race," whether representing them as "absurdly like the Irish" in their ways or resembling a "real negro" in their appearance (Anand 2007: 32). In juxtaposing Tibetan nannies as "Number One" and West Indian nannies at the lowest rank, these parents participate in a process of differentiation that implies the idealization of some non-Western natives and the disfavoring of others.

Acting against archetype can also be problematic, at least for non-Tibetans who find Tibetan construction workers a curiosity and Tibetan criminals as an impending ethical crisis. As Houston and Wright argue, "On the ground, Tibetans put into practice individual performances of identity that may disrupt tidy, stereotyped scripts (Houston and Wright 2003: 223). Violence can disrupt representations of Tibetan-ness. As an advocate, Jennifer was hesitant to contradict an essentialism of Tibetans as docile and non-aggressive which has served the Tibetan movement well.

In this study I found no instances in which Tibetan immigrant themselves perpetuated the esssentialized rendering of Tibet (e.g., as peaceful, Zen, spiritually enlightened); I never felt that anyone was trying to "sell" Exotica Tibet. In their

ethnography of low-income Tibetan youth culture in the U.S., however, Yeh and Lama (2006) pointed to the negative effect these archetypes have on Tibetans themselves, including instances when they guide or hinder their own actions. They point to deleterious consequences such as internalized racism, problematic representations of mental illness, and community reactions to violence. They relate a case in the U.S. Tibetan community in which a Tibetan man is alleged to have raped a Tibetan girl. Both the girl and her mother were pressured by the community members and organizations not to report the case to the police "explicitly because of intense fear that this would reflect negatively upon the entire Tibetan community" (827). Reminiscent of Jennifer's dilemma over the young Tibetan men, this story points to the need for Tibetans to represent an uncomplicated victimhood.

Similarly, when the Dalai Lama cited the March violence as "suicidal to the Tibetan cause," he was speaking not only of the continued maiming and death of protestors by Chinese security forces but also of the consequence of overturning the archetype of Tibetans as peaceful. The disbelief evoked by reports of Tibetan protesters turning over cars and attacking police and Chinese residents is similar to the disbelief evoked when Westerners are confronted with the image of rough and tumble Tibetan construction workers in NYC or Tibetan street thugs in Lhasa. Ultimately these entities cast doubt on the veracity of the "script," on the archetype of Exotica Tibet, as well as calling into question who the audience for this script is.

Negotiating ethnicity in a transnational city

Western projections of Exotica Tibet may materialize and impinge on Tibetan immigrants' everyday lives in various ways; however, Tibetan survivors of political violence must negotiate their own diasporic identities within a larger frame of ethnicity, nationalism, and interaction that goes well beyond the scope of Western fetish. Moreover, the Tibetan immigrants in this study negotiate their day-to-day lives with minimal resources and within the existing political economy of NYC. The realities of the large Chinese immigrant community in NYC, and the need for Tibetans to perform their ethnic identity within it, can lead to Tibetan encounters with Chinese immigrants that can range from awkward (as with Dohna and myself) to openly antagonistic (as with Kalden and his supervisor). For Tibetans who have suffered torture, the presence of the Chinese community can create tensions that can be read, as Pemba reported, "from the face."

The workplace can constitute both sites of conflict with and respite from encounters with Chinese immigrants. For men especially, Chinese immigrant economic enclaves may serve as ready sources of employment. The irony for survivors of political violence is that their most beneficial form of cultural capital on the job market, Mandarin language ability, is a byproduct of Chinese government oppression. Tibetan women, for their part, are more likely to be employed as domestics, often as nannies. The Western fetishization of Tibetans has carved a niche for these women in the upper class sensibilities of NYC's wealthiest populations.

