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The Case for Resilience in African Refugees: A Literature Review and Suggestions for Future Research

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Abstract

The current literature review aims to examine research findings on the various risks experienced by African refugees, address sources of resilience in African refugees, and provide suggestions for future research. Because of the occurrence of mental health problems such as post-traumatic stress disorder, anxiety disorders, and depression in some refugee populations, a medicalized approach and trauma-focused treatment models have dominated research with this population. At the same time, there has been an emergence of research examining resilience in refugees. Some researchers have argued that, despite the negative experiences during different phases of migration, not all refugees develop mental health problems. Instead, and in spite of the risks, some refugees manage to be resilient. Against this background, this review seeks to (a) examine what is known about resilience in African refugees and (b) provide suggestions for future research.

Keywords: African refugees, risk factors, resilience, protective factors, social support, family, community, religion

Refugee migrations from original home countries to countries of resettlement for safety and security purposes is not a new trend. Armed conflicts and civil wars have been rampant across different continents due to a variety of reasons. An armed conflict is defined as "a contested incompatibility that concerns government and/or territory where the use of armed force between two parties, of which at least one is the government of a state, results in at least 25 battle-related deaths in one calendar year" (Themner & Wallensteen, 2012, p. 572). Prime examples of armed conflicts as recent as 2011 include the Arab Spring uprisings in Tunisia, Egypt, Syria, Libya, and Yemen. Currently, the United Nations High Commissioner for Refugees (UNHCR; 2015) estimates indicate a global refugee population of 20.2 million. Over the years, trends have shown that refugees migrating from the African continent come from countries such as Somalia,

Sudan, Democratic Republic of Congo, Rwanda, and Burundi (Ellis, Lincoln, et al., 2010; UNHCR, 2008, 2011). For African refugees from Somalia and Sudan, armed conflicts have been ongoing experiences that date as far back as the 1980s (Themner & Wallensteen, 2012). Research has indicated that among the refugee population, children, adolescents, and the elderly are considered the most vulnerable groups (Bemak, Chung, & Pedersen, 2002). Among these vulnerable groups, statistics have indicated that over half of the refugee population are children and adolescents under the age of 18 (UNHCR, 2011). Notably, migration during adolescence has been found to be riskier than any other period in an individual's life (Beiser, Dion, Gotowiec, Hyman, & Vu, 1995) because of the dual transitions adolescents have to negotiate: first, coping as new arrivals in unfamiliar environments and, second, dealing with normative developmental processes, including identity formation (Kovacev & Shute, 2004; Tingvold, Middlethon, Allen, & Hauff, 2012).

Why Focus on Resilience?

Mental health problems in African adolescent and adult refugees have been documented (Abu-Ras & Abu-Bader, 2008; Halcon et al., 2004; Huemer et al., 2011; Huemer et al., 2013; Kia-Keating & Ellis, 2007; Perera et al., 2013). Consequently, researchers have undertaken a trauma-focused medical model approach in the diagnosis of problems. In this model, there is emphasis on pathology of refugee populations to determine psychological problems or conditions and treatment modalities (Ryan, Dooley, & Benson, 2008). In this regard, some treatment approaches, including trauma-based cognitive behavioral therapy, group trauma-based cognitive behavioral therapy, cognitive behavioral group therapy, and narrative therapy, have been found to be efficacious in the treatment of diagnosed mental health problems (Ehntholt, Smith, & Yule, 2005; McMullen, O'Callaghan, Shannon, Black, & Eakin, 2013; Murray, Cohen, Ellis, & Mannarino, 2008; Pacione, Measham, & Rousseau, 2013; Unterhitzenberger et al., 2015). The use of these trauma-focused models seems similar to other findings in working with groups in the general population (such as adolescents facing risks and adversities). That is, "traditional methods to enhance the health and well-being of young people have focused on a problem-focused paradigm . . ." (Short & Russell-Mayhew, 2009, p. 216). At the same time, there is a paradigm shift as evidenced by an emerging body of literature examining resilience in refugees (Lustig et al., 2004; Rana, Qin, Bates, Luster, & Saltarelli, 2011; Sleijpen, Heide, Mooren, Boeije, & Kleber, 2013). To this end, some researchers have argued that, despite the difficult migration experiences prior to, during, or post resettlement, not all refugees develop mental health responses (Lustig et al., 2004). Instead, in spite of the risks and negative experiences, some refugees manage to be resilient and are unharmed permanently (Amone-P'Olak', 2007; Halcon et al., 2004; Rousseau & Drapeau, 2003).

Against this background, the current literature review aims to examine research findings on sources of resilience in African refugees and to provide suggestions for future research. As it has been observed in the literature, "this paradigm shift moves away from a problem-focused paradigm, and provides counselors . . . and policy makers with a way to identify an individual's strengths, as opposed to targeting weaknesses, or areas of concern" (Short & Russell-Mayhew, 2009, p. 221). Furthermore, with ever-increasing

numbers of refugees in resettlement countries, an understanding of resilience may inform mental health service providers in various agencies about the culturally relevant and appropriate interventions to tailor when working with African refugees. In sum, the overarching aims of this review are to address: (a) what is known about resilience in African refugees, and (b) what we need to do next.

