

# Quality Of Life And Temporal Adaptation Of Refugees Relocating To New Environments

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## I. INTRODUCTION

The United States resettles a significant number of refugees that flee from their countries (Larsen, 2004). Refugees are displaced from home due to war, political turmoil, persecution, and conflict (Driver & Beltran, 1998). Their resettlement process is strenuous despite existing environmental supports. Refugees often adapt to their new environments however their adaptation trajectories are not well researched.

## II. LITERATURE REVIEW

The UNHCR (1951) defines a refugee as-

A person owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. (p.16)

Refugees are uprooted from their stable homes, experience disruptions in everyday lives, and have to rebuild their existence from the ground up. Limitations to their participation and inability to perform occupations that are central to adaptation often leave refugees unable to integrate successfully in their new communities (Gupta, 2012).

The term adaptation is derived from the Latin work 'adaptare' which means to fit. Adaptation has been extensively studied in biology as an explanation for evolution, in physiology as change in an organ or organism in response to sensory stimulation, and in psychology as change in quality of the experience with changes in the environmental contexts. The concept of occupational adaptation was introduced within occupational therapy when Meyer adopted the notion from psychiatry in 1922. He stated that most psychiatric conditions were 'problems of adaptation' and their remedy was participation in work. He is also credited with introduction of the concepts of 'systematic use of time' and 'engagement of interest' within occupational therapy (Meyer, 1922). Since then, the concept of adaptation has been used liberally in the OT literature described as adaptive responses, adaptive equipment, adaptive skills, and adaptive environments (Reed & Sanderson, 1999). According to

the most recent Occupational Therapy Practice Framework (2008), occupational adaptation is the response that the client makes when encountered by an occupational challenge. Thus, occupational adaptation is related to personal factors, environmental factors, and time.

Some research within occupational therapy has addressed adaptation and refugee issues. Suleman and Whiteford (2013) explored the use of occupations in understanding refugee resettlement and improving occupational adaptation with the use of life skills training. They highlighted the supports and barriers the environment presents to the resettlement process; for example, as a positive, resettlement camps may even inculcate attributes like resilience, persistence, and determination. Successful adaptation is influenced by various factors including physical and psychological health, in addition to the environmental challenges. Many refugees may have experienced physical ailments like amputations, war related injuries, chronic health conditions such as multiple sclerosis, preventable vaccine related health crisis such as tuberculosis, malaria, and various forms of malnutrition (Burnett & Peel, 2001; Hollifield et al., 2002). Psychological health issues are also prevalent in refugees. Post-traumatic stress disorder, a stress reaction to traumatic events, is very well documented in this population (Papadopoulos, 2002; Friedman, 2002; Van de Put & Eisenbruch 2004). These stress related disorders along with depression, hopelessness, and a lack of security are all related closely to quality of life.

Quality of life can be defined as 'a person's perception of his or her position in life in the context of the culture and value systems in which he or she lives and in relation to his or her goals, expectations, standards, and concerns (Szabo, 1996, p.355). The Center for Disease Control (CDC) states that on an individual level, quality of life includes perceptions of physical and mental health. It is not limited to an individual's functional status or social support, and includes resources and policies on a community level. Occupational therapy strives to assist individuals to maximize their capabilities, adapt to their physical environments, interact with society, and take charge of their lives thus improving quality of life (Hammell, 2004). There is a scarcity of measures that assess adaptation to new environments, especially that of refugees. In her dissertation, Grist (2010) studied the relationship between adaptation to disability as measured by an adaptation to disability index and examined quality of life as measured by a sense of well-being inventory and found a strong positive correlation. Thus, it is

believed that successful adaptation can be depicted by positive changes on a quality of life measures.