It is unclear to me how much Tibetan nannies, or Tibetans in this project in general, have "benefited" from this patronage. It is apparent from the Tibetan Nanny discourse that certain parents are eager to have a Tibetan nanny as a status symbol, but

are they trying to do so "on the cheap"? They never explicitly state a willingness to pay the nannies more. As mentioned in the previous chapter, the Tibetan clients at PSOT do not earn any more income than their counterparts from other regions (again, the only statistically significant difference between groups was when comparing African versus non-African clients). As with the low-income Tibetan youth in Yeh and Lama's 2006 ethnography, the Tibetans I spoke with occupy an immigrant underclass, struggling to secure legal status and, even after being granted asylum, continuing to work in low-income labor intensive jobs. Though overall the post-Cold War Western patronage of Tibet as a "cause" (rather than as a strategic military site) has been crucial to the success of the Tibetan diaspora, this relationship does not necessarily materialize as tangible resources or benefits in the everyday lives of these individuals. In fact, Tibetan clients at the clinic are not any more likely statistically to have legal representation or be granted asylum status than any other national group, nor do they have a higher rate of employment or weekly income. Despite the cultural "cachet" that Tibetans are afforded by the fetishizing Western gaze, as involuntary and unskilled migrants, they still occupy the bottom rung of Portes and Rumbaut's immigrant typology (1996).

As a matter of politics, some Tibetan respondents may find it more meaningful to build alliances with the Chinese, as Kalden asserts, "Not all Chinese are like [his supervisor]." Kalden differentiated between the Falun Gong followers and Taiwanese as the more sympathetic among Chinese immigrants, just as Dohna singled out the Hmong as fellow victims of Chinese oppressors, as a selective rendering of pan-ethnic identity. Beyond the social interactions among the Tibetan immigrants, these alliances are significant on an international level; During the March 31, 2008 Olympic Ceremony in

Greece in which the "Olympic Torch" was handed over to China, Falun Gong members protesting China's internal policies were arrested alongside Tibetan protesters. For Tibetan immigrants in this study, sorting through the "good" versus "bad" Chinese represents acts of differentiation that parallel the parents' delineation between Tibetan nannies (good) and West Indian nannies (bad). In the case of the Tibetans, they are deployed to better negotiate diasporic identity in their everyday lives, just as the parents' differentiation represents efforts to negotiate the child care options available to them in the specialized "ethnic" labor market.

Intergenerational transmission of identity

It is ironic that while upper-class parents hope that their romanticized image of a Tibetan nanny's "Buddhist heritage" would transmit "spiritual development" to their children, the priority among Tibetans themselves is to pass their own "Tibetan-ness" – as culture, politics, and personal stories – down to their own children. For the Tibetan survivors of political violence in this study, these stories encompass torture and dead bodies and abject fear that would overpower any "Zen-like" reserve. The parent who seeks a Tibetan nanny for her innate serenity, yet at the same time is frightened that a traumatized Tibetan might hurt her charge during a flashback, is selectively engaging in this identity discourse, fetishizing the supposed virtues of Tibetan Buddhism while denying the victimhood and injustice of their plight. It is this selective rendering of Tibet, as something amorphous and vague which the realities of a flashback would disrupt, that they hope a Tibetan nanny would transmit to their children.

Tibetans are interested in transmitting culture and politics; furthering the Tibetan cause seems to serve as a collective goal. Nearly every Tibetan immigrant I have spoken with evidenced a strong sense of transnational activism, speaking passionately about the Tibetan cause and, like Dohna offering me her copy of *Kundun*, very passionate about educating and informing others. There was also, however, an element of deep personal history that was unique among the Tibetan survivors of political violence who participated in this study. For almost all of the Tibetan immigrants in this study, their history of persecution by the Chinese government began with their parents, many of whom were in the first generation of Tibetan resistance. The Tibetans in this study inherited their parents' activism as a result both of the transmission of their stories, as well as the continued targeted harassment and persecution that the family suffered. For many, such as Pasang who watched his parents disintegrate and die, the Chinese were childhood monsters from whom his children had to be spared.