Literature Review Methodology

Inclusion Criteria

Journal articles that met the following search criteria were considered for selection: (a) age range of 15 years and above (youth/adolescents and adults); (b) research methodologies including qualitative, quantitative, and mixed-methods analyses; (c) countries of origin including Burundi, Democratic Republic of Congo (DRC), Liberia, Somalia, Sierra Leone, Sudan, Rwanda, or Zimbabwe; (d) countries of resettlement had to be developed countries such as the United States, Canada, Australia, United Kingdom, Germany, or the Netherlands; and (d) date range of journal publication between the year 2000 to present. As previously stated, research on the mental health and well-being of refugees (particularly adolescent refugees) has mainly focused on psychopathology and treatment modalities. The date range was mainly because research on resilience and well-being of refugee populations has only recently emerged in the literature, even though resilience as an area of study is not a new phenomenon (Ungar, 2008). For example, research literature on resilience in the well-being and development of children in the presence of risk has been documented (Fergus & Zimmerman, 2005; Luthar, 1991; Masten, Best, & Garmezy, 1990; Rutter, 1985, 1987). In relation to refugee populations, this is an emerging area of focus. Therefore, the intention (in the choice of date range) was to determine what has been found thus far and provide suggestions for future research.

Search Terms and Selection Criteria

The Web of Science Core Collection database (MEDLINE, PsychINFO, and PubMed) was used in the search process. The search terms included: *African refugees and resilience*, *African adolescent refugees*, *African refugees, resilience and refugee mental health, refugee mental health and adjustment*, *resilience and refugees*, *refugee risk factors*, *refugee protective factors*, *resilience*, *refugee mental health*, and *well-being of refugees*. Search outcomes included 261 articles from the selected search areas. From the total findings, research that was conducted in countries not included in the scope of the search were excluded. Further, to narrow the search to refugees from Africa, the author selected two domain areas—Social Sciences and Arts and Humanities, specifically Psychology, Psychiatry, and Sociology. Using the selected search criteria yielded 49 journal articles. To determine if articles met the inclusion criteria, the author scanned the various titles and abstracts. Following this, journal articles that included immigrants and refugees as participants were excluded (because immigrants were not included in the scope of this literature review), as well as conceptual and theoretical articles. Also, three journal articles were excluded because they only met partial criteria for selection (Ellis, MacDonald, et al., 2010; Kia-Keating & Ellis, 2007). In the final analysis, nine journal articles met the criteria for inclusion.

Refugees' Migration Experiences

Refugee migrations are characterized by different periods before the refugees' final resettlement in a new country. These include pre-migration, trans-migration, and post-migration periods. African refugees' resilience can be better understood through the lens of the various risks they encounter during these periods. These risks range from close encounters with death in the country of origin, witnessing death and torture or being tortured, scarcity of basic needs, and discrimination among others.

Pre-Migration

Pre-migration experiences are those encountered before fleeing the country of origin and also may encompass possible problems pre-existing before the outbreak of conflicts. This period is characterized by different experiences depending on the nature of conflicts and location of occurrence. For example, refugees from the Sudan who fled from their homes have reported instances where entire villages were burnt with no place for refuge for those who survived and were left behind (Goodman, 2004). Refugees' exposure to atrocities, such as witnessing the death of family members or other community members and violent torture (particularly for the most vulnerable children and adolescents), leaves them susceptible to developing serious mental health problems such as conduct disorders, sleep problems, post-traumatic stress disorder (PTSD), depression, anxiety disorder, and psychosis, among others (Carlson, Cacciatore, & Klimek, 2012; Derluyn, Mels, & Broekaert 2009; Ehntholt et al., 2005; Haffejee, 2015; Lustig et al., 2004). Further, some children also are forcibly recruited by rebel fighters to fight in their armies against the enemy, in this instance government forces. These children, commonly known as *child soldiers*, may be forced to kill their own family members and engage in other forms of violence, such as looting food, for survival (Carlson et al., 2012; Lustig et al., 2004). Also, girl child soldiers may be either raped on a continuous basis or forced into marriage to the rebel leaders. Those who have endured such past traumatic experiences and manage to escape, or are rescued by government forces, are most vulnerable and may develop mental health disorders that may not be addressed. This is because, from a cultural perspective, talking about trauma within the family is uncommon among African refugees (Haffejee, 2015; Savic, Chur-Hansen, Mahmood, & Moore, 2016).

Additionally, research shows that the majority of refugees come from collectivistic and community-oriented backgrounds (Bemak et al., 2002). During this phase, the social fabric that forms their value systems and overall cultural identities is destroyed through eradication of homes, ways of life (such as farming and pastoralism), and symbols that may have been passed down for many generations (Summerfield, 2000). Such a process, sometimes referred to as *cultural bereavement* (Eisenbruch, 1991), may lead to potential mental health problems for some refugees during the post-migration phase. Cultural bereavement may have a stronger negative impact on adults and the elderly who might find starting over in a new environment foreign to their norms and ways of livelihood. Also, separation from family members and loved ones is another key characteristic during this phase. This separation may be the result of men being captured by rebel groups to be soldiers and leaving the weak (women and the elderly) behind, a group that may not defend the family or community. Additionally, women are

also sometimes raped in front of their husbands and/or children. Eventually, during the post-migration period, some men may find it difficult to deal with memories of their inability to defend their wives or families. They may end up leaving their wives and families to avoid shame, while the women find it difficult to cope with this past trauma (Haffejee, 2015). In other instances, separation may be due to loss of family members to killings or escaping to seek safety and survival. A sense of helplessness, powerless, and hopelessness characterizes this period. Survivors of violence and atrocities are faced with daily struggles of their inability to help those who may have suffered serious physical and emotional scars (Goodman, 2004; Jorden, Matheson, & Anisman, 2009). Living with survivor's guilt may be a pre-cursor to other problems in the family.