### **Purpose**

Refugees enter their host countries with a long term goal of becoming successful members of the society. However, they are often faced with ailments related to physical and mental health such as communicable diseases, chronic conditions like HIV/AIDS, depression, post-traumatic stress disorder (PTSD) etc. Limited access to healthcare services and an inability to comprehend and navigate the system places them at a further disadvantage (Burnett & Peel, 2001). Moreover, individual perceptions of their health, social supports, and environment are crucial to the quality of life experience. This research served to explore adaptation as measured by a health related quality of life measure in the refugee population by examining the temporal aspects of the experience in the host country. The research question was: Is there a relationship between quality of life, as measured by a health related quality of life scale, and temporal adaptation?

## **III. METHODOLOGY**

### *Design*

In this study the research question was addressed using a mixed method design with a primarily quantitative focus to explore whether or not temporal adaptation improves health related quality of life in the participant refugee population. Kielhofner (2008) states, 'Occupation is the purposeful use of time by humans to fulfill their own internal urges toward exploring and mastering their environment' (p. 659) and explained temporal adaptation as adaptation over time. The World Health Organization Quality of Life Measure-Brief (WHOQOL- BREF) was used as the quantitative measure.

### *Participants*

Five refugees, who had been in the USA for different lengths of time, participated in the quantitative survey. The participants were obtained using a snowball sampling approach: two participants were recommended by a personal friend who teaches English as a second language, the other three were references from personal contacts/ community members known for their work with the refugee population. All five individuals were English speaking and agreed to participate in the study. The refugees were contacted via phone, informed consents were obtained, and the WHOQOL-BREF was administered at a location of their preference. Participants 1, 2 and 3 completed the survey in their homes; participants 4 and 5 completed the survey in their place of work. The participants completed the questionnaire by answering the questions individually with the researcher present and available for any clarification; two of the refugees needed clarification for some of the questions. The measure was administered at one time and the refugees were then asked to explain their choices on the questionnaire. The tool required 10-15 minutes to administer and the discussion was audiotaped for all participants except participant 3 (pseudonym: Sheila).

### *Data Collection Tool*

The WHOQOL-BREF is an abbreviated version of the WHO quality of life measure that has 100 questions. Twenty six questions addressing four (physical, psychological, social relationships, and environmental) domains are present within the brief measure. The scoring uses an ordinal scale ranging from 1-5, 1 being poor and 5 being very good for most questions. The WHOQOL- BREF was developed by the WHO to understand perceptions about culture and value systems and how these factors affect everyday life.

The tool has been used with a variety of populations, translated in various languages and provides a cross-cultural comparison of quality of life indices internationally. The WHOQOL- BREF has good to excellent reliability and validity and has been tested with adolescents in Bangladesh, urban community residents in China, individuals with pulmonary tuberculosis in Taiwan, older adults in Brazil, and the general population in Norway and Iran (Trompenaars, Masthoff, Van Heck, Hodiament, & De Vries, 2005; Izutsu et al., 2005; Xia, Li, Hau, Liu, & Lu, 2012; Chung, Lan, & Yang, 2012; Chachamovich, Trentini, & Fleck, 2007; Hanestad, Rustøen, Knudsen, Lerdal, & Wahl, 2004; Nedjat, Montazeri, Holakouie, Mohammad, & Majdzadeh, 2008). In clinical practice, the WHOQOL assessment assists clinicians in making judgments about the areas in which a patient is most affected by disease and in making treatment decisions. In some developing countries, where resources for health care may be limited, treatments aimed at improving quality of life through palliation, for example, can be both effective and inexpensive. Together with other measures, the WHOQOL-BREF enables health professionals to assess changes in quality of life over the course of treatment. The tool is attached as Appendix A.

### *Data Analysis and Management*

The data were stripped of any identifying information and entered into a Microsoft Excel sheet. The data form included demographic information such as age, gender, marital status, education and current health status. The raw QoL scores were converted into transformed scores so they can be analyzed on a 0-100 range using instructions from the WHO. Domain scores are scaled in a positive direction where higher scores indicate higher quality of life. Basic descriptive statistics such as mean and ranges were obtained. The domain scores were correlated to the answers the participants provided for their choices to obtain an understanding of the general changes in scores and their relationship to time spent in the host country.