The "one important thing," then, is to bring to a close the vertical transmission of oppression but to continue the transmission of Tibetan identity, both cultural and political. The threat to this transmission was not the proximal troubles of "Americanization" (as might typically be the case among immigrant parents in the U.S.), but rather the Chinese decimation of Tibetan culture thousands of miles away. Tibet faced the physical destruction of religious artifacts, the exclusion of its culture in the schools, and as Pasang worried, the deliberate introduction by the Chinese of cultural ills such as drinking and partying into Tibetan youth culture. To Tibetan immigrants the priority is to pass the totality of Tibetan identity – both politics and practice – to their

children rather than perpetuating neutered expressions of Exotica Tibet as delicately transformative bedtime stories for other peoples' children.

Conclusion

My parents were children in China during WWII. They have now lived in the U.S. for at least 40 years but, up until recently, they would never eat in a Japanese restaurant. I suspect this only changed a few years back when they realized that, just like the sushi restaurant that Kalden worked in, a great many of the Japanese restaurants in their neighborhood in Queens were actually owned and run by other Chinese immigrants. I realize now that my parent's predilections may in fact constitute a form of internal ethnicity (if one would consider "East Asian" an umbrella ethnicity), but it never occurred to me that it was anything noteworthy sociologically. It seems like a reasonable reaction; my parents are sometimes leery of Japanese people because of a fairly recent history of Sino-Nippon conflict. Ironically, it didn't occur to me that, given their *very* recent history of oppression and violence, the Tibetan survivors of political violence described in this chapter might naturally have a similar, though obviously much stronger, aversion to Chinese people in the U.S.

As a part of the Tibetan community overall, Tibetan immigrants who have survived political violence negotiate their ethnic identity in an environment that includes those who are antagonistic of it (e.g., Kalden's Chinese supervisor) as well as those who commodify it (e.g., wealthy parents seeking child care). Reactions to the Tibetan community in general seem to present situations in which archetypes of Exotica Tibet are both deployed and challenged.

In her analysis of the commercial consumption of Native American spirituality. Aldred (2000) argues that the New Age movement in the U.S. is primarily a consumerist movement in which attaining the highest levels of human potential "will not take place through concerted political change. Rather it will be achieved through individual personal transformation." The parallels with Tibet are striking. In the U.S., conceptualizations of Tibet encompass over half a century of political, diplomatic and military machinations and alternately render Tibetans as strategic Cold War military allies and, after the Cold War, as apolitical "cultural ambassadors." This second phase of U.S. interest in Tibet that the Dalai Lama alluded to was driven by New Age priority to purchase spiritual awakening, to consume Exotica Tibet. Not only could individuals could selectively purchase objects of import to Tibetan Buddhism (as with Native American paraphernalia), but in NYC the political economy of immigrant labor happened to evolve in a way that they were now able to go one step further and buy Tibetan nannies.

As fascinating as this exploration of the fetishization of Tibet is, the Tibetan survivors of political violence in this research had more significant concerns. Individuals like Pemba must appropriately present their experiences, not to potential wealthy employers who did not want to know about tortured Tibetans with potential flashbacks, but to institutions like PSOT that might acknowledge her trauma by require that she be traumatized in a certain way, i.e., in a manner that psychotherapy could cure. Moreover, NYC is a transnational city where Chinese immigrants are a prominent figure of the immigrant landscape and informal political economy. For the survivors of political violence in this research (who are not necessarily representative of Tibetan immigrants overall), structural factors, such as having Mandarin language ability in lieu formal

education or training, as well as the dominance of Chinese businesses throughout the informal sector (e.g., including in all the Japanese restaurants in my parents' neighborhood) often create antagonistic situations.