Trans-Migration

Trans-migration experiences are those encountered during the flight phase. Sometimes, refugees' destinations are overcrowded refugee camps where they have to deal with numerous challenges as new arrivals. Before arriving in refugee camps, some refugees may have to walk for several days from their countries. During this time, they face a host of dangers, including the possibility of death by wild animals in forests, being swallowed by crocodiles as they swim across rivers, being killed by rebel soldiers (Carlson et al., 2012; Goodman, 2004; Haffejee, 2015; Lustig et al., 2004), or risk of committing suicide due to the intense emotional torture as they witness the deaths of their fellow family or community members (Goodman, 2004). Because of congestions and minimal basic amenities (e.g., food, water), refugees are prone to infectious diseases, malnutrition, and sometimes death, particularly young children whose immune systems may not be fully developed (Carlson et al., 2012). Also, it is not uncommon for refugees to face harassment either from within (as rival refugee groups) or without (from the locals; Perera et al., 2013). Lack of shelter and having to move from one place to another is another common feature during this period. Later, during the post-migration phase, some refugees are diagnosed with diseases, such as water-borne illnesses, that they may have contracted during the flight phase as a result of drinking dirty water from the rivers or unsafe water from refugee camps (Goodman, 2004). At the same time, children and adolescent refugees' educational trajectories are disrupted due to limited opportunities in refugee camps (Haffejee, 2015). Girls also face instances of being raped and having unplanned pregnancies. Children born to these refugee girls encounter untold developmental challenges due to the disruptive environments and insufficient food and medical amenities (Lustig et al., 2004). Further, not knowing what the future holds is a common feature of this phase. Refugees may be considered unwelcome visitors by the citizens of the various countries they flee into. Because of this, there is potential for animosity, partly because the refugees have to compete for the same minimal resources that may be available for the local people.

Post-Migration

Post-migration experiences are those encountered during the resettlement period in a host country. These experiences include those stemming from having a different culture, language barriers and/or problems, housing problems, unemployment or underemployment, uncertainties about immigration processes, racism and discrimination, challenges navigating the social services and legal systems, sense of isolation and

disconnectedness, and financial challenges (Ehntholt et al., 2005; Perera et al., 2013). For older refugees, the stress of adapting to a new culture provides greater challenges as they have to learn a new language, a process that has been found to be difficult compared to younger refugees (Kia-Keating & Ellis, 2007; Perera et al., 2013). As observed by some younger refugees, "The elders . . . it took them a very long time to adapt. . . . Some of the parents (are) not even adapted to the American ways, they are more resistant . . . we [the youth] go through it every day . . . parents, they're more . . . like, trying to keep the old alive" (Betancourt et al., 2015, p. 120). Relatedly, due to the fast rate of language acquisition and assimilation of refugee children and youth, changes in family roles and subsequent intergenerational conflicts are common occurrences in families (Lustig et al., 2004). For instance, children may act as language brokers for their parents and older extended family members, an endeavor that may be deemed culturally inappropriate by older generations. These experiences may be precursors to mental health problems such as depression and anxieties (Rana et al., 2011). Additionally, although an overall sense of loss (of culture, individual and collective identities and possessions) is characteristic of all experiences, ambiguous loss is even more prevalent during this period. Some refugees may be in "a situation of unclear loss resulting from not knowing whether a loved one is dead or alive, absent or present" (Boss, 2004, p. 554). Such a situation, coupled with present ongoing stressors during resettlement, may also increase susceptibility to mental health problems (Luster, Qin, Bates, Johnson, & Rana, 2008). In this regard, research has found that exposure to war-related trauma is a leading factor for PTSD, and current ongoing stressors and lack of social support are causes for depression (Ehntholt et al., 2005).

Risk and Protective Factors

Risk factors "are defined as those variables that increase the likelihood of experiencing psychological distress" (Hooberman, Rosenfeld, & Rasmussen, 2010, p. 557). For refugees, this may mean there could be potential for negative adjustment and/or adaptation outcomes due to the presence of risks (at pre-, trans-, and post-migration periods). For African refugees, similar to their counterparts from other continents, facing risks is a familiar reality they encounter almost on a daily basis. This reality may vary based on within-group differences such as age at the time of migration (e.g., riskier for younger refugees). As an example, continuous exposure to traumatic and violent experiences, such as witnessing killings of loved ones or even worse, participating in the killings, presents some of the highest risks for problems later. Because of previous depletion of the social networks through death or ambiguous loss, African refugees are left to start over the rebuilding process of several aspects that inform their identities during the post-migration period, a process that may be marred with negative mental health outcomes. All these variables constitute risks that may negatively impact adjustment.