## **IV. RESULTS**

The WHOQOL-BREF measures physical, psychological, social relationships, and environments as four domains of well-being/ quality of life. Demographic information is provided in Table 1 with researcher chosen pseudonyms for the five participants. Raw domain scores are shown in Table 2 and the transformed domain scores of the participants are shown in Table 3.

Physical health questions addressed activities of daily living, energy, mobility, sleep and rest, and work capacity. Norma (a researcher chosen pseudonym) addressed this stating: "I am working, my husband is working. I have one daughter and we

registered her in a school and she is healthy and this is very important to me.” The psychological domain addressed positive and negative feelings, spirituality, bodily image, and appearance. Sheila, a young Nepali refugee, who had limited opportunities for leisure and education, explained her feelings about satisfaction with her life stating: “I am happy that I have work but I want to study more”. Social relationships included social support and sexual activity. Evan explained social relationships in his neighborhood: “Everybody here is immigrant; everybody here cares for each other.” The environment included physical safety, home, opportunities for participation, acquiring new information, transport and financial resources. Evan highlighted the importance of safety: “We are safe. We are in this country and we are not persecuted or intimidated. We have security in the condominium, everything is near, and so for that reason I feel safe.” He did report difficulty with transport,

I don’t drive right now. That is a big problem. Right now we don’t know the city. We need more information about how to move in the bus. We don’t know where some parts are. We know where we live, we know our address but we don’t know how to get to other places.

Norma explains her feelings of anxiety secondary to being away from her parents, “Actually I have family back home and the situation in Iraq is not good. So I am always worried about them, the explosions and all the things you know, it’s not settled. It’s not peaceful.” George explained the lack of time for leisure activities that included travel and seeing different countries, “I feel sometimes though that time available for leisure activities is not enough.”

The refugees who were new to the host country and in the process of becoming familiar with the new environment showed fairly good quality of life depicted by higher scores (Evan and Rebecca). In contrast, once the refugees have lived here for a while and understood the system; their scores took a dip (participants Sheila and George). The QoL scores were higher again for participants who had lived in the USA for a longer period of time (Norma). This pattern was most evident for domain three, the social relationships area. The graphical representation of the different domain scores for each of the five participants is provided as graphs 1 through 5. Evan scored high on social relationships and environment domains. For Rebecca and Norma, social relationships were scored the highest. George scored highest on domain four (environment). Although the overall QoL score for Sheila was low, she scored high in the psychological domain. Her lowest scores were social relationships and environment.

## V. DISCUSSION

The WHOQOL-BREF measure completed by the five participants provided an understanding of their health related quality of lives. The refugees who were fairly new had only good experiences from the agencies, reported their environments were satisfactory, and had fewer complaints. They were satisfied with their lives as they had ‘house, food, electricity- the minimal conditions’ that were necessary for living. A refugee who had been here more than two years appeared to understand that she was surviving on basic amenities and could have access to opportunities that would better her life. She highlighted the lack

of adequate services that would allow her to study and work at the same time and lack of transportation facilities as she was unable to drive. She did not address this as a sole responsibility of the resettling agency but perceived that it was a system level change that needed to happen to accommodate more people like her. Another refugee female who had lived nine years in the host country expected more out of life and wanted to study. She reported having difficulty with finding appropriate employment and education opportunities.

The domain scores did not necessarily show a linear positive or negative disposition with respect to time spent in the United States. Conversely, the refugees appeared to have a variable trajectory of adaptation or quality of life when compared with each other. Every participant answered the questions based on their current status. For example, one female participant was pregnant and attributed lower scores to having less energy and time to complete leisure activities and decreased satisfaction with physical appearance. She described her situation relative to being very close to her due date and hence she was unable to partake in those tasks to the best of her abilities and to the level of her satisfaction. All five refugees reported having a good quality of life and primarily attributed it to safety. One refugee commented that he felt he was not persecuted or intimidated and felt he was in a safe place being here in the United States. Two of the refugees addressed lack of appropriate information as limiting successful participation in tasks of their choice. The domain scores showed areas of strengths as well as weaknesses for each participant for e.g. Sheila and George had limited socialization but Evan reported a strong nurturing environment.