The contrasts in representations of Exotica Tibet and the very concrete struggle against Chinese oppression in particular came to a head during the March 2008 riots. Aldred (2000: 330) argues that New Age consumption of largely imagined culture and "their fetishization of Native American spirituality not only masks the social oppression of real Indian peoples but also perpetuates it." This is very likely the case for Tibet, where violence disrupts the representations of an apolitical Tibetan identity. Under the auspices of Exotica Tibet, Tibetans are denied any multi-faceted identity that would allow for a matrix of domination (Collins 1990) in which the Dalai Lama and Tibetan Buddhism can co-exist with Tibetan rioters, street gangs, criminals, or just the specter of tattooed and cursing construction workers.

In order to preserve the archetype (for whatever purpose), Tibetans can never be perpetrators. However, the dictates of diplomatic relations with China, as well as the visceral abhorrence of juxtaposing human suffering with "Zen-like" calm, require that Tibetans can also not be victims. The 1,000 TURSP settles were not designated refugees (i.e., fleeing persecution). After the Cold War tensions with China eased, Western money went from arming the Tibetan resistance against a common opponent to supporting Tibetan settlements that could perhaps maintain a non-confrontational Tibetan culture outside Tibet in perpetuity. Politically, non-Tibetan powers must represent the Tibetan cause in a way that somehow sidesteps victimhood. Culturally, the gerontified archetype of a Tibetan requires that a torture victim be able to rise above "flashbacks" in order to be

a spiritually sound and adequate Tibetan Nanny, in contrast to the disciplinarian West Indian Nanny.

When discussing their plight, Tibetan clients will emphasize the half century wrongdoing by the Chinese government, rather than depicting themselves as somehow inherently virtuous, wise, or "saint-like." Confronting the full complexity of Tibetan identity, particularly among survivors of political violence, is incriminating to the political powers that have relegated Tibet as a "boutique" social cause in order to maintain a profitable alliance with China, and to the sympathizers and consumers of Exotica Tibet who are subject to both manipulation and selective interpretation of Tibetan-ness. To this end, perhaps China's tight control over images and news coming out of Tibet, its efforts to hide the bodies, works equally well with both antagonistic supporters of China and adherents of an apolitical idealization of Exotica Tibet, both of whom would prefer not see them.

CHAPTER SIX: Conclusion: The Pathology of Victimhood

On methodology

"In the end, our survival depends on how well our stories are told," a community health activist once said to me. This has been a guiding principle when I consider the responsibility of telling the stories of people who don't necessarily have the luxury of telling it themselves, but especially in how I regard research methodology. This dissertation represents the multitude of ways that stories can be told – with numbers and statistics, with maps, with legal and medical documents, and with spoken narrative. There is no single underlying story or truth that the unification of these different research techniques will uncover. Rather, the goal here is to create as many avenues of inquiry into a lived experience as possible, and present as many of the co-existing and often contradictory truths (that numbers tell, that documents tell, that people tell) as possible, in order to best capture and interpret the complexities of the lived experience.

Trauma as social control

The convergence of medical and legal/political status

For the PSOT clients in this research, there is a powerful convergence of medical and legal jurisdiction, such that their medical treatment (for PTSD or any torture-related pathology) is intrinsically linked to the legal substantiation of their victimhood. The potential of getting political asylum and obtaining the state benefits conferred there within depends on this substantiation. For the individuals in this research it seems exceedingly beneficial from a legal perspective to occupy the sick role, to be as

traumatized as possible by conforming to whatever normative demands are made of a "traumatized refugee."

But where do these normative standards come from? As described in Chapter 2, the social history of PTSD indicates that knowledge production about trauma as a medical pathology has largely arisen after military events – WWI, WWII, Vietnam War, etc. Contemporary conflicts, such as those the individuals in this research are victims of, are more ambiguous in their political nature. Is the political conflict in Angola, which has on paper been resolved, really still so prevalent that Zareb has credible fear of returning? Is Tibet, as supporters claim, the world's largest remaining colony? Without reliable or consistent proof of country conditions, legal decision-making can be swayed by medical "facts" that are honed from a science that is biased towards the most research-worthy populations. With Eastern Europeans as the normative "traumatized refugee," who is most credible in their reports of victimhood and anguish, the over-endorsing African or the under-endorsing Tibetan?