Protective factors provide sources of resilience for individuals in the midst of risks as avenues for positive adaptation and adjustment outcomes. Betancourt and Khan (2008) observed that protective factors "refer to often exogenous variables whose presence is associated with desirable outcomes in populations deemed at risk for mental health and other problems" (p. 318). Similarly, Earvolino-Ramirez (2007) stated that

protective factors are "specific attributes or situations that are necessary for the process of resilience to occur" (p. 75). Research with adolescents in the general population has shown that protective factors, such as the role of parents, families, community, and schools, are central buffers against risks during development (Short & Russell-Mayhew, 2009). In a study specific to African adolescent refugees, these factors also have been suggested to comprise agents, resources, and mechanisms (Weine et al., 2014). Protective agents refer to "those individuals, groups, organizations and systems that can contribute either directly or indirectly to promoting adolescent refugees' psychosocial well-being. Protective agents can include parents, schools, and churches" (Weine et al., 2014, p. 4). It is fair to speculate that this composition of protective agents (i.e., individuals, groups, organizations, and churches) may yield similar positive outcomes of well-being in African refugee adults due to the communal orientation of this group.

Resilience: Definitions, Background, and Theoretical Framework

Various definitions have been proposed for resilience. Richardson (2002) stated that resilience is "the process of coping with adversity, change, or opportunity in a manner that results in the identification, fortification, and enrichment of resilient qualities or protective factors" (p. 308). Other authors observed that "resilience is a dynamic process wherein individuals display positive adaptation despite experiences of significant adversity or trauma" (Luthar & Cicchetti, 2000, p. 858). There seems to be a lack of consensus in resilience research on a specific way to define resilience. It has been argued that

> resilience researchers have focused on outcomes that are: 1) Western-based with an emphasis on individual and relational factors typical of mainstream populations and their definitions of healthy functioning . . . and 2) lacking in sensitivity to community and cultural factors that contextualize how resilience is defined by different populations and manifested in everyday practices. (Ungar, 2008, p. 219)

Despite the lack of consensus, across resilience definitions there are two overarching themes: that of the presence of *adversity* or *risks*, and, in spite of those risks, the ability to have *successful* or *positive outcomes.* For the purpose of this literature review, Ungar's (2008) more contextualized definition of resilience will be employed. That is,

> In the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community, and culture to provide these health resources and experiences in a culturally meaningful way. (p. 225)

The origins of resilience have been documented in the field of medicine and psychiatry. Its resurgence in the field of behavioral sciences did not begin until around 1970 as researchers sought "to understand and prevent the development of psychopathology" (Masten, 2011, p. 493). Further, the development of resilience as a topic in research can be divided into three waves. The first wave was from scientists with a goal of understanding and preventing the development of psychopathology (Masten,

2011; Masten & Obradovic, 2006). In the second wave, researchers sought to determine the processes and systems that determined "protective factors associated with resilience" (Zolkoski & Bullock, 2012, p. 2298). In the third wave, there was "a sense of urgency for the welfare of children growing up with adversities focusing on promoting resilience through prevention, intervention, and policy" (Zolkoski & Bullock, 2012, p. 2298). This sense of urgency may have been due in part to the overall physical health and well-being of children from difficult environmental risks such as poor neighborhoods.

The current literature review is guided by the protective factor theoretical model of resilience because, at the core of being resilient, there has to be an element of risk and protective factors. In the context of African refugees, a protective model is exemplified when the relationship between past traumatic experiences (and present post-migration stressors) and mental health problems, such as anxiety or trauma- and stressor-related disorders, are reduced due to the presence of assets. For instance, as already stated for African refugee youth, these assets may be in the form of parental or guardian support. In this case, "parental or guardian support operates as protective factors because it moderates the effects of" (Fergus & Zimmerman, 2005, p. 402) pre-, trans-, and post-migration trauma and psychiatric or psychological disorders.

Further, the protective factor model may be conceptualized in various ways, including protective-stabilizing ("when a protective factor helps to neutralize the effects of risks") and protective-reactive ("when a protective factor diminishes but does not completely remove the expected correlation between a risk and an outcome"; Fergus & Zimmerman, 2009, p. 403). This literature review is guided by the former model (protective-stabilizing). Protective factors comprise three main categories: (a) individual characteristics, (b) family relationships, and (c) community resources (Betancourt & Khan 2008; Fergus & Zimmerman, 2005; Masten, 2011; Short & Russell-Mayhew, 2009). Although the individual characteristics, family relationships, and community resources are central in eventual positive outcomes, it is worth noting that contextual variables have to be taken into consideration because different individuals may present different attributes and responses to available resources. That means, "protective factors are contextual, situational, and individual and lead to varying outcomes. Protective factors that are present or beneficial for one individual may not be present or beneficial for a similar individual" (Earvolino-Ramirez, 2007, p. 76).

Literature Review Findings: Resilience in African Refugees

In the selected review articles (see Table 1), a number of factors emerged that may be considered central in resilience of African refugees. Overall, these factors included the following: religion or spirituality, social support (from family, friends/peers, community), education or belonging to school, reframing, suppression, and individual factors, with variations depending on the age of refugees. The most notable themes that may be consistent from African refugees' cultural backgrounds are social support (from family, friends, and community) and religion or spirituality. These themes seem to provide a more contextual understanding of resilience in African refugees due to the emphasis on collectivistic and communal cultural aspects that are key features of the majority of refugee populations. Education, while not a critical theme in the reviewed

articles, is considered valuable, a means to a better life, and sometimes, a means away from a life of poverty.