The WHOQOL-BREF measure evaluates health related quality of life. Although none of the refugees had any physical ailments at the time of administration of the tool, the psychological factors involved in adaptation were revealed. Psychometric studies on the WHOQOL-BREF showed that QoL scores decreased with an increase in psychiatric symptoms such as depression, somatic symptoms as well as perception of social support (Trompenaars et al., 2005). It is evident that adaptation is related to the psychosocial make up, personal experiences, and environmental press of each individual, and how the individual then deals with the challenges.

Berry, Phinney, Sam and Vedder (2006) researched the relationship between acculturation and adaptation of immigrant youth to new societies and discussed the results of their factor analysis, which revealed two important themes of adaptation: psychological and sociocultural adaptation. This is assumed to be true with the refugee population as well. Stevens and colleagues researched problems in adaptation as a result of migration and resettlement, and the factors that influence this process from a psychological perspective. They undertook qualitative interviews with six Russian speaking immigrants to a novel culture in New Zealand and found that immigrants experience struggles during the process of their psychological and sociocultural adaptation to the host culture and these interactions with the host environment have far-reaching effects on their mental health, employment and participation in society. All the participants in their study experienced high levels of psychological distress in the initial stage of their resettlement, but those who later chose the integration strategy of acculturation were more successful and satisfied with their adaptation. In this study, when compared with

each other, the five participants showed various degrees and methods of temporal adaptation to their environments. They also had variable individual trajectories that highlight the dynamic nature of adaptation. Adaptation was thus observed to be a non-linear phenomenon, multi-factorial, and influenced by time.

## VI. LIMITATIONS

The WHOQOL measure is a personal evaluation of functioning, hence comparative analysis between participants was only based on the subjective understanding of their adaptation trajectories. Additionally, secondary to the low number of participants (five), no statistical analysis could be conducted; only descriptive analysis could be completed. The study was not longitudinal in nature and hence was unable to capture changes in the domain scores, if any, which happen over time, spent in this country. A qualitative assessment tool with in depth questions about choices and how they relate to adaptation would have strengthened the study.

## VII. CONCLUSIONS

Occupational therapists need to appreciate that there are multiple factors affecting quality of life in the refugee population. These individuals have been deprived of basic amenities in camps and may have fled from their countries for safety. Hence, they are often very appreciative of the services provided by agencies like basic self-care needs and safety. We, as therapists, have to be open-minded and have a genuine interest in knowing their needs and priorities in order to assist them in adapting successfully. In fact, this is not very different from the process outlined by AOTA of obtaining an extensive occupational profile in our clients with conventional physical or mental health care needs.

During the assessment and intervention process, therapists also need to understand the different trajectories of adaptation that individuals pass through in their lives. Adaptation implies change and change is dynamic. It is influenced by multiple factors, both internal such as personal resilience and external such as social supports. In addition, the adaptation process is not always linear and one-directional. There are peaks and valleys along the path of adaptation. Penrod, Hupcey, Baney and Loeb (2011) describe the caregiving trajectories of caregivers who provide end-of-life care. They interviewed 46 informal family caregivers to individuals with terminal conditions such as cancer and found that trajectories of death influenced the caregiver experience. They also report how an in-depth understanding of the trajectories can assist clinicians in planning service delivery with respect to the nature and timing for individuals with terminal diseases and their caregivers. Similarly, therapists' understanding of temporal adaptation and adaptation trajectories can inform their clinical reasoning while working with forced migrants. Future research studies could address individual adaptation trajectories further by conducting longitudinal studies with a larger sample of participants.

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