No matter how the power-knowledge of trauma is produced, it must be appropriately employed as much by the patient as the doctor. Social control rests on the insertion of medical language into the field of what are, in fact, social problems (Conrad 1992). For example, PSOT clients need the clinic for more than its mental health care. Pemba, the Tibetan woman who had to promise to give therapy a try, discovered the consequences of admitting this. The assertion of trauma as psychopathology represents the deployment of biopower, in that it works to internalize the state-identified threats to the health and productivity of its population – in this instance, mental distress. Patients go to doctors because they believe they are sick, in seeking care they must recognize some

aspect of their state of being as deviant and pathological. Though she had been tortured and evidenced great material need (she had a two month old child and was suffering from seizures and had dwindling health care), Pemba failed to adequately recapitulate her trauma in the language of medicine, thus was nearly denied needed benefits as a result.

Moreover, seeking psychological assistance, the cornerstone of the PSOT's services, is perceived as an individual voluntary act (i.e., as opposed to being committed to a psychiatric institution). Just as governmentality represents a strategy of power in which states work to ''affect the actions of individuals by working on their conduct – that is, on the ways in which they regulate their own behavior'' (Hindess 1996: 106), the seemingly voluntary seeking and accepting of patient status among survivors of political violence belies the fact that, if they are not accepted into the program, they may not have any other opportunity to obtain basic health care, or any type of legal assistance. Thus even if immigrants do not feel they have a mental health problem, they are still coerced into patienthood by the vital material gains proffered by such status.

Levels of medicalization

The reassignment of lived experiences as medical pathology occurs at multiple levels – conceptual, institutional, and doctor-patient. Figure 6.1 shows how, as this dissertation has described, the medicalization of trauma as psychopathology has occupied all levels of medicalization.

Figure 6.1. Levels of medicalization in the social construction of PTSD (adapted from Conrad and Schneider 1980)

CONCEPTUAL	A specialized segment of the medical profession introduces medical vocabulary (or models) to "order" or define the problem at hand. Medical definitions are often presented in the form of scientific discoveries and subsequently disseminated in medical and academic journals.	Inclusion of PTSD in 1980 DSM-III; Growth of trauma research, especially among refugee samples.
INSTITUTIONAL	Medical professionals serve to legitimate the medicalization of whatever issues their organizations specialize in. They function as gatekeepers of state benefits which are now legitimated by medical diagnoses.	Medical testimony by clinicians to proffer state benefits (i.e., political asylum)
DOCTOR-PATIENT	Physician diagnoses a phenomenon as medical, and the patient assumes or resists the sick role.	Examples include Besa's rejection of the sick role (i.e., "White people and their questions") and Pemba's eventual acceptance of psychotherapy

Immigration as trauma

Contexts of exit

In support of a realist perspective on refugee migration this research indicates that, on the level of lived experience, immigrants who have been forced to flee their country are fundamentally unlike voluntary migrants. This dissertation has told the story of Adanna fleeing Sierra Leone with literally what she could carry in her hands; Kalden's 16 year old daughter suffering severe frostbite in the perilous "Freedom Climb" from Tibet to India through the Himalayas; Haamid leaving Guinea in secret such that his family thought he was dead; and Zareb taking his two infant children from Angola to the

U.S. where he has no family, friends or place to go. These are extraordinary contexts of exit, evidenced especially in the migration stories of the African clients in this sample. Exit stories, like all migration stories, often reflect larger international immigrant settings. Many of the Tibetan clients at PSOT leave Tibet and live in established exile communities in India or Nepal before proceeding to the U.S.; this is most often beneficial to their immigration trajectory here. However, African clients' often experience more acute migrations which have ramifications for how their lives play out in the U.S., notably in terms of economic and occupational preparedness.