Social Support

Social support was found to be one of the main sources of resilience in African refugees that positively impacted adjustment outcomes. In the reviews, refugees identified social support as a major aspect in surviving the risks and adversities they had experienced. For refugee youth, this form of support was provided by and through various agents, from the immediate and extended family members or guardians, older siblings, friends or peers, as well as through refugee communities (Weine et al., 2014). For example, friends or peers in schools or communities were available to play together or share and listen to each other's problems. Parents provided "emotional, material, and educational support, monitoring and supervision, cultural connection, and access to faith communities" (Weine et al., 2014, pp. 8–9). It is evident that parents played an important role in their well-being and adjustment in a new environment. In the process of helping their children, adult refugees may become overwhelmed with family-related demands and their own functioning. For their own support, they relied on friendships among themselves (e.g., women relied on each other in the refugee communities; Sherwood & Liebling-Kalifani, 2012). For unaccompanied refugee youth, they derived their emotional support through the friendships formed during migration (Goodman, 2004). It seems that in the absence of immediate and extended family members, as well as community members for guidance, they formed surrogate families along their journeys until they were resettled in a new country. The direct and indirect emotional support and the motivation not to give up were central in eventual adjustment outcomes during post-migration. "The friends that had helped me a lot, because they were always there telling me what to do, and if things don't go right to always keep your head up high and keep trying" (Rana et al., 2011, p. 2099).

Additionally, the roles of the community (i.e., refugee community) and local community agencies in resettlement were found to be important agents in resilience. The refugee community was particularly valuable as it provided a place of cultural belonging and identity. Refugees' values and beliefs were found to be important in helping refugees stay connected to their heritage (Weine at al., 2014). Thus, within-group community resources provided immediate avenues in coping with risks (Haffejee, 2015; Khawaja, White, Schweitzer, & Greenslade, 2008; Rana et al., 2011; Sherwood & Liebling-Kalifani, 2012). Refugee community gatherings for various cultural events were avenues for people to give and/or find emotional support from each other and also gather information about individuals that may require more attention due to their specific areas of need. Further, local community agencies acted as avenues to connect African refugees with a wider refugee community from Africa using various available means, including phone calls (Goodman, 2004). This facilitated community connections being kept with relatives and friends back in their countries. Also local agencies were instrumental in linking African refugees to the available resources (e.g., financial for adults), accessing basic needs (such as food and clothing), tutoring in English as a second language, and healthcare services, among others (Weine et al., 2014).

Religion and Spirituality

Religion and spirituality were found to be a major source of resilience in African refugees. Through practice, prayer, and meditation, refugees were able to adjust in the midst of several risks at different phases. Some refugees "placed their fate in God and . . . the church assisted them by providing emotional and material support" (Khawaja el at., 2008, p. 504). This was found during pre-migration and trans-migration periods. Other refugees attributed their survival from war experiences and being alive as "God's will rather than struggle with questions about why God would allow them to live and others die" (Goodman, 2004, p. 1187). It appears that even through the myriad risks (pre-migration and during transit), some refugees had an understanding that it was not their time to die, and when God willed it to happen, then they would accept it (Carlson et al., 2012; Goodman, 2004). Such meaning-making processes acted as a buffer against potential serious mental health problems and provided the much needed hope that things will get better for them. In fact, some refugees found comfort in knowing that their religious beliefs provided an example of suffering, and therefore they could not question their present circumstances. This was mainly because it paled in comparison to what "Jesus went through" (Sherwood & Liebling-Kalifani, 2012, p. 100). Similarly, because counseling is a relatively new phenomenon to many refugees (Savic et al., 2016), some translated or understood praying to God as the closest form of therapy they may have in dealing with past trauma: "We pray to God . . . So if you are asking what kind of 'therapy' we have (laughter), in Somali culture we don't go to therapy" (Betancourt et al., 2015, p. 120).

Education

Reviews of research revealed that African refugees seized the opportunities in resettlement countries to go to school and get formal education. For many, this was not only for individual fulfillment but also was a means to eventually secure employment and help family members and relatives left behind (Goodman, 2004; Haffejee, 2015; Khawaja et al., 2008). Specifically, there seemed to be a sense of responsibility and desire to give back to those who may be going through greater hardships in their countries of origin, as evidenced by some of the refugees' narratives such as, "My dream was if I could finish my school, so I could work for my people" (Khawaja et al., 2008, p. 502). Also, some refugee women expressed a sense of fulfilling their dreams through education (Sherwood & Liebling-Kalifani, 2012). Overall, the desire to start, continue, or complete education may be particularly important for African refugees because even under normal circumstances without conflicts, education is perceived as an avenue to a better life from poverty. It may not be surprising, therefore, for African refugee parents to be particularly keen on encouraging their younger ones not to waste the opportunity to go to school. In addition, in spite of the risks associated with the post-migration phase, some refugee youth do not consider these risks comparable to the toils and challenges they may have already survived and, thus, they are resilient as they seek to achieve a better life than their pasts (Haffejee, 2015).

Discussion

The aims of this literature review were twofold: to (a) determine what is known about resilience in African adolescent and adult refugees and (b) provide suggestions for future research. As previously stated, for resilience to occur, there has to be an element of risk for the individual. For African refugees, risk factors range from pre-migration, trans-migration, and post-migration factors in resettlement. Resilience sources, including social support, religion, and education, have been documented to account for positive outcomes in African refugees. These factors seem to be embedded in the collectivistic, cultural identities and values for most African refugees. Social support from immediate and extended family, friends/peers, and the community are to be expected due to the community-oriented nature of African refugees. Even in the midst of adversities, a sense of "we" and not "I" seems to be the preferred perspective (Goodman, 2004; Khawaja et al., 2008). Thus, during resettlement, some of the most urgent needs (in addition to basic necessities) are the establishment, nurturance, and maintenance of social support networks. For African refugees, an understanding of resilience from their perspective may need to be a priority consideration for mental health and other service providers. Strengthening social support networks has been echoed elsewhere by community service providers working with African refugee adults (Savic et al., 2016). In other words, emphasis on a "holistic approach" (Savic et al., 2016, p. 78) seems to offer positive resettlement outcomes. While it is important not to underestimate the possibility of previous traumatic experiences, there is a need for service providers to consider "the consequences of traumatic events to be affected by the ability of resettling refugees to rebuild their social worlds as well as individual resilience. . . trauma issues could only be dealt with once needs associated with rebuilding social worlds had been met" (Savic et al., p. 78).

Findings on the role of community support and belonging in the resilience of African refugee youth and adults are consistent with available research with this population group (Ellis, Abdi, Miller, White, & Lincoln, 2015; Savic et al., 2016). Savic et al. (2016) found that the Sudanese community had their own way of handling within-group problems that affected the members. This comprised various processes from making the problem known to community leaders to eventual meetings with the individual or individuals in need of help. Problems such as "possible emotional distress, alcohol issues, family crises, social isolation and other stressful events experienced by members . . ." (Savic et al., 2016, p. 80) were observed and dealt with within the community structure. It was found that although mental health concepts (such as depression) may not have a specific name in the Sudanese culture, situations such as "hearing voices" or "saying things that don't make sense" (Savic et al., 2016, p. 79) were better explained from a cultural perspective as normal day-to-day occurrences that did not necessarily require seeking therapy. Instead, the refugees used community resources they referred to as "Sudanese way of counseling" that "included surveillance and information gathering, mobilization of appropriate community resources and provision of collective support and advice" (Savic et al., 2016, pp. 79–80). In addition, for African refugee women, a sense of community seemed to provide help as they shared their problems with each other in a group setting. These observations further underscore the collectivistic and communal nature of dealing with problems among African refugees.

Very often, particularly in the third world, it is very difficult to see women talking one to one but in a group setting of people of their own background they feel much more trustful and comfortable. . . . So if they talk to each other and share their problems sometimes what one person has undergone can be of help to another person and they explain how to deal with a particular service so that is a very effective way of helping. (Savic et al., 2016, p. 80)

Consistent with other research findings in culturally diverse populations (Ellis, Lincoln, et al., 2010; Khawaja, Moisuc, & Ramirez, 2014; Steffen & Merrill, 2011) and refugee youth (Sleijpen, Boeije, Kleber, & Mooren, 2016), religion and spirituality were found to be another factor in resilience. This is also closely related to other research findings with African refugee women who attributed spirituality with their ability to cope with being away from family members and even making it to a resettlement (Clarke & Borders, 2014). It is important to note that various African refugee groups may define and attach meaning to these aspects in different ways, but at the core of coping and dealing with several risks is the understanding that there is a higher power, God, Allah, or other forms of spirituality that provide comfort, encouragement, and hope beyond current circumstances. It is possible to find refugees who talk about God or a higher power but are not actively involved in any structural community to express their beliefs, or some may be actively involved in church as practicing Christians or Muslims. Through religion and spirituality, some refugees seem to derive purpose, meaning, and a hope for the future.

Limitations and Future Research

A number of limitations about the review are to be noted. First, out of the total reviewed journal articles, there were seven qualitative studies and one quantitative study. Although a qualitative methodology is a good way to capture the narratives and lived experiences of African refugees, there seems to be a scarcity of more rigorous examinations of resilience using a variety of quantitative methodologies. The author speculates that some aspects of African refugees' experiences may not be fully articulated verbatim (such as through structured interviews, focus groups, or open-ended questions), partly because of the potential re-traumatization of participants as they relate their experiences. To avoid this, some participants may censor the specifics of what they share through various qualitative methods. Coupled with this, discussing personal or family-related issues with a "stranger" is not common from the African cultural perspective. Future researchers may need to address resilience in African refugees using more rigorous quantitative studies, such as mixed methods, that may have potential to provide opportunities to use actual resilience measures with culturally diverse groups. To this author's knowledge, resilience measures that have been specifically tailored and normed with refugee groups are non-existent. One measure that could address resilience with culturally diverse groups is the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlaem, Zimet, & Farley, 1988), a 12-item self-report scale that addresses three areas: friends, family, and significant others. This scale could be used with youth and adults but has yet to be used with refugee populations. Another notable measure is the Child and Youth Resilience Measure (Ungar, 2008), a 58-item measure with good reliability that was developed for use across different cultures.