However traumatic these contexts of exits may be, contexts of reception also fundamentally shape the experiences of the survivors of political violence in this research. This dissertation has focused on two overlapping categories of post-migration concerns: Structural factors, such as immigration status and employment opportunities, and the negotiation of ethnic identity in the context of existing immigrant communities.

Structural challenges in the post-migration environment

Structural factors of the post-migration environment, specifically tenuous legal status, the threat of repatriation, and the lack of basic health and social services from the state are traumatizing. As articulated with statistics in Chapter 3, as well as stories such as Haamid's suicidal encounters with his asylum case, mental health (using any possible definition) is damaged by stringent immigration policies in the U.S. Far beyond the psychological measures presented in Chapter 3, post-migration structural deficits compromise fundamental physical health and well-being: Zareb was unable to care for his infant daughters to the point that the Administration for Child Services (ACS) might

have removed them; Lesedi struggled with four young children in the city shelter system, despite having asylum; Haamid was suicidal in part because he was also persistently homeless during the three years that his asylum case was being decided.

Negotiating ethnic networks and identity

According to Menjivar (2000), structural forces such as policies of reception and the dynamics of the local economy, together with the organization of the receiving community, shape the structure of opportunities that immigrants encounter and the ways in which they form or react to social networks. As there is no "survivor community," these survivors of political violence interact with the existing immigrant communities in NYC. This dissertation asserts that those encounters can also be embedded with trauma.

For some of the African clients in this research for whom material hardships were prevalent, co-national social networks presented a problem rather than an asset. This was certainly the case for Haamid, who immediately left for "the middle of nowhere" upon finding the sizable Guinean community here. For the clients from Tibet, though they seem to have no qualms about associating with other Tibetans, the dynamics of the local economy often created difficult racial encounters with Chinese immigrants.

Policy implications and recommendations

There are many urgent policy changes that would benefit survivors of political violence in multiple facets of their lives overall, and that would require systematic reforms in immigration, health care, and social service provision. The recommendations

below address only those policy remedies that are implicated by the narratives presented in this dissertation.

In many instances, these policy changes would positively impact the lives of all immigrants, rather than solely these individuals who, again, represent a narrow subsection of the larger U.S. immigrant population. In particular, this section addresses federal legislation passed in 1996: the Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA), and the Personal Responsibility and Work Opportunity Reconciliation Act (PROWA). The fact that proposed remedies, such as the appeal or revision of these laws, are so overarching speaks to the fundamental inadequacy of the existing legal and political structure which systematically denies basic human rights provisions (i.e., access to health care) to immigrants overall.

Immigration reform

The survivors of political violence in this research face overwhelming challenges in seeking legal immigration status. One policy recommendation is to work towards reform of the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA), including its provision for mandatory detention of undocumented asylum-seekers; its requirement that an asylum applicant who is in the U.S. legally file for asylum within one year of arrival; and the determination of asylum ineligibility due to criminal convictions under current categorizations of "aggravated felony."[33]

[33] The dramatic redefinition of "aggravated felony" enacted by IIRAIRA is controversial in that includes an array of non-violent crimes and also makes the definition retroactive. For example, due to the retroactive aggravated felon provisions, Xuan Wilson, a 32 year old woman who came to the U.S. at age 4 faced deportation because of a check she forged for $19.83 prior to 1996 (Coonan 1998).

As noted in Chapter 2, there is a lack of consistency among the over 200 immigration judges currently serving the court system. Asylum denial rates can range from 96.7 percent to 9.8 percent (TRAC 2006). The difference between which jurisdiction an applicant files their application in, as well as which immigration judge they are assigned amounts to "asylum roulette." Thus, another policy recommendation is to institute more stringent and comprehensive training for immigration judges, as well as comprehensive judicial reviews of immigration judges' asylum decisions. As decried by the Canadian government and a multitude of other human rights organizations, the routine repatriation of asylum-seekers to countries where they face persecution and torture is a violation of international human rights and must be rectified by the U.S. immigration court system. Moreover, one of the most important factors that affect the outcome of asylum cases is the presence of legal representation, thus a third recommendation for immigration reform is the requirement of court-appointed counsel for indigent asylum applicants.