Second, in the selected review articles, the majority of participants' country of origin was Sudan (for both adolescents and adults). It is unclear whether findings in the reviewed articles would be similar or different with African refugee participants from other countries. In fact, there are within-group differences that also need to be considered because of the different ethnic and tribal groups that characterize some African refugees, even if they come from the same country (Baak, 2014). Additionally, this review focused on adolescents and adult African refugees. For a more targeted focus due to the different needs for each age group, addressing resilience in specific refugee groups (e.g., resilience in unaccompanied refugee youth, adults, and elderly, gender differences in refugee groups) may yield more generalizable outcomes to inform mental health providers in designing intervention strategies when working with these population groups. Similarly, research on resilience in youth in the general population (Olsson, Bond, Burns, Brodrick, & Sawyer, 2003; Short & Russell-Mayhew, 2009; Zolkoski & Bullock, 2012) and, to an extent, refugee youth (De Haene, Grietens, & Verschueren, 2007; Sleijpen et al., 2016), has been documented. There seems to be more focus on youth than adults and the elderly, yet the latter are also considered one of the most at-risk refugee groups (Bemak et al., 2002). For instance, none of the articles reviewed specifically addressed resilience with elderly refugees, a group considered to be resourceful (for wisdom and advice during difficult times). Women are also considered to be strong builders of their families from the African cultural perspective. Addressing resilience in African refugee women and the elderly could be an area of focus for future researchers.

Third, it is worth noting that, in all the reviewed articles, African refugees in resettlement countries either came directly from their home countries or from refugee camps. In some instances, refugees had arrived in the camps at a very young age. This situation may provide different narratives in lived realities, so much so that resilience may be perceived differently depending on where an individual came from. Therefore, resilience factors may need to be interpreted cautiously with consideration of each individual's status before, during, and upon resettlement. In relation to this, future researchers studying resilience in African refugees may also want to examine various groups separately (such as refugees specifically from refugee camps).

Fourth, the length of residency in resettlement and its impact on resilience in African refugees may be another aspect to explore in future research. In all of the reviewed journal articles, the duration of residence in a host country at the time the research studies were carried out varied. For instance, some refugees had lived in the host country for a long period of time after migrating as youth and were now adults with children. Others were as young as 10 years old when they fled their countries to refugee camps; then they were resettled after another 10 years or even longer. Still, some arrived as children and were now in high school or college. Given these diversities, some refugees may rely on memory to determine their resilience in the midst of several risks. This author also speculates that resilience may be understood and defined differently for someone who experienced adversities at various periods, for instance 10 years ago compared to one who may be a new arrival from a country of origin or from a refugee camp. Therefore, in further understanding of resilience in African refugees, duration of residence in a resettlement country may be another area for consideration.

Implications for Practice

From a practical standpoint, mental health counselors and service providers working with African refugees may need to consider the following: (a) exploring what resilience *means* and *what* it may *look like* from refugees' cultural perspectives; (b) seeking to help African refugees of all ages access more opportunities to interact with each other (e.g., sports activities for youth, women's groups such as crafting or sewing); and (c) advocating for longer periods of government support (such as financial) for refugees to be able to attain self-efficacy in their daily activities. The financial aspect may be particularly salient for refugees as they navigate the systems and various agencies seeking employment in a new environment. In working with refugee youth (including unaccompanied minors), counselors or school personnel may consider ways to help them form groups amongst themselves as a continuation of the closely-knit support systems they may have created to depend on each other for their own survival (Goodman, 2004). One way to accomplish this may be to design big brother or big sister groups whereby older refugee youth can act as leaders as they engage in various activities at the community or school level for emotional support. This intervention may be important because refugee youth have been shown to depend more on friends and peers from their own cultural background than those in their new culture (Weine et al., 2014)

Additionally, mental health counselors need to have an awareness of culturally-bound explanations of problems and ways of coping among African refugees. Without this, it would be premature to assume that what a refugee may be experiencing (e.g., somatic complaints, anxieties, and other manifestations) are necessarily related to previous experiences. Respecting and honoring ways of understanding and explaining their experiences, feelings, and manifestations may provide avenues to engage with within-group refugee resources. For instance, at the refugees' community level, community elders may be the first go-to persons when someone is experiencing difficulties and is in need of support. As previously observed in a sample of Sudanese refugees, it appears that, from a cultural perspective, these elders are considered *counselors* in the *Sudanese way of counseling*. Therefore, mental health counselors may serve African refugees' needs better by seeking various ways to involve whatever forms of within-community resources are available for their own well-being. For the few who may seek professional counseling services, the elders (or sometimes aunties, uncles, older siblings) may serve as adjuncts to services provided beyond the counseling environment.