Health care and social service access

Acceptance into PSOT is crucial for many of the survivors of political violence who apply to the program. PSOT, which provides free medical, psychological and social service care to immigrants regardless of legal status, is often their last chance to get the services that they and their families desperately need. This is in large part because there are no longer any federal provisions for access to health care for undocumented immigrants, and there is a policy of delayed access to care for those who are documented. Thus one recommendation is to work towards repealing the immigrant provisions of the

1996 Personal Responsibility and Work Opportunity Reconciliation Act (PROWA). PROWA barred undocumented immigrants from any means-tested, federally funded assistance (i.e., Temporary Assistance for Needy Families (TANF), Medicaid, Supplemental Security Income, and Food Stamps) except for assistance for medical emergencies, and barred documented immigrants from receiving benefits for their first five years in the country.

Identification and accommodation of torture survivors

As mentioned throughout this dissertation, it is difficult to know how many immigrants have experienced political violence – it is estimated that half of all countries in the world routinely practice torture (Hargraeves 2002). Individuals who have refugee status or have applied for asylum represent only the sub-group of survivors of political violence who have identified themselves to the state.

The best way of identifying individuals who may have had experiences of political violence (and thus know to inquire about any potential victimization) is to recognize risk factors and physical signs. A heightened awareness of the physical signs of torture, such as during a routine physical exam, is by itself often inadequate because various torture techniques practiced around the world are meant to leave no scars.[34] Risk factors from a patient's history that may indicate such experiences include: being from a country that is/has been politically unstable, having a history of arrest or detention in their country of origin, being the relative of a torture survivor, and being the member of a

[34] In countries such as Sri Lanka and Zimbabwe, for instance, the army uses a technique in which a plastic bag containing a small amount of petrol or foul water is wrapped around the victim's head; the smell of the substance is partially asphyxiates the victim, and makes them feel sick and faint (Hargraeves 2002).

minority group in their country of origin (Piwowarczyk et al. 2000). Moreover, of the available tools for health care professionals, Physicians for Human Rights (2001) provides a guide on medical and psychological evaluations of torture. Eisenman et al. (1998) – who found that half of Latino immigrants presenting in low-income clinics in Los Angeles had been exposed to political violence – developed a screening questionnaire to detect torture survivors in medical settings.

Yet health care professionals are often stymied by the same hindrances that affect the care of many their immigrant patients, for example a lack of a third party interpreter (i.e., someone other than a patient's friend or family member) (Hargraeves 2002). Moreover, many immigrants, regardless of torture status, do not have adequate access to any health care and thus never get to the doctor. As such, social service providers and community workers whose clientele include immigrant populations should be appropriately trained to identify potential survivors of political violence, as well as to accommodate their needs.

Providing multidisciplinary care and innovative treatment modalities

For psychologists and clinicians who already treat survivors of political violence, one recommendation arising from this research is to provide a multidisciplinary support structure, similar to PSOT, which provides English instruction, social service assistance and legal liaisons in addition to health and psychological care. Where an organization lacks the resources to offer such services directly, partnership with local CBO's and social service and charitable organizations is essential.

Another recommendation specifically for mental health professionals is the use of innovative treatment modalities, such as Narrative Exposure Therapy (described in Chapter 2). These techniques are thought to have therapeutic value and can also assist a client in preparation for court testimony if needed. For example, the "testimony method" is "a special, highly structured technique in which the trauma story is drawn out over a series of sessions and shaped explicitly into a prescribed form by the clinician with the consent and participation of the client" (McKinney 2007: 266). After the story is audiotaped and transcribed, it now exists in document form for the client to possess or sometimes to be disseminated "into the wider social and political arena" (McKinney 2007: 266).

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