Further, it is essential for mental health and other service providers to respect African refugees' religious or spiritual affiliations. For refugees who may not be aware of available opportunities to practice their religious or spiritual beliefs, mental health providers can help connect them to available religious or spiritual resources in the community, be it church, temple, or mosque locations, or provide them with information about religious leaders who may be more familiar with their cultural backgrounds. The need for counselors to respect the various affiliations may be particularly important when working with refugees who identify as Muslims because of the wave of Islamophobia (Betancourt et al., 2015; Haffejee, 2015) and other negative outcomes that some groups who identify with this religion have had to experience post 9/11 and other global occurrences. There is an underlying potential for countertransference to occur at various times as the refugees navigate the different agencies for their needs. Also, counselors

may need to be aware of the different meanings of religion or spirituality to specific African refugee groups (including youth/adolescents, adults, and the elderly). For instance, it may not be surprising to find parents fully immersed in religion or spirituality practices while their children are not affiliated in any way. This awareness may be particularly necessary because research findings on resilience across cultures with youth from different continents indicated that

> spirituality . . . and attendance at religious events were valued differently and meant different things to children in different contexts, making it difficult to say with certainty whether consistent attendance at a place of worship, having well-articulated . . . spiritual beliefs were equally important aspects to resilience for each population studied. (Ungar, 2008, p. 229)

Conclusion

This research review explored findings on the subject of resilience in African adolescent and adult refugees. For African refugees (just like other refugee populations from other continents), the lived experiences of loss at multiple levels and a host of other negative experiences place them at risk in developing serious mental health problems. In spite of this fact, not all refugees are negatively impacted by their experiences. Several sources of resilience account for such an outcome. By providing these research review findings, the intention is to add to the conversations around examining resilience in African refugee groups, particularly because this area is still developing in comparison to studies that have explored pathological aspects in African refugees. Even within the same group, resilience research with adults is clearly lacking. At a time when refugee resettlement in developed countries has been steadily increasing, investigating resilience in African refugees can increase awareness and competence in culturally appropriate intervention strategies when working with this population.

Table 1

Studies Included in Review

Study, Author(s), and Year	Risk Factors	Protective Factors (Sources of Resilience)
Carlson, Cacciatore, & Klimek (2012)	During transit: Separation from family members, witnessing death of peers during transit Refugee camp: starvation and witnessing killings in refugee camps, malnutrition, dehydration Post-migration: health problems (developed during transit)	Individual factors: easy temperament, belief in a higher power or religiosity, good coping skills (positive attitude, outgoing personality, willingness to help others despite individual problems, exercise), strong desire for education Family factors: loving foster family environment Community factors: support from community resettlement agency, strong connection to people with same culture Contextual factors (i.e., community connections): Only one case study, difficult to generalize

Study, Author(s), and Year	Risk Factors	Protective Factors (Sources of Resilience)
Rana, Qin, Bates, Luster, & Saltarelli (2011)	Post-migration: learning a new language, different curriculum in school, low educational expectations from teachers, mental health problems (PTSD, depressive symptoms, somatic complaints,) racism and discrimination	Individual factors: motivation and focus (desire to succeed, hard work, perseverance, self-efficacy in dealing with problems) Family factors: support from foster parents Peers: support from peers (from same culture) Community factors: resources (e.g., private tuition) and opportunities
Goodman (2004)	Pre-migration: violence, death, hunger, thirst. powerlessness During transit: hostile territories (enemies along the way), dangers from wild animals, diseases, hunger Refugee camp: food shortages, hopelessness and powerlessness, constant fear of death	Community and sense of collectivity (support from elders and larger refugee community). **NOTE:** Sense of collective coping and identity, depended on each other to survive, even in adversity, they knew they were together and no one was in it alone. Suppression and distraction Belief in power of God Hope (after resettlement) for the future through education
Haffejee (2015)	Pre-migration: witnessing rape and death of family members During transit: violence in camps, hunger and starvation, recurrent flashbacks, nightmares, isolation Post-migration: lack of understanding from teachers, racism, discrimination, Islamophobia	Support from parents Biculturalism, cultural/ethnic traditions and values, support from parents and guardians, self-determination to be successful through education and help those who were left behind
Betancourt et al., (2015)	Pre-migration: alienation from family members Post-migration: unemployment, poverty, change in family roles, loss of status, new culture, harassment, discrimination, language barriers, acculturative stress, cultural loss	Religion Community resources/connectedness
Schweitzer, Melville, Steel, & Lacherez (2006)	Pre-migration: separation from family members, witnessing killings (of family and friends), isolation, rape During transit: health problems, sexual abuse, lack of shelter Post-migration: unemployment, new culture, racial discrimination, challenges with immigration process, challenges accessing healthcare services	Social support (family, community)

Study, Author(s), and Year	Risk Factors	Protective Factors (Sources of Resilience)
Sherwood & Liebling-Kalifani (2012)	Pre-migration: witnessing violence (physical and sexual), torture, death of family members/loved ones shame, anger, guilt, powerlessness Post-migration: isolation, uncertainty about the future, unemployment	Positive thinking and self-talk Religion Support (family, friends) Education
Khawaja, White, Schweitzer, & Greenslade (2008)	Pre-migration: lack of basic needs (food, water, medical needs, shelter), separation from loved ones, separation and/or death of family members, disruption of daily routines (education, employment), physical trauma (torture, beatings, interrogations), fear, persecution, witnessing violence and death Transit: lack of basic needs (food, water, shelter, healthcare, loss (separation from family members), death of loved ones, disruption of daily routines (e.g., education), physical and psychological violence, racism, abuse, instability, fear of the future Post-migration: perceived racism, lack of environmental mastery, financial difficulties, social isolation	Religion Social support networks (family, friends, neighbors) Reframing of circumstances (inner strength, belief "not the only one going through this" Hope for the future Reliance upon government services
Weine et al. (2014)		Family (parents, older siblings, extended family) School teachers, staff, coaches Church Health and mental health providers

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